ABSTRACT

Title: COUPLE THERAPY: DOES IT IMPROVE INDIVIDUAL AND RELATIONAL WELL-BEING IN COUPLES EXPERIENCING MILD TO MODERATE AGGRESSION?

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The present study examined effects of couple therapy in improving partners' emotional comfort regarding couple conflict-resolution communication and trust in each other, within a sample of 55 couples that experiencing psychological aggression and mild to moderate physical aggression in their relationships. This secondary analysis was conducted on previously collected data from a treatment outcome study that already had shown evidence that the couple therapy had reduced aggressive behavior and increased partners' relationship satisfaction. Paired *t*-tests comparing pre- to post-therapy indicated that women improved on all measures of well-being; men improved on measures of trust and positive mood, but not in state anxiety. Women's changes in positive mood and anxiety, but not their level of trust, were associated with some changes in their partner's level of physical and psychological aggression. Men's changes in all three measures of well-being were associated with changes in their partner's level of physical and psychological aggression.

COUPLE THERAPY: DOES IT IMPROVE INDIVIDUAL AND RELATIONAL WELL-BEING IN COUPLES EXPERIENCING MILD TO MODERATE AGGRESSION?

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CHAPTER 1: INTRODUCTION

Statement of the Problem

Some professionals and lay people have feared that couple therapy with couples experiencing physical and psychological aggression in their relationship can place recipients of aggressive acts in danger of being victimized further. This is especially true if therapists take the perspective that both partners are responsible for relationship problems and for the occurrence of aggression. Risk from couple therapy also is anticipated because topics discussed during sessions may elicit subsequent retaliatory violence by an abusive partner after sessions. However, several studies have found couple therapy to be effective in treating aggression (Fals-Stewart, Kashdan, O'Farrell, & Birchler, 2002; LaTaillade, Epstein, & Werlinich, 2006; O'Leary, Heyman, & Neidig, 2002). In addition, studies have found that couple therapy with couples experiencing low to moderate aggression not only reduces aggression but also increases relationship satisfaction (Stith, Rosen, McCollum, & Thomsen, 2004). Furthermore, studies have found that physical and psychological aggression often go hand-in-hand, and that psychological aggression can be just as detrimental as physical aggression (Coker, Smith, Bethea, King, & McKeon, 2000; Follingstad, Rutledge, Berg, Hause, Polek, 1990). Therefore, it is important to examine and address both physical and psychological aggression when studying and intervening with effects of aggression in couples.

In addition, aggression in couple relationships has been associated with a variety of negative mental health outcomes, including post-traumatic stress disorder, depression, and anxiety (Astin, Lawrence, & Foy, 1993; Holtzworth-Munroe, Smutzler, & Sandin, 1997). This correlation seems to be particularly present for women. Sackett and Saunders

(1999) conducted a study with battered women and found that psychological and physical abuse both independently contributed to women's depression and lowered self-esteem. Furthermore, incidents of aggression detract from the quality of the couple relationship, undermining individuals' views that their partner can be trusted and that their relationship is a safe environment. Not only can being a victim of aggression lead to the development of anxiety disorders; it also may result in partners being wary of interacting with each other in a context in which disagreement may elicit psychologically or physically violent outbursts.

Given the association between intimate partner violence and psychological and relationship well-being, this study was designed to test the effectiveness of couple therapy in reducing partners' anxiety associated with their anticipation of discussing conflictual issues in their relationships, as well as improving their trust in each other, within a sample of couples that had experienced prior mild to moderate aggression in their relationship. Prior research has not investigated the effectiveness of couple therapy in reducing partners' anxiety associated with communicating with each other, increasing their comfort with such communication, and increasing their trust in each other.

Purpose

The purpose of this study was to examine the effects of couple therapy on the well-being of a sample of couples that have experienced psychological aggression and mild to moderate physical aggression in their relationship. Specifically, the study examined changes over the course of therapy in the levels of anxious and positive moods that members of couples experienced when they knew they were about to have a problem-solving discussion with their partner regarding a conflict topic. In addition, it

assessed changes in individuals' levels of trust in their partner. Given the negative impacts that aggressive behavior commonly has on partners' well-being within their relationships, it appeared possible that couple interventions focused on helping partners mange conflict constructively and reduce aggression would reduce anxiety about discussing conflictual topics, increase comfort with such interactions, and increase partners' trust in each other. Furthermore, it was expected that actual changes in the level of aggression in couples' relationships would be associated with improvements in partners' anxious moods, positive moods, and trust.

The study was a secondary analysis of data previously collected for a study that has evaluated effects of couple therapies for couples experiencing psychological and mild to moderate physical abuse. The effects of several different couple therapy theoretical models (e.g., cognitive-behavioral therapy, emotion-focused therapy, narrative therapy) were assessed, but each of these types of therapy was not compared to the others for individual effectiveness, because the sample from the original study did not include a sufficient number of cases for each model to allow such comparisons. The treatment received by couples did not target or directly seek to reduce partners' anxiety, increase their positive moods, or increase their trust, so the present study investigates some important positive "side effects" that the couple interventions may have on the individual members.

In addition, the study explored whether or not improvements that were examined differed between male and female partners. The study was an attempt to fill a gap in research, because no studies had explored the effectiveness of therapy in reducing state anxiety or increasing positive affect and trust in a population of couples that have

experienced aggression in their relationships. The findings from this study might help increase therapists' awareness of the effects that couple therapy can have on the well-being of individual partners in a relationship. Results of this study might also have implications for therapists' decisions regarding the degree to which couple therapy is sufficient to improve emotional well-being or whether partners may need supplemental individual therapy to address difficulties with their personal psychological functioning.

Literature Review

Theoretical base. The hypothesis that a decrease in the level of couple aggression would be associated with an improvement in emotional well-being and trust in one's partner was based on a family systems framework. The major assumptions of systems theory indicate that all parts of a system are interconnected, that understanding is only possible when viewing the system as a whole, and that the behaviors within a system affects its environment, and vice versa (White & Klein, 2008). These assumptions apply directly to the study and understanding of intimate relationships, the factors that lead to aggressive behaviors, and the consequences these behaviors can have on partners' emotional well-being.

There are several specific concepts in systems theory that apply to this research. The concept of *system* is one of the most important to understanding couple interaction. White and Klein (2008) define a *system* as "a unit that can be distinguished from and that affects its environment" (p.158). In other words, a system is separate from the environment it is part of and has the ability to interact with the environment and have an effect on it. A couple relationship is a system that may be part of a larger system, such as a nuclear family, and what happens in the relationship can affect the environment of

which the couple is a part. Another important concept is *rules of transformation.* This concept refers to the relationship between two parts of a system (White & Klein, 2008), such as the two partners in a couple system. A rule of transformation for this system might be that when one member of the couple criticizes the other, the criticized person acts aggressively in return. This concept involving reciprocity might help to understand some of the negative changes that take place in a couple relationship. The systems theory concept of *feedback* also can be helpful in understanding the dynamics in distressed couple relationships such as those examined in this study. The feedback concept focuses on circular processes among components within a system, as well as between the system and its environment; each part of the system receives input from other parts and creates output. For example, a husband who has a bad day at work may come home and be verbally aggressive toward his wife. The wife's internal sense of well-being is affected by that aggressive input, and she may respond by becoming irritable with her children or extended family. Systems theory distinguishes between negative and positive forms of feedback. Negative feedback restrains or reduces movement toward change, as when a parent's threat of punishment results in a child stopping an aversive behavior. In contrast, positive feedback enhances an existing behavior, as when one member of a couple criticizes the other's behavior and the other member responds by spitefully escalating the behavior. Such concepts are useful for conceptualizing patterns of aggressive behavior in couple relationships.

