

ABSTRACT

Title of Thesis:

THE RELATIONSHIP BETWEEN
PSYCHOLOGICAL AGGRESSION
VICTIMIZATION AND WOMEN'S ANXIETY:
ALCOHOL USE AS A MODERATOR

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Intimate partner aggression is a serious concern, creating problematic issues among individuals and couples in romantic relationships. Psychological aggression, specifically, has shown to have detrimental effects on physical and mental health. Victims of such abuse often times find different ways to cope with the negative feelings that accompany being a recipient of partner aggression. The present study examines psychological aggression in relationships and its resulting associations with female partner anxiety symptoms. Further, the study explores alcohol use as a possible coping strategy and the way this tactic moderates the relationship between partner aggression and anxiety. Results from the study show that there was no significant association between partner aggression and anxiety symptoms and that alcohol use did not act as a moderator for this association. However, it was found that for two subtypes of psychological aggression (domination/intimidation and denigration) there were negative associations between aggression victimization and anxiety. Unlike the other subscales of psychological aggression (hostile withdrawal and restrictive engulfment), which showed no significance, higher levels of domination/intimidation, restrictive engulfment, and denigration were associated with lower levels of anxiety. Implications of the findings for future research and clinical practice are discussed.

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MODERATOR

By

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CHAPTER 1: INTRODUCTION

Statement of Problem

Intimate partner violence (IPV), or partner aggression, is a serious public health issue that affects numerous couples worldwide. It can be defined as “physical, sexual, or psychological harm by a current or former partner or spouse” (Centers for Disease Control and Prevention, 2017). For the purpose of this paper, it will be identified as partner “aggression” as opposed to “violence”. This term helps to encompass a more extensive and inclusive definition of what it means to be in a relationship with IPV. The term “violence” easily can be misconstrued as only including physical acts of violence, particularly those that are more severe in nature. That being so, it is important to use more comprehensive terminology that represents the broader range of types of aggression between members of intimate relationships, from mild to extreme and both physical to psychological.

Whereas most of the existing professional literature on partner aggression has focused primarily on examining male-to-female physical and psychological aggression, Prospero and Kim (2009) claim that the converse is also prevalent, and that, in some contexts, many perpetrators are likely to be victims as well. In fact, Epstein, Werlinich and LaTaillade (2015) explain that the majority of partner aggression cases fall into the “mild to moderate aggression” range and frequently involve aggressive behavior by both members of a relationship, especially in regard to psychological aggression and mild/moderate physical aggression. A study by Archer (2000) provided evidence that there is much bidirectional partner aggression. Despite this being true, many studies show that in heterosexual couples males are much more likely to inflict severe physical

violence on female partners, resulting in various forms of serious mental and physical harm (Anderson, 2002; Strauss et al., 2009). Women, therefore, are more likely than men to become injured, need medical assistance, and suffer psychologically (Cunradi, Caetano, & Shaefer, 2002). Currently, about 1 in 3 women report lifetime experiences of being victims of partner aggression, with over 5% experiencing it annually (Black et al., 2011). According to Pico-Alfonso et al. (2006), victims of partner aggression are at high risk for developing mental health problems such as depression, anxiety, low self-esteem, and suicidal risk. In addition to these mental health complications, female victims in particular are more likely to develop physical health problems such as eating disorders, sleep dysregulation, and substance abuse disorders.

Although prior research has indicated that partner aggression victimization is associated with a variety of mental health problems, most studies examining such links have failed to differentiate forms of partner aggression, rather than studying a composite of forms, that may have different associations with mental health problems. There is a very small body of literature on the independent associations of physical, psychological, and sexual forms of partner aggression with mental health outcomes among victimized women.

In addition, studies have tended to investigate consequences of partner aggression for overall mental health (e.g., self-ratings of global psychological well-being), so gaps in the research exist in looking at specific forms of psychological problems alone, such as anxiety symptoms. Anxiety symptoms remain an important and understudied consequence of partner aggression, in that they are a common core component of the dynamics of abusive relationships. Victims of partner aggression are forced to be

constantly aware of the danger around them, leaving them in a chronic heightened state of “fight or flight”. For example, a study by Brown, Burnette, and Cerulli (2015) found that in a sample of 190 African American women, there was a strong positive correlation between the amount of danger that women perceived in their abusive relationships and the severity of PTSD symptoms that they experienced.

Some evidence exists that at times a victim’s anxiety about continued victimization may be so high that she may instigate a episode of couple violence so that it will more quickly be resolved and subside. The National Coalition Against Domestic Violence (NCADV) postulates that there are different reasons why victims may fight back against an aggressor, one reason being that they may do whatever it takes to stop the violence and negative feelings, even if that means instigating a violent episode (NCADV, 2017).

When victims’ anxiety is marked by a constant state of negative arousal and uncertainty about the environment of their couple relationship, this may leave them in a perpetual state of fear and cause them to be more hyper-reactive to stressful life stimuli in general. In a study by Lang, Kennedy, and Stein (2002), anxiety sensitivity (an individual’s attunement to their own bodily symptoms of anxiety) was examined in relation to victims’ experiences of physical and emotional IPV and their PTSD symptoms. In a sample of 72 women (30 with no trauma history and 23 who experienced IPV but were not diagnosed with PTSD, and 19 who experienced IPV and PTSD), it was found that, regardless of the diagnosis of PTSD, individuals who experienced some sort of occurrence of IPV were much more likely to have a heightened sensitivity to anxiety symptoms. It seems clear that individuals who experience partner aggression live in a

chronic state of fear and anxiety, not knowing and if (and when) they will be victimized next. Being that these experiences of anxiety may preoccupy a victim of partner aggression on a daily basis, it is crucial that more research be focused on victim anxiety in these couple relationships.

Some research has shown that negative mental health effects experienced from psychological aggression and physical aggression can look fairly similar. For example, Winstok and Sowan-Basheer (2015) concluded from their review of research literature that psychological aggression that specifically causes limitations in victims' familial, social, and occupational opportunities can be just as detrimental to women as physical aggression. In addition to this, Follingstad (2009) argued that in many cases physical abuse can even *be* a form of psychological abuse, given the amount of fear and damage to the recipient's psyche. Other existing literature has indicated that, among the different forms of partner aggression, psychological aggression is more common, and it has serious consequences for women's mental health (Vickerman & Margolin, 2008).

However, psychological partner aggression is often disregarded and unaddressed as a pervasive public health concern because of its "subtlety" compared to physical partner aggression, especially severe violence. According to Vickerman and Argolan (2008), psychological/emotional violence has major consequences for victims' well-being, in that it has been found to be equally or even more harmful than physical violence (Murphy & O'Leary, 1989), and it is a key aspect in the assessment of whether an individual feels safe in a couple relationship. For example, according to Jaquier, Flannagan and Sullivan (2015), women who are only exposed to psychological partner aggression, as opposed to forms of physical or sexual violence, were more likely to

develop anxiety disorders that commonly are intense and lasting. Despite this significant finding, there has been a lack of studies on the relationship between women's experiences of psychological aggression and anxiety symptoms.

Given that physical violence often results in more obvious and physical damage for the victim than psychological aggression, often requiring immediate medical aid, it remains one of the most commonly studied forms of partner aggression, leaving psychological abuse in second place despite its equally harmful repercussions. Being that psychological aggression is the most common form of aggression in couple relationships and can be equally harmful to physical violence, it warrants more research. Psychological aggression has severe psychological and physical health consequences even when it is studied alone. In addition, psychological aggression commonly precedes physical aggression (Murphy & O'Leary, 1989). Therefore, identifying causes and consequences of psychological precursors to other kinds of partner aggression can help pave the way to developing interventions for overall partner aggression reduction.

Another important line of research concerns ways that victims of partner aggression tend to try to cope with the distress caused by the aggression. Experiences of partner aggression have been found to be associated with alcohol use among victimized women (Wilson, Graham, & Taft, 2014). Ulloa and Hammet (2016) concluded that women have an elevated likelihood of engaging in alcohol use as a result of being in an abusive relationship, likely as a means of coping with their emotional distress. Jaquier et al. (2015) state, "women may (mis)use alcohol or drugs to cope with the distress associated with their IPV victimization and mental health problems as they expect that

substance use will alleviate the negative physical and psychological sequelae of IPV” (p.446).

Unfortunately, alcohol use as a way coping with partner aggression victimization or any other life stressor commonly has negative consequences. Overall, alcohol use has been linked with mental health symptoms such as anxiety, suicidality, depression, and PTSD among victims of partner aggression (Ulloa & Hammet, 2016). In addition, alcohol use by one or both partners may raise the risk of aggressive interactions. Cunradi, Caetano, and Shaefer (2002) claim that the consumption of alcohol is likely to come before an abusive encounter between members of a couple who engage in partner aggression. Additionally, their study shows that alcohol-related problems, including alcohol dependency and drinking-related social consequences, experienced by both male and female partners, put couples at greater risk for male to female partner aggression. Thus, individuals may resort to alcohol use as a way of coping with relationship conflict, but it is likely that this strategy will backfire and increase the chance of partner aggression and further negative psychological consequences. However, there has been limited research on the extent to which drinking by female victims of partner aggression exacerbates versus lessens negative effects of partner aggression such as anxiety. The present study addresses this gap in knowledge.

Much of the existing research on partner aggression primarily focuses on male-to-female aggression. Although more information is needed regarding effects of male victimization, this study will extend the research on female victimization for several reasons. For one, research has repeatedly shown that women face more consequences from partner aggression than men, both psychological and physical. Because women

suffer so greatly, it is crucial that more research be done in this regard. Further, the overall prevalence of female victimization is higher than male victimization, making it an issue that needs to be more addressed thoroughly. It is also more likely for women to report their experience of victimization more openly than men, as it has been proposed that men are more reluctant to admit their victimization by a female partner. Tsui, Venus, Cheung, Monit, et al. (2012) stated that men are much less likely than women to seek services for mental health problems and victimization. Furthermore, not only are they less likely to report their own partner aggression victimization; they are also more reluctant to report about their perpetration toward a female partner. By societal standards, there may be a stronger stigma attached to a male being abused by a female, this leading males to be less likely to self-disclose being abused.

The National Survey of Families and Households indicated that there is a higher likelihood of mental health complications in emotionally abusive heterosexual relationships in which the aggression is bidirectional or when the female is the victim (Anderson, 2002). However, there has been limited research on the effect of victimized females' alcohol use on their anxiety. More research needs to be done on whether the level of a female's psychological partner aggression victimization is related to her alcohol consumption, and whether her level of alcohol use moderates the association between the degree of psychological aggression victimization and her experience of anxiety symptoms.

Lazarus and Folkman (1984) developed a stress and coping theory in which individuals use degrees of various strategies to cope with stressful life situations and experiences. These coping responses can be used as means of protection and distancing

from dangerous and stress-inducing situations. Some coping strategies involve inner cognitive experiences (e.g., denial of danger), whereas others involve overt behaviors (e.g., engaging in distracting or tension-reducing actions). Lazarus and Folkman (1984) differentiate between *emotion-focused coping strategies* that are intended to reduce the individual's emotional distress associated with the stressor events, and *problem-focused coping strategies* that involve direct actions intended to reduce or eliminate the stressors. Examples of emotion-focused coping are exercising, sleeping, and substance use, whereas examples of problem-focused coping are generating new solutions to try and seeking social support from others who can help one solve problems. In general, research has indicated that coping that emphasizes avoidance is less effective in reducing negative effects of stressors than is coping that targets active problem-solving (Moos et al., 2006).

Thus, alcohol and drug use are common negative coping behaviors that may temporarily decrease the emotional distress of partner aggression victims but ultimately interfere with active problem-solving that could help the individual lower risks for victimization. Studies have shown that there are high rates of alcohol use among victims of partner aggression. According to Rivera et al. (2015), the co-occurring rate for partner aggression victimization and substance abuse varies from 18-72%. Prior research suggests that within relationships involving psychological aggression, one or both partners may be using alcohol as a means to cope with some of the negative thoughts and emotions associated with such incidents. Whether it precedes an encounter with one's aggressive partner as an way to alleviate anticipatory fear, or follows aggressive incidents a way of self-soothing after being victimized, alcohol is often used as a means of numbing.

In addition to alcohol consumption serving as a means of coping, it also can act as a catalyst for perpetration, creating a vicious cycle. According to the World Health Organization, alcohol can serve as a risk factor for both victimization and perpetration. While it may begin as a way of coping with an abusive encounter, additional alcohol use can result non-rational thinking and agitation, resulting in the individual behaving provocatively toward the partner and even perpetrating violent behavior (WHO, 2006). Research has been limited in examining how much couples use alcohol as a way of coping with conflict, and how this level of use is associated with partners' mental health. The present study was intended to increase knowledge in this area by investigating the possible influence that alcohol use has on the association between psychological partner aggression victimization and victims' experiences of anxiety.

Purpose

Thus, the purpose of the present study was to examine the associations among psychological partner aggression victimization, alcohol use, and anxiety symptoms within a clinical sample of female members of heterosexual couples who sought therapy for various relationship issues. In particular, the purpose was to test the relationship between women's experiences of psychological aggression and their anxiety symptoms. In addition, the study examined the degree to which exposure to psychological partner aggression was associated with females' alcohol consumption. Finally, this study tested the degree to which female partners' alcohol use serves as a possible moderator of the relationship between psychological partner aggression victimization and the females' anxiety symptoms.

This study investigated these factors in couples' relationships in a cross-sectional manner, to determine if there are relevant associations. In the context of alcohol use, it is important to see if consumption for females may be a protective factor or risk factor for anxiety in abusive relationships, and if so, to what degree. It is important to gain information on the extent to which females' use of alcohol has potential to alleviate their anxiety or exacerbate it.

The research questions that were addressed are:

1. How much of an association exists between women's psychological partner aggression victimization and their level of anxiety symptoms?
2. How much of an association exists between women's alcohol use and their anxiety symptoms?
3. To what extent does women's alcohol use moderate the association between their psychological partner aggression victimization and their level of anxiety symptoms?

Theoretical Framework for the Study

The conceptual model and design of this study are based on the psychological theory of stress that was developed by Richard Lazarus and Susan Folkman (1984). In general, this theory postulates that stressors involving various degrees of danger and aversive situations and experiences are ubiquitous in people's lives. Lazarus and Folkman note that in the interactions between an individual and his or her environment, the person actively engages in two types of appraisal of a stimulus that is impinging on him or her (i.e., requiring a response). In the *primary appraisal*, the individual judges how much of a threat or danger the situation poses for the person's well-being. The

secondary appraisal focuses on an assessment of the resources that the person has available to reduce or eliminate the stressor, including actions that he or she can take.

Coping is the process by which an individual chooses to apply strategies to deal with a stressor. Individuals vary in the strategies that they develop through their life experiences (e.g., observation of others' behavior, their own trial and error efforts) for coping with stressors, some of which are more constructive and effective than others. The functions of the coping responses are to avoid stressors, eliminate their presence, or reduce their emotional impact on the individual. These protective response patterns can prove to be adaptive or maladaptive and have been categorized as emotion-focused and problem-focused strategies (Lazarus & Folkman, 1984). Problem-focused strategies are specific behavioral actions that are taken to change the external realities of a stressful situation. For example, this can be characterized by behaviors such as problem solving, removing oneself from a stressful situation, and time-management. In using these strategies, the stressor itself is actively addressed and removed, thereby reducing the negative feelings/emotions attached to the stressor. In contrast, emotion-focused strategies are internal means of reducing negative and unwanted emotional responses to a stressor (Lazarus & Folkman, 1984). For example, emotional distress associated with a stressor can be reduced by avoiding the stressor behaviorally or cognitively (not thinking about it), through physically relaxing activities such as exercise, and through substance use that dulls distress. An individual is likely to use a variety of coping strategies, but may rely on particular ones.