Effects of physical and psychological aggression on victims. A link has been established between the occurrence of aggression in relationships and negative psychological outcomes. Several studies have examined the occurrence of negative

outcomes among individuals who *engage* in aggressive behaviors in their relationship, as well as implications for those who are *victims* of this relationship aggression. For the purposes of this study, poor psychological functioning as a risk factor for behaving aggressively will not be examined and that literature will not be discussed further.

The partners of aggressive individuals exhibit symptoms of trauma, depression, anxiety, and lowered overall well-being. Studies have found that an immense burden is placed on the physical and mental health of victims of interpersonal violence (Dutton et al., 2006). Golding (1999) conducted a meta-analysis of literature on mental health outcomes for women who experience intimate partner violence. It was found that the mean prevalence of depression was 47.6%, for suicidality it was 17.9%, for PTSD it was 63.8%, for alcohol abuse it was 18.5%, and for drug abuse it was 8.9%. Aguilar and Nightingale (1994) examined the self-esteem of 48 battered women as compared to 48 non-battered women. They found that the battered women experienced lower self-esteem than the non-battered participants. Randle and Graham (2011) reviewed literature on the effects of intimate partner violence (IPV) on men and found that men experience significant psychological consequences as victims of IPV. They found associations between IPV and symptoms of PTSD, depression, and suicidal ideation.

Although much research in the past has studied the impact of physical abuse on a victim, it is also clear that psychological abuse can be just as detrimental. Several studies have demonstrated the impact that psychological aggression can have on a victim. Coker and colleagues (2000) studied the prevalence of intimate partner violence and its effects among women seeking primary health care. They found that 53.6% of women had experienced partner violence and that women experiencing psychological violence were

significantly more likely to suffer poor physical and mental health. More specifically, psychological violence was associated with several negative health outcomes, including a disability that prevented them from working, chronic pain, migraine and other frequent headaches, stammering, sexually transmitted infections, chronic pelvic pain, spastic colon, and frequent indigestion, diarrhea, or constipation.

Lawrence and colleagues (2009) studied the impact of psychological aggression on symptoms of depression and anxiety in the early years of marriage. A total of 103 recently married couples living in the Midwest participated in the study. Husbands were on average 26.4 years of age, whereas wives averaged 25 years of age. The modal joint couple income was in the $35,001 to $45,000 income bracket. Ninety-five percent of husbands and 94% of wives were Caucasian. Couples completed measures of psychological abuse (*Multidimensional Measure of Emotional Abuse Scale*; Murphy & Hoover, 1999), physical abuse (*Conflict Tactics Scale-2*; Straus, Hamby, Boney-McCoy, & Sugarman, 1996), depression (*Beck Depression Inventory-II*; Beck, Steer, & Brown, 1996), and anxiety (*Beck Anxiety Inventory*; Beck, Epstein, Brown, & Steer, 1988). Measures were collected at four time points between 3 and 33 months into the marriage. They found that to the extent that psychological abuse increased, so did symptoms of anxiety and depression. This study suggests that psychological abuse is as detrimental and might be even more detrimental than physical abuse for psychopathology and emotional distress symptoms among couples.

Taft and colleagues (2006) examined the relationships between psychological aggression and depression, anxiety, and physical health symptoms. Participants were 145 couples in which 99% of the females were Caucasian and averaged 39.7 years of age and

had completed an average of 14.9 years of education. Ninety-four percent of the males were Caucasian, they averaged 41.6 years of age, and they had completed 14.7 years of education, on average. Physical and psychological forms of aggression were measured using the *Conflict Tactics Scale* (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) and the *Psychological Maltreatment of Women Inventory* (Tolman, 1989). Psychological symptoms were measured using the *Brief Symptom Inventory* (BSI; DeRogatis, 1993), specifically the BSI Global Severity Index and the depression and anxiety subscales. Physical health symptoms were assessed using the physical symptom subscale of the *Health and Daily Living Form* (Moos, Cronkite, Billings, & Finney, 1984). Results showed that receiving higher levels of psychological aggression was associated with greater psychological distress, anxiety, and physical health symptoms in both men and women. Additionally, psychological aggression was associated with higher levels of depression in women.

Common couple violence. Johnson (1995) conducted a review of the literature on couple violence and found that it is possible to categorize couple violence into different types. Reviewing data from community surveys as well as shelter populations, Johnson argues that couple violence can be categorized as either patriarchal terrorism or common couple violence. Patriarchal terrorism, according to Johnson, refers to the type of violence that has for a long time been studied by feminist researchers and is based on the patriarchal belief that men should be able to control their wives. This type of violence often manifests in the form of "violence, economic subordination, threats, isolation, and other control tactics" (Johnson, 1995, p. 284). Common couple violence, on the other hand, refers to the much more frequently occurring level of aggression that occurs

between members of couples when they are interacting regarding areas of conflict in their relationships. It involves physically aggressive acts of relatively mild to moderate severity (e.g., pushing, grabbing, slapping) that rarely escalate to more severe acts. Johnson (1995) also notes that common couple violence tends to be perpetrated equally by women and men. The term “common couple violence” is not used in an evaluative sense (i.e., it does not suggest that the violence is acceptable) but only in a statistical sense, meaning that unfortunately such aggressive behavior in fact has been demonstrated to be common.

Graham-Kevan and Archer (2003) designed a study that would replicate and extends Johnson's (1995) work. In their study, participants included 43 females in a domestic violence shelter, 104 mixed-sex students, 4 men attending a treatment program for domestic violence, and 97 male inmates from a prison in England. Each participant reported on their own behavior, as well as their partner's. Participants ranged in age from 16-65 years with a mean age of 33 years. Partners' age range was very similar. Length of relationship ranged from 1 to 504 months, with a mean of 104 months.

A wide variety of measures were used in the study. The researchers measured the use of controlling behaviors with the Controlling Behaviors Scale (CBS), which they had designed. They measured the frequency of acts of physical aggression using eight items of the 17-item Aggression subscale of the CTS (Straus, 1979). Level of escalation was measured using the item, “During the time you and your partner have been/were together, has the use of physical force increased, stayed the same, or decreased?” Finally, severity of violence was measured using two items that were developed by Morse (1995) and that were introduced in the following way: “Regarding the past year with your partner, or the

last year you were with your partner, please answer the following questions: 1. How many times were you (your spouse/partner) physically injured (e.g., knocked down, bruised, scratched, cut, choked, bones broken, eyes or teeth injured?); 2. In how many of these fights in which you (your spouse/partner) were physically injured did you (he/she) go to the doctor, clinic, or hospital for medical treatment?" Results showed support for Johnson's (1995) previous findings, in particular the existence of both intimate terrorism (patriarchal terrorism) involving frequent, escalating, non-reciprocal violence perpetrated primarily by males, and common couple violence involving less frequent, non-escalating, milder, reciprocal violence.

Couple therapy for aggression. Numerous studies have found that couple therapy can be effective in treating a variety of problems regarding both individual functioning and relationship issues (Baucom et al., 1998; Johnson & Lebow, 2000). The range of problems that have been effectively treated by couple therapies is wide, from marital distress to obsessive compulsive disorder, agoraphobia, and sexual dysfunctions (Baucom et al., 1998). Researchers have also found couple therapy to be effective in treating depression, both when compared to no treatment and to other forms of treatment, including individual therapy for the depressed partner (Beach & O'Leary, 1992; Gilliam & Cottone, 2005; Gupta, Coyne, & Beach, 2003; O'Leary & Beach, 1990).