Studies show that problem-focused strategies are much more effective for reducing individuals' distress associated with stressors. One study analyzed the

difference between problem-focused coping and passive coping among Chinese women who experienced physical, emotional, and sexual abuse from their partners. Results indicated that problem-focused strategies such as seeking instrumental support from others and safety planning not only had an effect on positive health outcomes and reduced anxiety, but also mediated the relationship between intimate partner violence and negative mental health in the female victims (Wong et al., 2016). In a meta-analytic study by Shin et al. (2014), 36 different research articles about burnout and coping were analyzed to look for common patterns. It was found that across samples problem-focused coping strategies were negatively correlated with three dimensions of burnout (emotional exhaustion, depersonalization, and reduced personal accomplishment), whereas emotion-focused strategies were positively correlated with degree of burnout. This study supports the notion that emotional exhaustion and depersonalization, components of emotion-focused coping strategies, are the main contributors to eventual burnout. This may be due to some of the intrinsic characteristics of emotion-focused coping, which include characteristics such as self-blame, denial, wishful thinking, and reinterpretation that may occur after a stressful event (Lazarus & Folkman, 1986). This conclusion is further supported by findings of a study by Ntoumanis and Biddle (2000) that examined the relationships among coping strategies, intensity of anxiety, and performance interpretation among athletes. It was found that emotion-focused strategies such as avoidance coping were positively correlated with anxiety severity. Conversely, problem-solving strategies used by these athletes, such as decreasing distractions and prioritizing goals, resulted in better emotional outcomes and low anxiety intensity.

Using alcohol as a means of avoidance and coping is not uncommon in situations of severe distress. In a prospective study by Jester, Steignberg, Heitzeg and Zucker (2015) two different alcohol coping strategies (drinking to cope and drinking to enhance positive affect) were assessed to see how victims and observers of familial abuse coped with their trauma and their subsequent alcohol use. A sample of 1,064 children and their parents were examined longitudinally. From the results, it was concluded that children who witness their parents' partner aggression are more likely to use alcohol as a means to cope with negative feelings and emotions. Further, results indicated that mothers in these families who experienced partner aggression were more likely to use alcohol as a means to increase positive feelings. The difference in alcohol expectancies (whether or not the mothers held a general expectancy that alcohol would make them feel better) determined whether the individuals in the study adopted negative or positive coping strategies as a result of their trauma. A study by Williams and Hasking (2010) looked at two moderating responses (alcohol use as a coping strategy and emotional regulation) and their effect on the relationship between psychological distress and non-suicidal self-injury. A sample of young adults were given questionnaires that asked about their alcohol use, emotional regulation ability, self injurious behaviors and current symptoms of psychological distress. It was found that for low levels of psychological distress, there was no relationship between self-injurious behavior and drinking. There was, however, a strong relationship between drinking to cope (emotional strategy) and self-injurious behaviors at high levels of psychological distress. Consistent with stress and coping theory, these studies indicate that when alcohol use becomes a way to cope with stressful stimuli, it can become maladaptive in nature.

Although alcohol is often used as a temporary way to relieve stress, most often than not it fails to actively solve the issue of the stressor and can cause additional problems down the road. According to The Mental Health Foundation (2006), using alcohol as a means to cope has two major types of negative long-term effects. For one, the MHF identifies alcohol as a *self-perpetuating* means of coping with stress, where cyclical behaviors are developed to alleviate stress. To illustrate, alcohol users continue to use alcohol as a means to relieve anxiety due to the depletion of neurochemicals in the brain that are naturally used to relieve stress. Because these essential chemicals are no longer being produced at normal rates, individuals are likely to instead turn to alcohol for relief, building up a tolerance over time. Secondly, because it is often difficult to gauge the appropriate amount of alcohol that is needed to alleviate any given state of anxiousness, “keeping the optimum balance of alcohol to reduce anxiety is almost impossible because the effect of alcohol on the brain is such that after the initial ‘euphoria’ or stimulation from the first drink, alcohol acts as a depressant and the feelings of anxiety may rapidly return” (p. 6). Both examples show that even though short-term effects of alcohol use seem to be adaptive and effective at first, eventually they tend to transition into behaviors that are longer-lasting and result in serious consequences.

The present study examined the degree to which women’s exposure to psychological partner aggression in their couple relationships is associated with their experience of anxiety symptoms, and the degree to which their use of the emotion-focused strategy of alcohol consumption may moderate that association between aggression exposure and anxiety. Substance use is one of the emotion-focused strategies that individuals can engage in to avoid negative thoughts and emotions associated with

psychological partner aggression victimization. According to the tension-reduction hypothesis, using alcohol has been known as a long-standing means to relieve stress in both humans and animals (Sayette, 1999), most often used to cope with negative affect (Ham & Hope, 2003). In other contexts, it has also been known to produce positive affect and heighten social interaction (Cooper, 1994). In relation to psychological partner aggression, this study investigated whether women's alcohol consumption trends serve as a means to cope with the harmful distress from partner aggression. Given that alcohol consumption also has well-documented negative effects on individuals' psychological and physical health, it is possible that women's consumption in the context of partner aggression may "backfire" and result in higher emotional distress. In either case of moderation (reducing or exacerbating anxiety in female victims), the results of this study have implications for intervention with female victims of psychological partner aggression. The study used Lazarus and Folkman's (1984) stress and coping theory to pose hypotheses regarding anxiety symptoms in female partners within relationships containing male-to-female psychological aggression and regarding the potential moderating effect of alcohol consumption as a coping strategy.

CHAPTER 2: LITERATURE REVIEW

Psychological Aggression

Psychological aggression is one of the three forms of intimate partner aggression that have been identified by theorists and researchers, and it is the most pervasive and frequent in couple relationships (Matt & LaFontaine, 2011). The other two forms of partner aggression are physical and sexual violence. Physical violence encompasses any physical behavior that is intended to injure or harm a partner, including punching, shoving, slapping, kicking, etc., spanning a range of severity from mild to life-threatening. Sexual violence, which also can fall under this physical category, is defined as any attempted or completed sexual act that is performed without the consent of the other partner; i.e., through coercion (CDC, 2017).

Alone, psychological aggression in non-clinical samples has been found to have an 80% incidence rate, constituting the majority of aggression in relationships containing partner aggression. Similarly, despite psychological aggression being a direct predictor for personal distress, the link between these two variables is often unobserved and unrecognized by those who engage in it, serving as “invisible harm” (Arriaga & Schkeryantz, 2015). Despite commonly being seen as less harmful, psychological aggression has severe negative consequences that often outweigh the consequences of other types of partner aggression (Follingstad, 2009). Thus, because of its lack of recognition and the common assumption that it is “normative” behavior, psychological aggression remains severely understudied.

Many theorists also have categorized forms of partner aggression on the basis of who in a relationship is involved in perpetration and what the function of the aggression

is. Four forms of partner aggression have been differentiated: *situational couple violence*, *intimate terrorism*, *violent resistance*, and *mutual violent control*. *Situational couple violence* is sporadic aggressive behavior, psychological or physical, that occurs during instances of conflict in a relationship, as an expression of the partners' frustration and dissatisfaction, but it is not a pervasive characteristic of the individuals or relationship. Although it is the most frequent type of partner aggression, it usually is infrequent in a given relationship, tends to be used more by younger couples, and has more minor consequences for the couple relationship and individual partners' well-being than the other forms. *Intimate terrorism*, by contrast, is a very severe form of partner aggression in which an individual uses violent acts to gain control over a partner, instilling fear and forcing compliance through infliction of physical and psychological pain. *Violent resistance* is usually a result of intimate terrorism in which a victimized partner uses violent tactics in order to defend himself or herself. Lastly, *mutual violent control* is characterized by both partners' intentions to dominate and control one another within their relationship (Johnson, 2011).

In a study by Capaldi and Crosby (1997), it was found that up to 80 percent of people, regardless of gender, engaged in at least one act of psychological aggression when observed with their partner in a laboratory-type setting while having a couple discussion of an area of conflict in their relationship. In the National Violence Against Women Survey, it was found that more than fifty percent of couples have experienced instances of what has been labeled emotional abuse or psychological aggression in America alone (CDC, 1998). A study by Carney and Barner (2012) found that "for emotional abuse, prevalence rates might average around 80%, with 40% of women and

32% of men reporting expressive aggression (i.e., verbal abuse or emotional violence in response to some agitating or aggravating circumstance), and 41% of women and 43% of men reporting some form of coercive control” (p. 2). Thus, regardless of the forms of psychological aggression addressed in various studies, the amount of these damaging types of negative behavior toward an intimate partner is substantial in the general population.

When considering the relative importance of types of partner aggression, it is crucial to understand that psychological partner aggression is commonly experienced concurrently with other forms of aggression, often preceding instances of physical and sexual aggression (Epstein, Werlinich & LaTaillade, 2015). Studies show that there is a strong likelihood of psychological aggression in the presence of physical aggression, and the psychological forms often come first in many relationships (Karakurt & Silver, 2013). Furthermore, in a study by Matte and Lafontaine (2011), in which 218 individuals were asked to report instances of aggression in their relationships, not only were both men and women likely to receive and perpetrate aggression in their relationship; simultaneous psychological and physical aggression perpetration occurred in both genders. When the types of aggression occur simultaneously, this combination exacerbates the intensity and severity of the violence and its negative effects on victims (Breiding et al., 2015).

Psychological aggression within relationships is likely to remain relatively consistent over the course of a couple’s relationship, with a slight increase of male to female aggression over time. A study by Vickerman and Margolin (2008) examined couple relationships following marriage and the continuing bidirectional prevalence of emotional and physical aggression over the span of a relationship. Data from a

community sample of 118 couples that were extracted from the data set of a previous longitudinal study about family conflict/community violence were examined to focus on emotional aggression in relationships. These couples had been given three different assessments that examined aspects of partner aggression. It was found that for female partners the longer the length of the marriage, the less likelihood of physical aggression perpetration by both husbands and wives, whereas the level of emotional aggression remained unchanged.

Types of Psychological Aggression

Psychological aggression encompasses a variety of verbal and nonverbal behaviors that are used to threaten, instill fear, and intentionally hurt an individual emotionally (Winstok & Sowan-Basheer, 2015). Perpetrators tend to use these types of behaviors to obtain control over another person through mental and psychological means. In the context of couple relationships, this can take on several forms. Some examples of psychological aggression identified by Breiding et al. (2015) are: exerting control over a partner's reproductive health (restricting use of contraceptives); using "mind games" and manipulation ("gaslighting") about what is true in situations in order to confuse a partner and get one's way; and exploiting a partner's vulnerabilities and insecurities such as lack of self-confidence. According to Engel (2002), psychological aggression can be used for purposes of isolation, control, humiliation, and punishment. Physically violent acts that do not involve any direct contact with the victim but can create fear and intimidate the victim (e.g., throwing objects, locking doors, driving recklessly, threatening property damage) can also be considered psychological aggression (Karakurt & Silver, 2013).

Forms of psychological aggression in which the perpetrator deprives the victim of basic needs or rights also have been identified. This can include withholding fulfillment of a partner's emotional needs through cold and distant behavior, denying them intimacy, love and affection, as well as refusal to engage in instrumental acts such as paying bills and getting groceries (Winstok, & Smadar-Dror, 2015). In Winstok and Smadar-Dror's (2015) study of a convenience sample, they interviewed 74 cohabitating heterosexual couples to examine couple behavior during conflict. They found a very high prevalence (over 90%) of instances of emotional withdrawal and refusal to perform instrumental acts (over 80%) for both men and women.

Murphy and Hoover's (1999) research on forms of psychological aggression revealed four major forms that overlap with the types identified by other researchers. These include denigration, domination/intimidation, hostile withdrawal, and restrictive engulfment. These different types of psychological aggression were adapted and reformed from a number of existing assessment instruments and were grouped together to create a more concrete and comprehensive list. Psychological aggression is a direct attack on an individual's emotional and psychological well-being, as opposed to any sort of direct bodily harm. An act of psychological or emotional aggression is intended to "produce fear, increase dependency, or damage the self concept of the recipient" (Murphy & Hoover, 1999, p. 30). *Domination/intimidation* includes behaviors that threaten or instill fear in an individual, such as destroying property or threatening to leave the relationship. This category of aggression has been shown to be positively correlated with perpetration of physical aggression (Murphy & Hoover, 1999). *Denigration* includes any act that is used to humiliate and degrade a person, encompassing contemptuous

remarks that serve to damage a victim's self-esteem. Denigration also is strongly correlated with physical violence and is often paired with domination/intimidation. Behaviors such as refusing to exhibit affection or communication toward a partner as a means to hurt the partner are characteristic of *hostile withdrawal*. Again, this category creates a harmful power dynamic that leaves the recipient insecure and uncertain about the status of the interaction/relationship. Lastly, *restrictive engulfment* is marked by actions that are used to purposefully restrict a partner's access to various resources (e.g., friends, money) as a means to monitor and control the partner. These behaviors typically are associated with extreme jealousy and a need for control on the part of the perpetrator, and they increase a recipient's dependency by means of isolating the individual. These four types of aggression have in common that they are not physical in nature, yet they can be extremely harmful to the recipient. In addition, they all can co-occur (Murphy & Hoover, 1999).

Gender Differences in the Experience of Psychological Aggression Victimization

Within an array of studies, there has been some variation in reports of prevalence of psychological aggression victimization across gender. A study by Costa et al. (2014) examined the role gender played in relation to psychological partner aggression victimization across various areas. A sample of men and women from six different European countries were interviewed about aggression in their couple relationships, along with their role in its perpetration and victimization. For psychological aggression, it was found that prevalence rates for victimization were relatively equal for the two genders (males ranging from 48.8% to 71.8%, and females ranging from 46.4% to 70.5%).

Conversely, a study by Phelan (2005) showed that women were more likely than men to be victims of emotional aggression. In a sample of hospital patients seeking emergency aid for partner aggression, it was found that women were more likely to have experienced acts of intimidation, control and domination from their male partners. In interviews, female partners identified more forms of emotional abuse and experienced more fear than male partners.

Physical and Psychological Health Effects of Psychological Aggression Victimization

Psychological aggression has been shown to have serious impacts on the physical and mental health of victims. Regarding effects on physical health, a study by Coker et al. (2002) investigated health consequences across differing levels of aggression exposure. The results indicated that the 13.6% of individuals who experienced psychological aggression without any other forms of partner aggression experienced more physical health problems such as disabilities interfering with work performance, chronic neck or back pain, arthritis, headaches, stuttering, vision problems, sexually transmitted infections, chronic pelvic pain, and a variety of gastrointestinal disorders. Those physiological issues manifested themselves despite psychological aggression being a mental and emotional process.

Concerning effects of psychological partner aggression on mental health, Começanhaa, Pereiraa, and Maiaa (2017) found that, regardless of sociodemographic characteristics, an “independent contribution of psychological abuse to clinical outcomes despite gender emerging as a predictor for post-traumatic stress symptoms, depression, and anxiety”(p. 124). In their sample of university students, it was also found that the

mental health complications were not only experienced while the aggression was occurring, but also several years following the aggression.

A study by Próspero and Kim (2009) examined severity of mental health outcomes for couples who engage in partner aggression. A racially diverse sample of 676 university students were asked questions about their mental health as it pertained to anxiety, depression and other factors. In addition, experiences of psychological, physical, and sexual partner aggression were recorded. These data were analyzed across gender and race, and it was found that partner aggression victimization contributed significantly to poorer mental health outcomes across all groups, regardless of gender or race, with the one exception of Asian men. It can be concluded from this study that regardless of gender and race, there is a significant connection between partner aggression victimization and mental health issues.

Within the realm of mental health, the present study focused on effects of psychological partner aggression on victims' anxiety symptoms. Most of the literature that exists regarding anxiety as a consequence of intimate partner violence or aggression has focused on partner aggression as a collective whole, including physical and sexual forms as well as psychological aggression. Therefore, the present review covers the existing evidence linking any form of partner aggression to victim anxiety, focusing on consequences of psychological aggression whenever possible. Additionally, because the present study focused on anxiety among female victims of partner aggression, the review highlights gender differences whenever they were found.

A study by Pico-Alfonso et al. (2006) looked at types of partner aggression and their effects on the mental health of female victims. The study consisted of a structured

interview in which a female psychologist asked a sample of women from 24-hour help centers about their life and general health. An ANOVA was used to compare 3 different groups of abused women (physically/psychologically abused, psychologically abused, and a non-abused control group) on their levels of depression and anxiety. Compared to the control group, women in the physically/psychologically abused, as well as the psychologically abused group, had significantly higher rates of depressive and anxious symptomology and suicidal thoughts. In addition, there were no differences in symptoms between the physically/psychologically abused and just psychologically abused groups.