Studies have also found couple therapy to be effective for couples experiencing physical and/or psychological aggression. In the past, most treatment for couple aggression was delivered to each member separately (i.e., group therapy for individuals who were identified as abusive to their partners and separate group therapy for victims of partner aggression), and this approach has been labeled "gender-specific" because it

typically involved separate groups for male perpetrators and female victims. More recently studies have looked at the efficacy of conjoint couple therapy for aggression. O'Leary and colleagues (1999) compared individual gender-specific therapy with a conjoint couple group therapy for psychological and physical aggression. Participants included 75 volunteer couples, most of whom were Caucasian and had a mean family income of $51,454. Women were on average 36.24 years old, whereas the mean age for men was 38.40. They found that wives participating in conjoint therapy were not fearful of participating with their partners, and during sessions they did not blame themselves for the violence. In addition, participants in both groups reduced their physical and psychological abuse. Significant improvements were also found for both spouses' marital adjustment, husbands' taking responsibility for aggression, and wives' depression. This study suggests that conjoint therapy is just as effective as gender-specific therapy in the reduction of psychological and physical aggression, and it also improves partners' individual psychological functioning. The study also demonstrated that when careful screening is used to select couples for conjoint treatment the danger of therapy eliciting violence is low.

A study by Dunford (2000), the San Diego Navy Experiment, evaluated the effectiveness of cognitive-behavioral interventions for male batterers. Participants were randomly assigned to a men's group, a conjoint group (in which couples received treatment with other couples), a rigorous monitoring group, or a control group. The men's group used a cognitive-behavioral approach, and participants met weekly for the first six months, then monthly for the next six months. The sessions included a didactic portion in which participants were taught several skills, including communication, empathy

enhancement, and anger management. Group leaders focused on the perpetrator's values and attitudes toward women and violence. The second part of the session was devoted to processing issues that came up. The conjoint group was organized similarly and included 26 weekly sessions followed by six monthly sessions that were also cognitive-behaviorally based and very similar to the men's group sessions. The only difference between this group and the men's group was the presence of wives in this group. The goal of the rigorous monitoring group was to hold abusers accountable for their behavior toward their wives. Participants had monthly individual sessions for a year, and their wives were contacted monthly to inquire about any new instances of abuse. Commanding officers were kept informed of any ongoing abuse. The control group did not receive any treatment. The wives in each of the four groups all received safety planning information. No differences in victims' or perpetrators' reports of abuse or official arrest records were found among the groups, suggesting that conjoint therapy is not an inferior intervention for couple abuse. The results also suggest that rigorous monitoring of the abusive partner might be equally as effective as other treatments, but the authors did not discuss what might have happened once the commanding officers stopped monitoring the couples, which could be an important concern.

Although researchers have found that conjoint couple treatments that specifically focus on reducing aggression are effective (Stith, Rosen, McCollum, & Thomsen, 2004), other studies have also examined the effectiveness of couple therapy that is not specifically aggression-focused in reducing aggressive behavior. Such therapies are representative of typical couple therapy, focused on general relationship problems, and not designed to treat aggression in the relationship. Simpson and colleagues (2008)

studied the effect of non-aggression-focused behavioral therapy for couples with and without a history of mild aggression. One hundred thirty-four couples were randomly assigned to one of two behavioral couple therapies. The mean age was 41.5 years for wives and 43.4 for husbands. Seventy-six percent of wives and 79% of husbands were Caucasian. Couples participated in up to 26 weekly sessions that had to be completed within one year. Individual adjustment and well-being were assessed using the COMPASS-OP (Howard, Martinovich, & Black, 1997), which is a 57-item self-report measure that provides an overall Mental Health Index; higher scores indicate better functioning. Relationship satisfaction was measured using the *Dyadic Adjustment Scale* (DAS; Spanier, 1976). Relationship aggression was measured using the *Conflict Tactics Scale-2* (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) and the *Frequency and Acceptability of Partner Behavior Inventory* (FAPB; Christensen & Jacobson, 1997). No differences in outcomes (which included relationship satisfaction, as well as individual adjustment and well-being) were found by history of presence versus absence of aggression, and couples maintained very low levels of aggression during and after treatment. These findings suggest that couple therapy can be effective for couples with a history of mild aggression, even if the focus of the therapy is not aggression-reduction.

In summary, the literature in this field has provided some knowledge about aggressive relationships and the effects of couple therapy. Studies have established links between aggression and lowered levels of well-being. Some studies have explored the effect of poor psychological functioning as a risk factor for individuals behaving aggressively in their couple relationships. Many other studies have examined the effect that aggression can have on its victims, suggesting that they are at risk of suffering a

variety of physical and psychological consequences, including anxiety and other psychological problems, as well as poor physical and mental health.

Researchers have also found that conjoint couple therapy can be as effective in reducing aggression as having separate treatment groups for victims and perpetrators. Other studies also suggest that couple therapy can be effective in reducing aggression even when the focus of therapy is not specifically on the treatment of aggression. However, studies did not specifically explore the effectiveness of couple therapy in reducing anxiety that is likely to occur when members of couples that have experienced aggression are anticipating having to interact with each other, especially regarding conflictual issues in their relationship. Neither have prior studies investigated whether couple therapy for aggression has the potential to increase partners' positive moods regarding problem-solving discussions and trust in one's partner. Furthermore, the prior studies had used generally racially homogeneous samples and had not explored the effects of therapy on a diverse population of couples. A goal of the present study was to examine effects of couple therapies on partners' well-being within a more diverse sample of couples.

Hypotheses and Research Questions

Based on prior research on treatments for aggression in couple relationships, the following hypotheses were proposed in the present study:

1) Members of couples receiving couple therapy for treatment of psychological aggression and mild to moderate physical aggression will exhibit a pre-to-post therapy decrease in anxious mood prior to engaging in a discussion with their partner of a conflictual relationship topic.

2) Members of couples receiving couple therapy for treatment of psychological aggression and mild to moderate physical aggression will exhibit a pre-to-post therapy increase in positive mood prior to engaging in a discussion with their partner of a conflictual relationship topic.
3) Members of couples receiving couple therapy for treatment of psychological aggression and mild to moderate physical aggression will exhibit a pre-to-post therapy decrease in distrust of their partner.
4) The degree of decrease in an individual's anxious mood prior to engaging in a discussion with their partner of a conflictual relationship topic will be positively associated with the degrees of decrease over the course of therapy in the partner's levels of psychological and physical aggression.
5) The degree of increase in an individual's positive mood prior to engaging in a discussion with their partner of a conflictual relationship topic will be associated with the degrees of decrease over the course of therapy in the partner's levels of psychological and physical aggression.
6) The degree of decrease in an individual's distrust in his or her partner will be positively associated with the degrees of decrease over the course of therapy in the partner's levels of psychological and physical aggression.

Research question 1: Are there differences between males and females in the degrees to which anxious moods, positive moods, and distrust of partner change over the course of couple therapy?

Research question 2: Are there differences between males and females in the degrees of association between changes over the course of therapy in physical and

psychological aggression and levels of anxious mood, positive mood, and distrust in partner?

The study did not compare effects of different couple therapy models on partners' improvements on well-being, due to an insufficient number of cases that received some of the therapy models.