Additional research has shown that women who have a history of physical and psychological partner aggression in their relationships are more likely to have anxiety disorders that have lasting impacts on their mental health. Norman et al. (2013) divided a sample of women into two groups (those with partner aggression in their relationship and those with no partner aggression) and administered an Overall Anxiety Severity and Impairment Scale (OASIS) self-report questionnaire to assess for unidentified anxiety and trauma. Findings showed that, compared to females with no histories of partner aggression, those with traumatic physical/sexual abuse histories had higher scores for anxiety and presence of PTSD symptoms. After controlling for lifetime victimization, Pico-Alfonso et al. (2006) interviewed abused and non abused women and found that “women exposed to physical/psychological and psychological IPV had a higher incidence and severity of depressive and anxiety symptoms, PTSD, and thoughts of suicide than control women, with no differences between the two abused groups” and “severity of state anxiety was higher in abused women with depressive symptoms or comorbidity, as was the incidence of suicidal thoughts in the physically/psychologically abused group”

(p. 599). These studies show that anxiety symptoms are worse for females who have experienced partner aggression.

A study by Al-Modallal (2012) examined a sample of women in refugee camps who had experienced psychological aggression over the course of their lives. Two different types of psychological aggression were assessed: emotional violence and control. Emotional violence was defined as name calling, hurting or threatening to hurt a person close to the individual, and destroying the individual's property. Controlling behaviors included limiting access to family, demanding to know one's location, and getting angry when the partner talked to another man. The results indicated that feelings of depression, stress, and anxiety followed relationship experiences in which the partner exerted copious amounts of control and emotional aggression. The presence of both of these types of aggression, as opposed to none or one, yielded higher depression and anxiety scores. Similarly, Tani, Peterson, and Smorti (2016) asked women who had been victims of physical, psychological, and sexual partner aggression to construct a personal written narrative about their experience. In the analysis of their writing, it was found that women who experienced victimization for longer durations used fewer negative words surrounding fear and anxiety, indicating that there was an adaptive quality to the interpretation of their abuse and that they had become more accustomed to the abuse.

Partner Aggression and Alcohol Use

Alcohol use as a risk factor for partner aggression perpetration. The presence of alcohol in instances of partner aggression is not uncommon. The majority of the research literature regarding partner aggression and alcohol use primarily has examined its consumption as a risk factor for perpetration -- how disinhibition, impeded

executive functioning, and impulsivity that occur while individuals are under the influence of alcohol contribute to conflict and aggressive behavior. Much of this research has examined males' alcohol use and their resulting perpetration of aggression against their female partners. For example, compared to men who drank no alcohol, men who engaged in acute alcohol consumption were more likely to engage in sexual aggression as well as intimate partner aggression (Crane, Godleski, Przybyla, Schlauch, & Testa, 2016). Watkins, Maldonado, and DiLillo (2014) concluded that when it comes to both physical and psychological aggression, decreased impulsivity control under the consumption of alcohol leads to more male-to-female violence.

Further, a study by Kachadourian, Taft, O'Farrell, Doron-LaMarca, and Murphy (2012) looked at psychological aggression and alcohol consumption in couples. They assessed a sample of men with alcohol issues and measured their resulting psychological aggression toward their female partners. Looking at four alcohol-related factors (percent of days with any use, percent days with heavy use, number of days alcohol consumed, number of drinks a day), it was found that higher levels of all four drinking indices were associated with higher rates of psychological aggression perpetration.

Most studies on alcohol consumption as a risk factor for partner aggression perpetration have focused on male alcohol intake as a predictor of partner aggression, with much less attention paid to the effect of female alcohol consumption on perpetration. However, a study by Miller, Downs, and Gondoli (1989) assessed differences between 45 women who were in an alcohol recovery program and a control group of 40 randomly selected nonalcoholic women. The study's aim was to look at the relationship between male to female partner aggression using the Conflict Tactics Scale (CTS) and females

alcohol intake/alcoholism. It was found that women who drank more engaged in more marital violence and experienced more violence from their spouses than women who drank little to no alcohol.

Other studies have shown that the amount of alcohol or substance use is positively correlated with the prevalence of partner aggression in relationships, for both victim and perpetrator roles, in both male-to-female violence and female-to-male violence. An example is Foran and O'Leary's (2008) study, in which they found that there are small to moderate effect sizes for the association of alcohol abuse and violence perpetration from both genders, and that level of consumption (amount of alcohol consumed before an incident) had more of an impact than did frequency.

Alcohol use as a factor protecting against partner aggression perpetration.

In contrast to the prior research that indicates that alcohol consumption is a risk factor for relationship conflict and aggression, there has been some speculation that small amounts of alcohol can serve as protective factors against relational conflict as well as temporarily assisting with stress. In this view, positive couple and family relationships and interactions can be strengthened by small amounts of partners' alcohol consumption, through improved mood and stress relief (Steinglass & Robertson, 1983). A study by Derrick et al. (2010) focused on the association between the amount of alcohol that is consumed by an individual and the individual's expectancies about the quality of their couple interactions. Results from the study indicated that in couples in which the female partner drank, the more that the women consumed alcohol the more they anticipated that there would be connectedness and positivity in their relationships with their male partners. However, the study did not assess the actual interactions of the couples and

whether greater female drinking truly was associated with positive or negative couple behavior.

Similarly, some researchers have hypothesized that individuals in relationships marked by conflict may use alcohol as a way to suppress emotional distress and urges to engage in aggressive behaviors toward their partners (Klostermann & Fals-Stewart, 2006). In a review by Marshal (2003), two conflicting hypotheses were put to the test to determine whether alcohol use by partners in a marriage were adaptive or maladaptive to their marriages' functioning. In the adaptive hypothesis, it is proposed that alcohol can be beneficial to temporarily relieving stressors and be protective against marital dysfunction and dissolution. In the alternative hypothesis, alcohol is seen as increasing marital dissatisfaction, negative couple interactions, and even partner aggression. Marshal (2003) reviewed 60 studies and concluded that the later hypothesis was supported, in that alcohol use was shown to be predictive of negative couple interactions and violence. According to Marshal (2003), the difference in whether the relationship *outcome* is maladaptive or adaptive is in part due to the amount of alcohol being consumed, with excessive amounts being maladaptive and small amounts being adaptive. Ideas and expectations an individual may have about their interactions may play a part in how much alcohol they choose to consume prior to engaging with a partner.

Alcohol Use as a Means of Coping with Partner Aggression

Although females' alcohol consumption can operate as a risk factor for their own partner aggression, as well as reducing aggression perpetration when used in a restricted manner, alcohol consumption also may serve as a coping response, albeit a potentially problematic one, among women who are victims of partner aggression. Most of the

literature focuses on alcohol use as a precedent or precursor for aggression.

Consequently, little is known about alcohol use in response to partner aggression victimization. There is a serious gap in the literature regarding ways that victims of partner aggression cope with that major stressor, and more specifically how alcohol may be used, particularly by females, as a strategy to cope with an abusive relationship,

General strategies for coping with partner aggression. The ways in which individuals cope with the harmful effects of intimate partner aggression are vast and varied. Although each victim's experience is different and subjective, there are common things that a person might do in these instances, some being more effective than others. According to Rizo (2016), there are 10 categories of victims' coping with the stresses of their abusive relationships: "(a) religious coping strategies, (b) emotion-focused coping strategies, (c) distraction/avoidance strategies, (d) cognitive coping strategies, (e) safety planning strategies, (f) placating strategies, (g) resistance/defiance strategies, (h) direct attempts to address the stressor, (i) help-seeking, and (j) other coping strategies" (p. 584). Rizo found that each of these methods of coping with partner aggression was used during the occurrence of abuse, as well as afterward.

In general, coping strategies that include more active problem-solving techniques are likely to have a positive effect on relieving stress and addressing the issue of violence (Lazarus & Folkman, 1986). In her study, Rizo (2016) interviewed 25 survivors of intimate partner violence to assess what strategies they had used to cope with their experience. Safety planning, seeking help from outside sources, and strategies to defying/resist the abuser served as helpful ways to cope. These include behaviors such as keeping car keys available, hiding weapons for safety, and avoiding settings in which

abuse tends to occur. A study by Reviere et al., (2007) looked at various coping strategies among a sample of low-income African American women experiencing at least physical partner aggression in their relationship. The study consisted of interviews with two different groups, women in abusive relationships who had attempted suicide and those who had not. The results indicated that women in abusive relationships who used more positive coping strategies, such as using resources around them (education, employment, transportation, finances, etc.) and seeking out social support from family and friends, and were able to do these things with higher self-efficacy and were significantly less likely to attempt suicide. In contrast, women who engaged in suicidal behaviors were most likely to engage in negative coping behaviors such as alcohol and substance abuse and used strategies that were aimed at accommodating the abuser.

According to Goodman, Dutton, Weinfurt, and Cook (2003), coping strategies that are done in private, as opposed to public were least effective in decreasing the occurrence of partner aggression. These behaviors, called resistance and placating strategies, included attempts by the victim to change the behavior of the abuser through both avoidance of confrontation and immediate confrontation. Examples of resistance behaviors included sleeping in a separate room, refusing to do what abuser asks, fighting back, while placating included acts such as submitting to abuser to end violence, keeping things quiet for abuser, refraining from crying, and avoiding the abuser altogether. Although the most commonly used, these private strategies were comparatively less effective than strategies that were more public (networking and safety planning), such as getting a legal system involved, staying in a shelter, having an escape plan, or getting

counseling for the violence. This further illustrates that problem-solving techniques that involve more action-oriented intervention, are more beneficial in cases of IPV.

Although sometimes less effective, victims may use strategies that are avoidant and more emotionally-focused (directly reducing emotional distress rather than changing the stressful circumstances) in nature. As further illustrated by Rizo (2015), these included behaviors such as venting to a friend, breaking dishes to relieve stress, engaging in a physical activity, letting themselves cry it out, and drinking alcohol and taking other substances. Iverson et al. (2013) examined various coping strategies and their risk for partner aggression victimization across 69 women who were seeking treatment for aggression victimization in their current/previous relationships. The study found that coping strategies that included “disengagement” (wishful thinking, self-criticism, social withdrawal, problem avoidance) were more likely to lead to re-victimization and increase their risk for further abuse in the future.

In a study by Weiss, Peasant, and Sullivan (2016) it was found that female victims who used only avoidant coping strategies (isolating themselves, disassociating, finding distractions), were likely to be victims of severe physical and psychological aggression. In this community sample of 212 women, it was found that these avoidant coping strategies moderated the relationship between physical, sexual, and psychological partner aggression severity and HIV-risk behaviors. The higher the levels of avoidant coping in the sample, the stronger the association was between HIV-risk and physical/psychological partner aggression. These studies support the notion that women who engage in strategies that are more problem-focused are better able to cope with their situations due to the fact that they are actively seeking and implementing solutions to their

circumstances. Although emotionally focused and avoidant strategies are commonly used, they only address immediate distress experienced in a given instance of partner aggression. Thus, using avoidant coping strategies in cases of partner aggression is not only likely perpetuate abuse in a relationship; it can also have severe consequences for physical and mental health outcomes.

Alcohol and coping. Using alcohol and other substances is one way that individuals may attempt to avoid or distract themselves from various stressors in their lives. Using this means of coping can often result in serious negative consequences. Research has shown that couples are likely to use alcohol as a coping mechanism for many different stressors, including interpersonal conflict and distress within their relationships. Although couples use alcohol as a way to manage negative affect associated with relational conflict, this means as coping has been shown to be associated with personal problems with alcohol dependence and anxiety later in life (Sher & Grekin, 2007). A study by Levitt and Leonard (2015) looked at “relationship-specific drinking to cope behaviors” (drinking to eliminate negative feelings that result from marital distress) as a mediator between the attachment styles of each individual and the frequency of marital discord due to drinking. A sample of 470 couples that had consumed alcohol in the past year was analyzed. These couples were interviewed and given self-report measures to assess their attachment styles, alcohol consumption, and “relationship-specific drinking to cope motives”. The study’s results showed that partners who exhibited “anxious” attachment styles were most likely to use alcohol as a means to cope with relationship stress and suffer from alcohol related problems, as opposed to partners with other attachment styles. This study showed that relationship-motivated drinking was

contingent on the attachment style of the individual, and when alcohol was used as a mechanism to cope with relationship distress more relationship distress/conflict was then reported.

A study by Gryl, Stith, and Byrd (1991) examined coping styles among college students in serious relationships containing partner aggression. They found that both men and women were likely to take part in escape/avoidance as well as confrontational and aggressive behaviors as a means to cope with aggression from their partners. Cooper, Frone, Russell and Mudar (1995) found that alcohol is often used as a coping mechanism to manage both positive and negative emotions. In two different samples, one consisting of only adults and one consisting of adolescents, it was found that alcohol use (and later abuse) was a result of both positive emotions and behaviors such as “emotional enhancement” and “sensation seeking,” and negative expectancies such as “avoidance coping” and “negative emotion”. This study supports the notion that expectancies and psychological motives play a part in why people engage in consuming alcohol, including as a means to reduce distress associated with partner aggression victimization.

A study by Jaquier et al. (2015) examined the relationship between alcohol abuse prevalence and the occurrence of anxiety and PTSD symptoms among women who experienced psychological, physical, and sexual intimate partner violence. The sample included 143 women in the community who were victims of partner aggression. It was found that higher levels of anxiety and PTSD symptoms among women who had severe cases of IPV were correlated with alcohol and drug abuse. This study’s investigators concluded that there is an association between higher anxiety and prevalence of increased alcohol use.

While in some situations alcohol can be used as a means to enjoy oneself and increase positive affect, it can also be consumed in efforts to relieve unwanted stress. A study by Tobin, Loxton, and Neighbors (2014) showed that, among young adults, alcohol is often used as a means to deal with the anxiety associated with causal uncertainty, having a direct effect between the two variables. In that study “causal uncertainty” was defined as doubt regarding whether or not an actual event or circumstance will occur. Within the study’s sample of college students, it also was found that higher levels of anxiety, drinking motives, and stress were associated with alcohol use. These young adults who were higher in those characteristics were more inclined to turn to alcohol to cope with these feelings, and were more likely to have alcohol-related problems. These findings suggest that individuals may be motivated to drink to help them disengage from the negative situations around them, rather than addressing them directly.

Chandley, Luebke, Messman-Moore and Ward (2014) found that anxiety sensitivity is indirectly related to alcohol use as a method of coping. As opposed to looking at direct stressors, this study focused on anxiety sensitivity, defined as the individual’s fear and worry regarding the symptoms of anxiety or the anticipation of experiencing anxiety in the future. This may serve as an explanation as to why people engage in alcohol use prior to a stressful event, in an attempt to eliminate the expected presence of dreaded anxiety symptoms.

Anker et al.’s (2016) study supports the notion that alcohol use and anxiety symptoms are reciprocally interacting dynamics that, when in conjunction with one another, can heighten each other’s negative qualities. The authors postulated that there is reason to believe that engaging in drinking as a means of coping with anxiety is a

moderator for the relationship between the experience of anxiety disorders and individuals' issues with alcohol abuse. This conceptual model was supported in their study, in which participants with various anxiety disorders coupled with alcohol dependence were asked to complete a questionnaire regarding their experiences with anxiety and drinking. It was found that "drinking to cope" significantly moderated the relationship between alcohol abuse and the existence of a co-occurring anxiety disorder.

Testa, Crane, Quigley, Levitt, and Leonard (2014) conducted a study to look at the effect of alcohol on couples' interactions. In their study, couples were asked to talk about a topic of contention in their relationship while one individual in the partnership was assigned to drink a moderate amount of alcohol. The results showed that immediate intake of alcohol resulted in positive interactions between partners and reduced negativity when one of the partners remained sober. Although there was no significant increase in negativity, participants in this sample who had engaged in partner aggression in the past did not produce the same "positive" interactional behaviors. Thus, the potential for alcohol consumption to serve as a coping response to influence couple interactions associated with conflict in positive ways depends on a couple's established patterns for dealing with conflict.