Table 1. Variables

Independent Variables	**Dependent Variables**
Assessment time	Experiences of partners
Pre-therapy	*State anxiety (PANAS)*
Post-therapy	*Positive affect (PANAS)*
Gender	*Trust (DTS)*
Male	*Physical aggression (CTS2)*
Female	*Psychological aggression (MDEAS)*

Note. PANAS = Positive and Negative Affect Scales; DTS = Dyadic Trust Scale; CTS2 = Revised Conflict Tactics Scales; MDEAS = Multidimensional Measure of Emotional Abuse.

CHAPTER 2: METHOD

Sample

This study involved a secondary analysis of pre- and post-therapy data from heterosexual couples who sought therapy from the Center for Healthy Families, a couple and family therapy clinic housed in the Department of Family Science at the University of Maryland, College Park. The data were collected previously as part of a larger treatment outcome study that examined the effectiveness of couple therapy in the treatment of aggression in couple relationships. All of the data were stored in a large database in the Center for Healthy Families, which includes no information that would reveal the identities of the participants. For the purpose of this study, the investigator had no direct contact with human subjects. Instead, couples' scores were accessed through the database and analyzed. Only scores on the measures directly related to the hypotheses were accessed.

The Center for Healthy Families is an outpatient couple and family therapy clinic located in on the campus of the University of Maryland, in College Park, Maryland. The therapists at the clinic are graduate students who are currently pursuing master's degrees in Couple and Family Therapy. The clinic uses a sliding-fee scale based on the client's income. Fees per session range from $20 to $60. Sessions are typically held once a week. Therapists are trained in a wide range of couple and family therapy models. Couples who participated in the study form a very diverse sample in terms of age, race/ethnicity, and socio-economic background, as they come to the clinic from the diverse population of the communities surrounding the university. Couples are typically referred by friends, schools, county family service centers, or through the court system. Couples sought

therapy for a variety of relationship problems but were found eligible through systematic screening and consented to participate in a study (previously approved by the University of Maryland IRB) that is evaluating different theoretical models of couple therapy for the treatment of psychologically and physically aggressive behavior. Couples were eligible to participate in the original treatment outcome study if they were at least 18 years old and at least one partner reported mild to moderate physical abuse during the past 4 months (that did not result in injury requiring medical treatment) as measured by the *Revised Conflict Tactics Scale* (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) and/or psychological abuse as measured by the *Multidimensional Measure of Emotional Abuse Scale* (MDEAS; Murphy & Hoover, 2001). Couples also had to express an interest in working on their relationship, spend time together each week, and not be receiving concurrent couple treatment elsewhere. They were ineligible to participate if the level of aggression in their relationship was more than mild to moderate; i.e., they had sustained any injuries due to violence in the relationship, that required medical treatment, the violence involved the use of weapons, or they had ongoing untreated substance abuse problems. Couples were assigned randomly to either a cognitive-behavioral couple therapy protocol or to usual treatment at the clinic, which consists of any other couple therapy model used at the clinic (e.g., solution-focused therapy, emotion-focused therapy, narrative therapy). The treatment received by couples did not target or directly seek to reduce psychopathology symptoms in each member of the couple.

The sample for this study consisted of 55 couples. The mean age for women was 31.4 (*SD=7.7*), and for men it was 33 (*SD=7.53*). Couples reported having been together for an average of 6.03 years. In regard to race/ethnicity of the female participants, 19.6%

identified as African American, 5.4% as Asian/Pacific Islander, 12.5% as Hispanic, 55.4% as Caucasian, and 5.4% as Other. Of the male participants 1.8% identified as Native American, 17.9% as African American, 5.4% as Hispanic, 64.3% as Caucasian, and 8.9% as Other. Women reported an average yearly gross income of $26,523, whereas men reported an average yearly gross income of $45,308. Table 2 presents relationship status data as reported by the participants, Table 3 presents participants' current employment status, and Table 4 presents participants' highest level of education.

Table 2. Relationship Status of the Sample

Relationship Status	**Percent**	**Frequency**
Currently married, living together	55.4%	31
Currently married, separated	3.6%	2
Living together, not married	25.0%	14
Dating, not living together	14.3%	8

Table 3: Employment Status of the Sample

	Women		**Men**	
Employment Status	**Percent**	**Frequency**	**Percent**	**Frequency**
Employed full time	51.8%	29	76.8%	43
Employed part time	17.9%	10	12.5%	7
Homemaker, not employed outside home	12.5%	7	0.0%	0
Student	8.9%	5	5.4%	3
Unemployed	7.1%	4	1.8%	1

Table 4. Education Level of the Sample

	Women		Men	
Level of Education	**Percent**	**Frequency**	**Percent**	**Frequency**
Some high school	5.4%	3	5.4%	3
High school diploma	8.9%	5	21.4%	12
Some college	25.0%	14	14.3%	8
Associate Degree	5.4%	3	5.4%	3
Bachelors Degree	16.1%	9	17.9%	10
Some graduate education	8.9%	5	12.5%	7
Masters Degree	16.1%	9	16.1%	9
Doctoral Degree	5.4%	3	5.4%	3
Trade school	7.1%	4	0.0%	0

Measures

This study used a subset of a standard set of measures completed by couples before they begin treatment at the clinic, as well as at the end of 10 double sessions of therapy: the *Positive and Negative Affect Schedule* (PANAS; Watson et al, 1988); the *Dyadic Trust Scale* (DTS; Larzelere & Huston, 1980); the *Conflict Tactics Scale, Revised* (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996); and the *Multi-Dimensional Emotional Abuse Scale* (MDEAS; Murphy & Hoover, 2001). The PANAS and DTS were used as measures of individual functioning and well-being because they were the measures that were administered to this clinical population.

The Positive and Negative Affect Schedule (PANAS) is a 22-item measure of affect originally developed by David Watson and colleagues (1988) and modified slightly for this population. It is comprised of adjectives that comprise 2 mood scales, one

positive and one negative. Participants are asked to indicate the extent to which each adjective describes the way they have been feeling, using a 5-point response scale ranging from 1 = very slightly or not at all to 5 = extremely. The PANAS has been used in previous studies to measure affect during different time periods, including today, the past week, the last few weeks, etc. In the present study, participants were asked to rate how they felt at this very moment. They were asked to complete the PANAS immediately prior to engaging in a 10-minute discussion regarding a topic that they disagree on, and with their consent their discussion was video recorded. Following the 10-minute conversation, participants were asked to complete the PANAS again.

Examples of items measuring positive affect are: 1) *interested,* 3) *excited,* 5) *strong,* and 9) *enthusiastic*. A total Positive Affect score is obtained by adding scores on all 11 positive items. The Cronbach alpha coefficients for the Positive Affect index were .91 for both women and men. For this study, an Anxiety index was created, using 6 of the negative mood items, which included *2) distressed, 4) upset, 7) scared, 16) nervous, 19) jittery, and 21) afraid*. The Cronbach alpha coefficients for this Anxiety index were .90 for both women and men. Watson and colleagues (1988) also have found the PANAS to have good internal consistency. Cronbach alpha coefficients have been found to range from .86 to .90 for the Positive Affect scale, and .84 to .87 for the Negative Affect scale. They also have also found that measures of distress and dysfunction, depression, and state anxiety are more highly correlated with the Negative Affect scale than with the Positive Affect scale.

Individuals' level of trust in their partner was measured using the Dyadic Trust Scale (DTS), which was developed by Larzelere and Huston (1980) to measure trust in

close relationships. It is an 8-item scale asking participants to rate their feelings about their partner on a 5-point scale ranging from 1 = disagree strongly to 5 = agree strongly. Five out of the eight items are reverse scored; a higher score implies a higher level of *distrust* in one's partner. Examples of items are: 2) *There are times when my partner cannot be trusted,* 3) *My partner is perfectly honest and truthful with me*, 7) *My partner treats me fairly and justly,* and 8) *I feel that my partner can be counted on to help me.* The DTS has demonstrated high reliability, with a Cronbach alpha of .93 and with item-total correlations ranging from .72 to .89 (Larzelere & Huston, 1980). Convergent validity was established by significant correlations between dyadic trust and love and depth of self-disclosure. Discriminant validity was established by low correlation with general trust and social desirability.

Physically abusive behavior was measured in the original study, from which the data for the present study were drawn, using the *Conflict Tactics Scale, Revised* (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). The CTS-2 examines both the presence and the severity of physical and psychological abuse in relationships. It consists of 39 pairs of items arranged into 5 subscales: Negotiation (positive interaction rather than aggression), psychological aggression, physical assault, sexual coercion, and injury. Each pair of items asks participants to rate how many times in the last 4 months they engaged in the behavior described, and how many times their partner did so. Cronbach alpha internal consistency for the scales has been found to range between .75 and .95 (Straus et al., 1996). Examples of items include: *1. I showed my partner I cared even though we disagreed, 2. My partner showed care for me even though we disagreed* (negotiation); *5. I insulted or swore at my partner, 6. My partner did this to me*

(psychological aggression); *9. I twisted my partner's arm or hair, 10. My partner did this to me* (physical assault); *15. I made my partner have sex without a condom, 16. My partner did this to me* (sexual coercion); *55. I had a broken bone from a fight with my partner, 56. My partner had a broken bone from a fight with me* (injury). In this study the physical assault and injury subscales were used to assess physical aggression. Physical assault includes all physical acts intended to hurt or scare one's partner. The Injury subscale refers to partner-inflicted injury "as indicated by bone or tissue damage, a need for medical attention, or pain continuing for a day or more" (Straus, Hamby, Boney-McCoy, & Sugarman, 1996, p. 290). These subscales can be found in Appendix A.

Finally, psychological abuse was measured using the *Multi-Dimensional Emotional Abuse Scale* (MDEAS; Murphy & Hoover, 2001). The MDEAS is a 28-item measure used to assess psychologically abusive behaviors in the relationship. Items are arranged into four subscales: Hostile Withdrawal, Denigration, Dominance/Intimidation, and Restrictive Engulfment. Hostile Withdrawal is described as "the tendency to withhold emotional contact and withdraw from the partner in a hostile fashion." Denigration refers to "humiliating and denigrating behaviors." Dominance/Intimidation is described as "threats, property violence, and intense displays of verbal aggression." Restrictive Engulfment refers to "behaviors intended to isolate the partner and restrict the partner's activities and social contacts, along with intense displays of jealousy and possessiveness." Participants are asked to rate how often in the last 4 months they and their partner have each engaged in the described behaviors. Cronbach alpha internal consistency for the scale has been found to range between .83 and .92 (Murphy & Hoover, 2001). Examples of items are: *15. Became so angry that s/he was unable or unwilling to*

talk (hostile withdrawal); *8. Said or implied that the other person was stupid* (denigration); *23. Put her/his face right in front of the other person's face to make a point more forcefully* (dominance/intimidation); 3. *Tried to stop the other person from seeing certain friends or family members* (restrictive engulfment). A total MDEAS score can range from 0 to 168 with higher scores indication greater levels of psychological abuse, In this study, each subscale was used separately to test the hypotheses regarding the association between change in aggression and changes in emotions and trust. These subscales can be found in Appendix A.

Procedure

This study involved secondary analysis of previously collected data. As part of the original therapy outcome study, couples completed assessment forms at the beginning of treatment and again at the completion of treatment. Treatment consisted of ten 90-minute sessions, completed within 4 ½ months from the time treatment started. Included in the assessment forms were measures of relationship quality, individual psychological functioning, communication patterns, and abusive behavior. This study examined participants' answers on the PANAS and DTS at two different time points: pre-treatment and post-treatment. In addition, looking at scores on the CTS2 and MDEAS, respectively, changes in level of physical and psychological violence from pre- to post-assessment were measured. The changes in aggression scores were examined in relation to changes in anxiety, positive moods, and distrust.

CHAPTER 3: RESULTS

Overview of Data Analyses

The present study used data previously collected and entered into an SPSS file. Variables had previously been coded, and this study used the PANAS Positive Affect, Anxiety, and DTS total score variables at pre- and at post-therapy assessment points. Paired *t*-tests were used because individuals' pre-therapy and post-therapy scores were not independent of each other; they were from the same sample of participants at different points in time. In addition, changes in levels of physical and psychological aggression were analyzed by using total subscale scores for the MDEAS and CTS-2, measuring change from pre- to post-therapy. Because the study focused on change over time, change scores were created by subtracting pre-therapy scores from post-therapy scores for each of the variables of interest. Finally, Pearson correlations were computed to test the hypothesized associations between reductions in physical and psychological aggression in the relationship and corresponding improvements on the measures of anxiety, positive mood, and distrust. For all of the tests of the hypotheses (*t*-tests and Pearson correlations), one-tailed tests were used, given that the hypotheses were directional.

Results for Tests of Hypotheses

Hypothesis 1: Members of couples receiving couple therapy for treatment of psychological aggression and mild to moderate physical aggression will exhibit a pre-to-post therapy decrease in anxious mood prior to engaging in a discussion with their partner of a conflictual relationship topic.

For female partners, results of the paired samples *t*-test revealed a significant decrease in state anxiety from pre-therapy (*M = 11.12, SD = 4.97*) to post-therapy (*M = 8.45, SD = 4.03*); *t*(50) = -3.32, *p* = .001. However, for men there was no significant change in state anxiety from pre-therapy (*M = 11.12, SD = 4.92*) to post-therapy (*M = 10.47, SD = 5.55*); *t*(48) = .75, *p* = .23. The hypothesis was supported for women but not for men.

Hypothesis 2: Members of couples receiving couple therapy for treatment of psychological aggression and mild to moderate physical aggression will exhibit a pre-to-post therapy increase in positive mood prior to engaging in a discussion with their partner of a conflictual relationship topic.

For female partners, a significant increase was found in positive affect from pre-therapy (*M = 29.48, SD = 9.9*) to post-therapy (*M = 33.32, SD = 9.89*); *t*(49) = 3.23, *p* = .001. Similarly, for male partners a significant increase in positive affect was found from pre-therapy (*M = 34.77, SD = 8.99*) to post-therapy (*M = 36.96, SD = 8.73*); *t*(47) = 1.84, *p* <.05. The hypothesis was supported for both men and women.

Hypothesis 3: Members of couples receiving couple therapy for treatment of psychological aggression and mild to moderate physical aggression will exhibit a pre-to-post therapy decrease in distrust of their partner.

For female partners, a significant decrease in distrust was found from pre-therapy (*M = 21.75, SD = 7.63*) to post-therapy (*M = 18.48, SD = 8.48*), *t*(51) = -3.69, *p* <.001. Similarly, for male partners, a significant decrease in distrust was revealed from pre-therapy (*M = 18.44, SD = 7.*56) to post-therapy (*M = 15.65, SD = 7.*00), *t*(51) = -3.72, *p* <.00l. The hypothesis was supported for both men and women.