Although alcohol consumption can have both positive and negative effects on relationship functioning, women report more positively on aspects such as intimacy and couple interactions when they engage in small amounts of drinking with their partner. However, women are more likely than men to engage with their partners in increased alcohol use when there have been previous relationship conflict/difficulties, negative male behavior, or low intimacy. Levitt and Cooper (2010) conclude that women are more

likely than men to regulate their emotions with alcohol as a means to alleviate tension felt in their couple relationships.

Given the common traumatic nature of intimate partner aggression, it seems plausible that victims could use alcohol consumption as a coping strategy to combat some of the anxiety and distress caused by the physical and/or psychological abuse that they face. However, the research reviewed here shows how this method of avoidance can serve to be maladaptive and have negative mental health and behavioral consequences. Although individuals may feel as if their anxiety is being relieved in the moment, repeated reliance on this coping strategy can lead eventually to cyclical negative interactions between partners and possibly more intense and severe anxiety in the future.

Long-term effects of alcohol use as a coping strategy. Adopting alcohol use as a coping strategy to deal with the stressors of partner aggression victimization can have lasting consequences for later alcohol use. In a study by Keller, El-Sheikh, Keiley, and Liao (2009) a sample of 158 married/cohabitating couples were assessed to look at problematic drinking, marital discord, and both male-to-female and female-to-male physical and verbal aggression over the span of two years. The results indicated that problem drinking at the first year (T1) from men was associated with higher physical aggression toward their female partner by the second year (T2). Additionally, physical aggression at T1 predicted more problematic drinking for women at T2. Verbal aggression, however was lower at T2 for women when there was problematic drinking for the female at T1. This study suggests a bidirectional relationship between alcohol use and partner violence that may hinder a couple's ability to address their conflicts

appropriately, while subsequently encouraging them to use alcohol as a means to cope with marital distress.

In a study by Ullman and Sigurvinsdottir (2015), a sample of 1,863 women who had been victims of sexual trauma were administered assessments regarding pre-assault drinking, methods of coping, and physical partner aggression victimization history. Among those sexual assault victims, there were greater levels of alcohol consumption and problematic drinking for those who had additionally experienced physical partner aggression in their life. Women reported drinking alcohol in efforts to block out unwanted thoughts and memories of past experiences. Similarly, Fairbairn and Cranford (2016) examined the longitudinal effect of individuals' hostile behaviors toward their partner on the partner's alcohol consumption. Forty-eight individuals with alcohol use disorders and their partners were studied over a period of six months to a year. Results from the study indicated that individuals' negative behaviors predicted their partners' increased drinking problems, in terms of increased drinking days and greater episodic drinking.

Most of the research reported in the existing literature examined links between physical partner aggression and victimized partners' coping with alcohol. There has been limited research on psychological aggression alone and victims' coping through alcohol use. The existing studies suggest that using alcohol as a means to cope is a maladaptive mechanism for dealing with the distress of partner aggression, and that type of coping is predictive of developing alcohol problems later in life. Given this gap in prior research, the present study was designed to examine the possible moderating effect that women's

alcohol use may have on the association between degree of psychological partner aggression victimization and their experience of anxiety symptoms.

Summary

It is clear that the various forms of psychological partner aggression are highly prevalent, and they commonly having devastating consequences on the victims who endure. Victims in relationships with partner aggression use a variety of strategies in order to cope with the anxiety and other distress inflicted by the aggression they experience, some of these strategies being positive and others negative. Alcohol use, known to be an avoidant coping mechanism, is one of the strategies that victims use in abusive relationships. Although we know that alcohol can serve as a positive buffer to some relationship distress, overarching research shows that using it as a way to cope can have serious repercussions over time.

Overall, there are several relationships that have been demonstrated among psychological aggression, anxiety symptoms, and alcohol use; however, gaps in knowledge exist in several areas. More information needs to be gathered about how alcohol is used as a coping mechanism for anxiety in relationships that include psychological partner aggression. For example, research is needed to see how varying levels of alcohol consumption have an adaptive or maladaptive effect on victimized females' experience of anxiety. The present study was designed to investigate such links among psychological partner aggression, alcohol consumption, and anxiety.

Hypotheses

Based on the literature on psychological aggression, anxiety, and alcohol use, the following hypotheses were tested:

1. Females who report experiencing more psychological partner aggression will report more anxiety symptoms.
2. Frequency of alcohol use will be associated with level of anxiety symptoms in female partners.
3. Female partners' alcohol use will moderate the association between their psychological partner aggression victimization and their level of anxiety symptoms. The association between degree of psychological partner aggression victimization and females' anxiety symptoms will be stronger for females who consume more alcohol than for females who consume less alcohol.

CHAPTER 3: METHODS

Sample

The sample for this study consisted of 617 couples that sought treatment at the Center for Healthy Families located at University of Maryland, College Park for a variety of relationship problems. The Center for Healthy Families (CHF) is an outpatient clinic that provides low-fee therapy services for couples, families, and individuals in the nearby community. The clients seek out services for an array of presenting problems such as communication difficulties, couple relationship conflict, parent-child conflict, separation and divorce issues, substance abuse, child school problems, and concerns with forms of mental illness. The clinic's client population is diverse in terms of gender, race, ethnicity, religion, sexual orientation, education level, and socio-economic status.

Table 1.1 presents the racial composition of the sample. This sample was moderately diverse, with the majority being African American and White. Ages for the sample ranged from 17-77, with the mean age being 32.01 (SD = 8.97). The mean length of the women's couple relationships was 7.06 (SD = 7.04), with relationships ranging from 0-56 years. Additionally, the women had a mean personal yearly gross income of \$27,617 (SD = \$24,469), with a range from \$0 to \$185,000.

In addition, Tables 1.2 and 1.3 present the sample's relationship status and highest level of education. The vast majority of the couples were in committed relationships and lived in the same household. Additionally, the sample tended to be highly educated, with the majority having received some higher education ranging from some college to graduate education.

The clients who attend the Center for Healthy Families typically are referred by schools in the community, mental health professionals in the community, the University of Maryland Health Center, the courts, and previous clients. The clinic's services are provided by graduate student therapists who are working toward completing their master's degrees in Couple and Family Therapy at the University of Maryland, College Park and are supervised by licensed full-time and adjunct faculty members.

A secondary analysis was conducted on data that previously were collected from couples who sought services at the CHF and completed a standard set of assessments before beginning therapy. A couple's initial contact with the clinic involves a phone intake interview during which a CHF clinician collects basic demographic information about the potential clients and their presenting problems. If a couple's needs match the services provided at the CHF, their case information is presented at the next weekly case staffing meeting, and as soon as possible they are assigned a single therapist or co-therapist team, who then call the couple to schedule an in-person assessment session.

During the assessment session, the clinicians provide information about the CHF services, policies, and procedures, and both members of the couple complete a written informed consent form. The partners are then placed in separate rooms to insure confidentiality and are asked to fill out a set of self-report questionnaires that assess individual psychological functioning (e.g., symptoms of psychopathology such as depression and anxiety) and couple relationship functioning (e.g., relationship satisfaction; physical, psychological and sexual partner aggression; positive partner behaviors). Each person also is interviewed individually regarding alcohol and drug use by oneself and one's partner, as well as about partner aggression and possible level of

fear about living with and participating in couple therapy with the partner. Finally, the couple is asked to discuss a topic that involves some conflict in their relationship for ten minutes, and that conversation is video recorded for later coding of communication quality. All of those data are included in a de-identified numerical data set on password-protected computers in the CHF.

From the CHF couple pre-therapy assessment data file, couple cases were selected for the present study based on inclusion criteria of: 1) couples in heterosexual relationships (given that the study examines effects of male-perpetrated partner aggression on females); and 2) took standard pre-therapy assessments. This investigator examined data from self-report scores from the female partner in the relationship. For each of the demographic variables that were considered, there were some “missing data” where participants failed to answer the questions regarding how they identified. The variable sample sizes are accounted for in the following tables. About 11-13 participants were missing for each category.