Thus, overall, the results mostly supported Hypotheses 1-3. There were significant improvements in anxiety, positive affect, and distrust for women, as well as in positive affect and distrust for men. Table 5 presents the mean scores on the measures of well-being for men and women from pre- to post-therapy.

Table 5. Mean Scores on Measures of Well-Being for Men and Women From Pre-to Post-Therapy.

	Women		**Men**	
	Mean	***SD***	***Mean***	***SD***
State Anxiety				
Pre-treatment	12.12	4.97	**11.12**	4.92
Post-treatment	8.45	4.03	**10.47**	5.55
Positive Mood				
Pre-treatment	24.98	9.9	34.77	8.99
Post-treatment	33.32	9.89	36.96	8.73
Distrust				
Pre-treatment	21.75	7.63	18.44	7.56
Post-treatment	18.48	8.48	15.65	7

Note. Means in bold were the only non-significant pre-post difference.

Hypothesis 4: The degree of decrease in an individual's anxious mood prior to engaging in a discussion with their partner of a conflictual relationship topic will be positively associated with the degrees of decrease over the course of therapy in the partner's levels of psychological and physical aggression.

The Pearson correlation results indicated that decrease in females' pre-discussion anxiety over the course of couple therapy was positively correlated with the change in females' reports of their male partners' physical assault ($r = .26$, $p < .05$), females' reports of the males' use of hostile withdrawal ($r = .25$, $p < .05$), and females' reports of males'

use of denigration (r = .28, p <.05). The correlations between decrease in females' anxiety and females' reports of males' infliction of injury, domination/intimidation, and restrictive engulfment were not significant.

For male partners, the Pearson correlations indicated that their decrease in pre-discussion anxiety was significantly associated only with the amount of decrease in the males' reports of their female partners' use of restrictive engulfment (r = .30, p <.05). None of the other changes in females' forms of physical and psychological aggression were associated with decreases in males' anxiety prior to engaging in problem-solving discussions with their partners.

Thus, there was partial support for the hypothesis, with no findings that were in the opposite direction to the pattern that had been hypothesized.

Hypothesis 5: The degree of increase in an individual's positive mood prior to engaging in a discussion with their partner of a conflictual relationship topic will be associated with the degrees of decrease over the course of therapy in the partner's levels of psychological and physical aggression.

For females, greater increase in their pre-discussion positive affect from pre-therapy to post-therapy was associated with greater decrease in the females' reports of their male partner's hostile withdrawal (r = -.34, p <.01). There were no other significant correlations between increase in females' positive moods and changes in forms of males' physical and psychological aggression.

For males, increase in their positive affect from pre-therapy to post-therapy was significantly correlated with decrease in the males' reports of their female partners' degree of physically injurious behavior (r = -.31, p <.05) and the females' degree of

physical assault (r = -.28, p <.05). There also was a trend toward the degree of increase in males' positive affect to be correlated with decrease in the males' reports of females' hostile withdrawal (r = .21, p =.08). Males' increase in positive affect was not related to changes in females' other forms of psychological aggression. Thus, there was partial support for the hypothesis, with no findings that were in the opposite direction to the pattern that had been hypothesized.

Hypothesis 6: The degree of decrease in an individual's distrust in his or her partner will be positively associated with the degrees of decrease over the course of therapy in the partner's levels of psychological and physical aggression.

No significant correlations were found between change in females' level of distrust in their male partners and their reports of the males' physical and psychological aggression. In contrast, for the males a significant association was found between decrease in their level of distrust in their female partners and their reports of the females' decreased use of restrictive engulfment (r = .31, p = .01). Trends were found between males' decrease in level of distrust and their reports of females' decrease in hostile withdrawal (r = .21, p <.10), as well as decrease in females' use of denigration (r = .23, p <.10). Thus, there was partial support for the hypothesis, particularly for men, with no findings that were in the opposite direction to the pattern that had been hypothesized.

Table 6 presents these correlational findings regarding associations between changes in individuals' anxiety, positive moods and distrust on the one hand and their partners' physical and psychological aggression.

Table 6. Correlations Between Changes in Positive Affect, Anxiety and Distrust and Changes in Reports of Partner's Physical and Psychological Aggression

	Partner Physical Assault	**Partner Injury**	**Partner Hostile Withdrawal**	**Partner Dominance Intimidation**	**Partner Denigration**	**Partner Restrictive Engulfment**
Women						
Positive Affect	.17	-.04	-.34**	-.16	-.17	-.12
Anxiety	.26*	-.08	.25*	.18	.28*	.16
Distrust	-.15	.19	.16	-.06	.10	.07
Men						
Positive Affect	-.28*	-.31*	.21	.03	.06	-.06
Anxiety	-.16	.02	.04	-.09	.23	.30*
Distrust	.14	.11	.21	.14	.23	.31**

Note. * = $p < .05$, ** = $p < .01$, *** = $p < .001$.

CHAPTER 4: DISCUSSION

Summary of Findings

The following is a summary of the patterns of the findings and their relation to the study's hypotheses. Given that the two research questions asked whether there are any gender differences in the experiences of members of the couples, any gender differences are described and discussed as the findings relevant to each hypothesis are considered. As will become evident, there indeed were some gender differences in the results, especially regarding which changes in partners' aggressive behavior were associated with changes in individuals' pre-discussion moods and overall trust.

The results of this study indicate that significant improvements on measures of well-being (e.g., positive affect, state anxiety, and distrust) occurred for couples participating in therapy for the treatment of physical and psychological aggression. When faced with having a discussion with their partner of a topic that was a source of conflict in their relationship, women reported significantly more positive affect and decreased anxiety just prior to the discussion at post-therapy than they did before therapy. They also reported significantly lower distrust in their partner after couple therapy. Men also reported significantly more positive affect and significantly lower distrust of their partner after couple therapy, but their change in level of pre-discussion anxiety was not significant.

With the exception of the lack of decrease in anxiety for the males, these findings are consistent with the hypotheses presented at the outset of this study, which predicted that couple interventions focused on managing conflict in non-aggressive ways would create a more positive, safe atmosphere in couples' relationships. The findings are also

consistent with the literature in this field. Several studies have found that couple therapy is effective in treating a variety of both individual and relational problems (Baucom et al., 1998; Johnson & Lebow, 2000). Improvements on other measures of well-being, such as measures of depression, obsessive compulsive disorder, and agoraphobia, have been documented by past studies. Female participants in this study were able to improve from pre- to post-therapy on all measures of their well-being that were investigated. In contrast to prior studies that assessed indices of psychopathology such as symptoms of depression and anxiety disorders, the present study focused on the degrees to which therapy made the couple relationship a safer environment, such that partners trusted each other more and had more positive emotions when anticipating engaging in discussions of conflictual issues in their relationship. Interestingly, men did not show significant change from pre- to post-therapy in their level of anxiety when confronted with having a potentially high-conflict discussion with their partner. This finding is consistent with other studies that have found that when assigned to a marital interaction task men exhibit higher cardiovascular response and find the task more taxing than women do. This reaction seems to hold true for men even during common marital tasks, such as collaborative problem solving (Smith et al., 2009). These findings suggest that men tend to be more aroused and anxious when engaging in any type of marital interaction task than women do, and that couple therapy, at least relatively brief therapy such as the treatment provided to the couples in this study, was not sufficient to reduce their arousal. In future research it would be important to investigate whether longer couple therapy has a greater effect on males' anxiety regarding interaction with female partners.

The results of this study also indicated that the increase in women's pre-discussion positive affect is correlated with decrease in their report of their partner's hostile withdrawal, one of the four forms of psychological aggression. Women's decrease in pre-discussion anxiety was associated with their reports of their partner's lower levels of physical assaults, hostile withdrawal, and denigration. Thus, as women perceive that their partners are engaging in less physically and psychologically aggressive behaviors, their positive affect increases and their anxiety decreases when they are about to communicate with their partner about conflictual issues. These significant findings supported the study's hypotheses, suggesting that decreases in aggressive behavior due to therapy contribute to a safer, more positive atmosphere in couples' relationships. Results also suggest that women are more sensitive to partners who withdraw and withhold emotional contact. It seems that a gender difference exists between men's and women's needs for emotional closeness; women's moods are directly associated with their partner's level of emotional engagement, but the same is not true for men.

In contrast, there were no significant associations found between women's trust for their partner and changes in the partner's amount of physical and psychological aggression. Apparently, for women the changes in males' aggressive behavior associated with the couple therapy were insufficient to increase their overall level of trust in their partners, even though the decrease in male aggression was associated with the women's feeling more comfortable discussing conflictual issues with their partners. Perhaps women are more likely to harbor positive and hopeful feelings about a relationship when they feel safer in the relationship and therefore exhibit positive moods when having a discussion with their partner.

However, it seems that trust does not depend solely on the individual feeling safe in a relationship. The literature suggests that trust might be more difficult to build and regain when one has been victimized. McMillan (2001) finds that victimization changes one's perceptions and beliefs about others; it identifies "others as sources of threat or harm rather than sources of support" (p. 12). Therefore, research suggests that victimization undermines an individual's sense of trust. The sample used in this study was composed of individuals who had reported being physically and/or psychologically victimized in their couple relationship. From previous research with this sample (LaTaillade et al., 2006), we know that aggressive victimization decreased over the course of couple therapy. But the decrease in victimization was not associated with the decrease in women's distrust of their partner. Studies have found that being in a mutually violent relationship is more psychologically and physically detrimental for women than for men (Swan et al., 2008). Perhaps this undermines women's sense of trust in their partner, thus making it difficult for women to trust their partners again. In addition, for men, decrease in distrust was associated with the decrease in only one type of aggression. Perhaps these results are based on differences in male versus female socialization regarding acceptability of aggressiveness in relations with other people and the expectation for men that one absorbs the blows and moves on. Overall, it is possible that trust is a much more complex concept and influenced by multiple factors that were not explored in this study. In future studies, it might be interesting to explore whether changes in trust are associated with other therapy factors, such as improvements in communication, or expression of affection. This difference also points to the importance

of couple therapists carefully assessing how members of couples interpret the meaning of changes that they observe in each other's negative behavior.

For men, there was a significant association between increase in pre-discussion positive affect and their reports of their partners' degrees of both forms of physical aggression: physical assault and injurious behavior. In other words, as men perceived their partner's physical aggression decreasing over the course of couple therapy, their positive affect right before engaging in a couple discussion increased. The results suggest that men's experience as victims of physical violence is more damaging to them than being abused psychologically. Being physically assaulted or injured by a partner might make the abuse more tangible for men and therefore make it more difficult for them to exhibit positive affect when having a potentially high-conflict conversation with their partner. Traditional gender role expectations also may contribute to men experiencing being a victim of physical aggression from a female partner especially distressing (perhaps involving loss of face for the male).

In addition, men's levels of anxiety and distrust in their partner decreased in association with their reports that their partners' use of restrictive engulfment decreased. These findings also supported the hypotheses that were based on the idea that reduction in aggression contributes to the couple relationship developing a more positive atmosphere. In contrast to the results for the females, the reduction in partners' aggression was associated with changes in males' general trust in their partners as well as with more state-dependent improvements in mood. Men were especially sensitive to levels of physical aggression from female partners and to the degree to which their partners attempted to control their autonomy (restrictive engulfment). Once again,

traditional gender role expectations might contribute to this finding. Hyper-masculinity refers to “an extreme form of adherence to the masculine gender role and encompasses calloused sexual attitudes toward women and beliefs that danger is exciting and violence is manly” (Reidy et al, 2009). Studies on hyper-masculinity find that hyper-masculine men are more prone to anger and aggression in response to violations of traditional gender roles. Although it is not assumed that all of the men in this study fit this description, it is possible that in this sample of aggressive couples at least some of the men adhere to some of these beliefs. That makes it more likely that they would react negatively to violations to traditional gender roles, and specifically to aggressive or controlling women.

Strengths of the Study

One of the strengths of this study is that the sample consisted of a very diverse population. Most of the studies on this topic to date have been conducted using a homogenous sample. The participants in this study represented a range of backgrounds, based on race/ethnicity, educational level, and relationship status.

Another strength of this study was that the population was appropriate for this type of research. It was based on a clinical sample of couples experiencing mild to moderate levels of aggression in their relationship. It would not have been appropriate to treat or study a sample of couples that engaged in severe violence, as it is widely accepted that couple therapy with batterers would place victimized partners at risk for physical harm. Thus, it was important to adhere to the exclusion criteria that were established for the study. The sample of couples in this study reported relatively mild

levels of aggression, and this was the population commonly seen in clinical practice and that this study was intended to address.

Another strength is that both psychological and physical violence were studied. Furthermore, physical and psychological violence subscales were used and analyzed separately. The results showed that only some subscales from each measure were significantly correlated with changes in participants' well-being. This pattern suggests that it is important for clinicians to differentiate the various types of psychological aggression when assessing couples and planning interventions.

Finally, it is a strength of this study that men's responses were analyzed separately from women's. This allowed for more in-depth exploration of gender role differences. Future research should use analyses that allow a more directional analysis of causal pathways among the variables that were found to be associated in this study.

Limitations of the Study

There were several limitations to this study. First, the sample size of 55 couples restricted the statistical power. It is possible that additional significant results might be found if the study were to be replicated with a larger sample. Second, couples were only studied over a 4-month period of time. Time was a limitation in this study because it is possible that greater improvements in well-being might have been found had we studied couples over a longer period of time. For example, it may take longer for individuals who observe reductions changes in their partner's aggressive behavior to experience an associated increase in trust, given their history of volatile behavior.

Third, the measures available for analysis in this study were limited by what had been previously collected in the original study (LaTaillade, Epstein, & Werlinich, 2006).

Perhaps using different measures of well-being would have yielded additional significant results. Previous studies have indicated that victims of relational aggression are at a greater risk for psychopathology symptoms, such as PTSD, depression, and clinical anxiety (Golding, 1999; Randle & Graham, 2011). Therefore, future studies should consider exploring the associations between those symptoms and changes in relational aggression. Furthermore, the study is based on self-report measures, and the possibility exists that participants might not have been completely honest in their reporting. With the measures of abuse in particular (CTS2, MDEAS), the results are based on the respondent's perception of their partner's behavior, making it more difficult to determine accuracy. Supplementing the self-reports regarding partner behavior with trained observers' coding of samples of couple behavior would enhance the assessment of aggressive behavior. Finally, the results presented in this study regarding associations between changes in aggressive behavior and changes in partners' moods and trust levels are correlational, making it difficult to draw conclusions about causality. Future studies could explore whether changes in level of physical and psychological aggression from pre- to post-therapy serve as predictors of changes in measures of well-being at a later time. Additional studies might distinguish between the type or model of therapy received by couples, to determine whether improvements in well-being are associated with a particular type of intervention.

Clinical Implications

The results of this study can provide useful information for clinicians working with couples and those interested in understanding the associations between relationship violence and individual and relational well-being. The findings suggest that both men and

women saw improvements from pre- to post-therapy on measures of individual and relational well-being, in terms of more positive moods and less anxiety prior to engaging in problem-solving discussions and increased overall trust in one's partner. Although the results do not provide a clear picture as to why these improvements occurred, they do suggest that couple therapy is effective in treating these types of problems in couples experiencing violence in their relationship. Further analyses of variables that were not assessed in the current study would be necessary to determine the factors that contributed to this improvement. Nevertheless, the results provide hope for both therapists and clients that physical and psychological aggression can be decreased and that partner's well-being within their relationship can improve.

More specifically, the results of the study suggest a number of things for clinicians. The finding that changes in women's distrust of their partner was not significantly correlated with changes in any of the measures of changes in men's physical or psychological violence suggest that there are other areas that might need to be improved before women can trust an abusive partner again. In addition, the finding that men's positive affect was positively associated with changes in women's physical violence suggests to clinicians that this should be an important focus of therapy. While often the focus is on men as perpetrators of violence, clinicians should be aware that the use of physical violence against men can have a very significant effect on their well-being, and clinical interventions should focus on decreasing these types of behaviors.

Finally, results suggest that trust is a complicated concept in relationships. It seems as though a number of factors not explored in this study contribute to partner's ability to trust each other. Clinicians should have an in-depth discussion with clients

regarding trust in the relationship. Results indicate that trust can increase significantly over the course of therapy, but perhaps clinicians can spend more time with clients exploring what factors into that change.

Directions for Future Research

This study should be replicated in the future using a larger sample of physically and psychologically aggressive couples, with a wider range of experiences. More specific measures of individual well-being, such as measures for symptoms of depression, trauma, and clinical anxiety, should be used.

Because level of distrust decreased significantly for both men and women over the course of therapy, but this change was not associated with changes in level of aggression, future research should explore this further. The results suggest that something in the therapy process might contribute to this change, and future studies should explore what additional factors are at play. Some other variables that might be associated with the change in distrust might be changes in communication, changes in expression of affection, or development of problem-solving skills. It would also be very interesting to explore partners' gender role expectations and assumptions, and how these relate to changes in level of distrust. Finally, it is important to note that this study did not measure a form of trust that was specific to aggression; rather, it focused on a more general assessment of individuals' trust in their partners. Future studies could replicate the study using a measure of trust that specifically targets participants' trust that their partner is becoming less aggressive.

Appendix A: Measures

PANAS (Positive and Negative Affect Scales)

This scale consists of a number of words that describe different feelings and emotions. Read each item and then mark the appropriate answer in the space next to that word. Select the number from the scale that shows your feelings towards/about your partner **at this very moment.**

1	2	3	4	5
very slightly or not at all	a little	moderately	quite a bit	extremely

____1. interested	____12. irritable
____2. distressed	____13. alert
____3. excited	____14. ashamed
____4. upset	____15. inspired
____5. strong	____16. nervous
____6. guilty	____17. determined
____7. scared	____18. attentive
____8. hostile	____19. jittery
____9. enthusiastic	____20. active
____10. proud	____21. afraid
____11. comfortable	____22. want revenge

DTS (Dyadic Trust Scale)

Directions: For each of the following statements, please answer each question according to the overall feeling you have of your relationship. Please indicate the extent to which you agree or disagree with the statement by placing the appropriate number to the left of the statement.

1=Disagree Strongly
2=Disagree Moderately
3=Neither Agree nor Disagree
4=Agree Moderately
5=Agree Strongly

_____ 1. My partner is primarily interested in his or her own welfare.

_____ 2. There are times when my partner cannot be trusted.

_____ 3. My partner is perfectly honest and truthful with me.

_____ 4. I feel that I can trust my partner completely.

_____ 5. My partner is truly sincere in his or her promises.

_____ 6. I feel that my partner does not show me enough consideration.

_____ 7. My partner treats me fairly and justly.

_____ 8. I feel that my partner can be counted on to help me.

(Conflict Tactics Scale – Revised)

CTS2

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	4 = 6-10 times in the past 4 months
1 = Once in the past 4 months	5 = 11-20 times in the past 4 months
2 = Twice in the past 4 months	6 = More than 20 times in the past 4 months
3 = 3-5 times in the past 4 months	9 = This has never happened

Physical Assault Subscale

7. I threw something at my partner that could hurt him/her
8. My partner did this to me
9. I twisted my partner's arm or hair
10. My partner did this to me
17. I pushed or shoved my partner
18. My partner did this to me
21. I used a knife or gun on my partner
22. My partner did this to me
27. I punched or hit my partner with something that could hurt
28. My partner did this to me
33. I choked my partner
34. My partner did this to me
37. I slammed my partner against a wall
38. My partner did this to me
43. I beat up my partner
44. My partner did this to me
45. I grabbed my partner
46. My partner did this to me
53. I slapped my partner
54. My partner did this to me
61. I burned or scalded my partner on purpose
62. My partner did this to me
73. I kicked my partner
74. My partner did this to me

Injury Subscale

11. I had a sprain, bruise, or small cut because of a fight with my partner
12. My partner had a sprain, bruise, or small cut because of a fight with me
23. I passed out from being hit on the head by my partner in a fight with me
24. My partner passed out from being hit on the head in a fight with me
31. I went to a doctor because of a fight with my partner
32. My partner went to a doctor because of a fight with me
41. I needed to see a doctor because of a fight with my partner, but I didn't
42. My partner needed to see a doctor because of a fight with me, but didn't
55. I had a broken bone from a fight with my partner
56. My partner had a broken bone from a fight with me
71. I felt physical pain that still hurt the next day because of a fight with my partner
72. My partner still felt physical pain the next day because of a fight we had

MDEAS

(Multi-Dimensional Measure of Emotional Abuse Scale)

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 time *(9) This has never happened*

Restrictive Engulfment Subscale

1. Asked the other person where s/he had been or who s/he was with in a suspicious manner.
2. Secretly searched through the other person's belongings.
3. Tried to stop the other person from seeing certain friends or family members.
4. Complained that the other person spends too much time with friends.
5. Got angry because the other person went somewhere without telling him/her.
6. Tried to make the other person feel guilty for not spending enough time together.
7. Checked up on the other person by asking friends where s/he was or who s/he was with.

Denigration Subscale

8. Said or implied that the other person was stupid.
9. Called the other person worthless.
10. Called the other person ugly.
11. Criticized the other person's appearance.
12. Called the other person a loser, failure, or similar term.
13. Belittled the other person in front of other people.
14. Said that someone else would be a better girlfriend or boyfriend.

Hostile Withdrawal Subscale

15. Became so angry that s/he was unable or unwilling to talk.
16. Acted cold or distant when angry.
17. Refused to have any discussion of a problem.
18. Changed the subject on purpose when the other person was trying to discuss a problem.
19. Refused to acknowledge a problem that the other felt was important.
20. Sulked or refused to talk about an issue.
21. Intentionally avoided the other person during a conflict or disagreement.

Domination/Intimidation Subscale

22. Became angry enough to frighten the other person.
23. Put her/his face right in front of the other person's face to make a point more forcefully.
24. Threatened to hit the other person.
25. Threaten to throw something at the other person.
26. Threw, smashed, hit, or kicked something in front of the other person.
27. Drove recklessly to frighten the other person.
28. Stood or hovered over the other person during a conflict or disagreement.

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