Table 1.1: Race of Female Respondent

Race	Frequency	Percent
African American	268	43.4
White	214	34.7
Hispanic	62	10.0
Asian/Pacific Islander	17	2.8
Native American	1	0.2
Other	42	6.8
Missing System	13	2.1
Total	617	100.0

Table 1.2 Relationship Status

Status	Frequency	Percent
Currently married, living together	284	46.0
Currently married, separated	58	9.4
Divorced	1	0.2
Living together, engaged	86	13.9
Engaged, not living together	8	1.3
Dating, living together	123	19.9
Dating, not living together	39	6.3
Domestic partnership	6	1.0
Missing	12	1.9
Total	617	100.0

Table 1.3 Female Respondent’s Highest Level of Education

Education	Frequency	Percent
Some high school	24	3.9
High school diploma	58	9.4
Some college	149	24.1
Trade School	51	8.3
Associates degree	76	12.3
Bachelors Degree	88	14.3
Some graduate education	80	13.0
Masters degree	55	8.9
Doctoral degree	25	4.1
Missing	11	1.8
Total	617	100.0

Measures

Psychological Partner Aggression

Psychological partner aggression was measured with the Multidimensional Measure of Emotional Abuse (MMEA; Murphy & Hoover, 1999). This measure assesses the individual’s experience of psychological partner aggression during the past 4 months, both as recipient and perpetrator (Carton & Egan, 2017). The 54 MMEA items describe a variety of specific behaviors and ask the respondent about the frequency with which each behavior occurred during the 4-month period. For each type of psychological partner aggression there is a pair of items (i.e., 28 pairs), one asking about one’s own behavior

and the other about the partner's behavior. Within the MMEA, there are four subscales that measure the dimensions of *Restrictive Engulfment*, *Denigration*, *Hostile Withdrawal* and *Dominance/Intimidation* (Murphy & Hoover, 1999; Shorey, Brasfield, Febres, Cornelius, & Stuart, 2012). *Restrictive engulfment* includes behaviors that restrict or inhibit another person's access to various resources and social rights, in efforts to make the partner more dependent on the perpetrator. *Denigration* is characterized by purposeful attacks on a partner's self-worth, usually through severe criticism and humiliation. Behaviors such as purposely denying a partner attention, emotional connection or affection are characteristic of the *Hostile Withdrawal* subscale. Lastly, *Dominance/Intimidation* is marked by aggressive behaviors that are intended to threaten, intimidate, and instill fear in another person. Examples of this include destruction of property, yelling and threatening one's partner, and driving recklessly (Shorey et al., 2012).

An example of an item for *Restrictive Engulfment* would be "Tried to stop the other person from seeing certain friends or family members". Items such as "Called the other person worthless, ugly, loser (or another negative labels)" characterize the *Denigration* subscale. An example of Hostile Withdrawal is "Intentionally avoided the other person during a conflict or disagreement". Lastly, the item "Stood or hovered over the other person during a conflict or disagreement" is representative of the *Dominance/Intimidation* subscale. The respondent reports the frequency of each behavior, using a 10-point Likert scale, ranging from "0" being "Never in the past 4 months" to "6" being "More than 20 times". Additionally, there is the option of selecting a 9, which means "Never in the relationship". A copy of the MMEA appears in Appendix

A. Scores for each subscale are calculated by computing a sum of all of the items on it, with higher scores indicating a higher frequency of partner aggression. The set of four subscale scores commonly have been used in prior research. In the present study, the four MMEA subscales were used to explore possible differences in impacts of the different forms of psychological aggression. The scores provided by the female partner, regarding her subjective experience of the psychological aggression inflicted upon her, were used.

Ro and Laurence (2007) report that the MMEA has high internal consistency, although the reliability differed depending on the subscale. Further, Shorey et al. (2012) reported that in addition to being an adequate instrument for assessing for a wide variety of psychologically aggressive behaviors, “the MMEA has demonstrated good validity and reliability” (p. 2). In the present sample, the Cronbach alpha coefficient for the MMEA Restrictive Engulfment subscale was .90, for Denigration it was .92, for Hostile Withdrawal it was .84, and for Domination/Intimidation it was .93. The Cronbach alpha for the total MMEA was .96.

Anxiety Symptoms

Subscales of the Trauma Symptom Inventory (TSI; Briere, 1995) were used in this study to measure anxiety symptoms. The TSI is an assessment tool that assesses acute and chronic trauma symptoms, as well as psychological-behavioral functioning experienced in relation to these symptoms experienced in the last six months. The TSI has been used to identify trauma symptoms resulting from experiences such as domestic abuse, rape, accidents, and even deeply rooted childhood trauma (Matešić, 2015). In total, there are 100 items. TSI items assess symptoms that are often associated with posttraumatic stress disorder (PTSD) and acute stress disorder (ASD), including anxiety

responses. Given the time frame covered by the TSI items, this assessment scale is not necessarily analyzing effects of one life stressor, but rather the accumulation of experiences over several months. The TSI items utilize a 4-point Likert response scale in which individuals report the frequencies of their symptoms. The Likert scale ranges from “0” (experiencing no symptoms) to “3” (experiencing a high frequency of symptoms) (Snyder et al., 2015). The TSI is comprised of 10 subscales. According to Snyder et al. (2015), “the 10 TSI clinical scales are the following, with the first five scales created to match DSM-IV-TR criteria: Anxious Arousal (AA), Depression (D), Anger/Irritability (AI), Intrusive Experiences (IE), Defensive Avoidance (DA), Dissociation (DIS), Sexual Concerns (SC), Dysfunctional Sexual Behavior (DSB), Impaired Self-Reference (ISR), and Tension-Reduction Behavior (TRB)” (p. 256). In addition, the TSI has three validity subscales that measure potential response biases: Response Level, Atypical Response, and Inconsistent Response (McDevitt-Murphy, Weathers, & Adkins, 2005).

This study focused on one specific TSI subscale (Anxious Arousal) that assesses symptoms associated with anxiety. The items that make up the Anxious Arousal subscale are questions (10) Periods of trembling or shaking, (13) Feeling tense or “on edge”, (15) Worrying about things, (20) Feeling jumpy, (23) High anxiety, (24) Nervousness, (40) Being startled or frightened by sudden noises, and (42) Feeling afraid you might die or be injured. These items reflect some of the autonomic physiological symptoms and the cognitions (e.g., worry) associated with subjective feelings of anxiety. Many of them mirror some of the symptoms experienced by an individual with an anxiety disorder such as PTSD or GAD and can be marked by an hypersensitive startle response and activation (Briere, 1995).

The respondent's scores on the items of each subscale are summed to get a total subscale score. The higher the score is, the higher the occurrence of the anxiety symptoms experienced. Internal consistency reliabilities previously found for the TSI subscales have been adequate, ranging between .84 and .87 (Snyder et al., 2015). Additionally, there appears to be both well-established criterion and construct validity (Briere, 1995; Snyder et al., 2015). For the Anxious Arousal subscale (8 items) used in the present study, the Cronbach alpha reliability previously has been found to be .81 (Matešić, 2015), and in the present sample it was .84.

For the present study, it was found that there were low to mild levels of anxiety experienced, with a mean score of 9.76. For this particular Anxious Arousal subscale of the TSI, the total possible score can range from 0-24 (with a 0-3 response scale used for each of the 8 questions). Therefore, the average anxiety level in this female sample was moderate.

Alcohol Use

The substance abuse section of the Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV; Brown, Di Nardo, & Barlow, 1994) was used to determine the level of alcohol consumption of the female partner in each couple. Most questions in the ADIS-IV focus on problematic behaviors during the last 4 months. This interview protocol asks the respondent questions about prevalence of consumption and associated cognitions and emotions, as well as impacts of use on the individual's interpersonal relationships and work performance. The questions ask the respondent about his or her own consumption and about the partner's consumption. The interview is conducted individually with each member of the couple. Likert scale questions and open-ended

questions ask about frequency of drinking, amount of drinking, and drinking in relation to destructive behaviors. For the present study, the question that was used to assess the woman's amount of alcohol consumption is:

1. How often, during the last four months, have **YOU** usually had ANY kind of beverage CONTAINING ALCOHOL, whether it was wine, beer, whiskey, or any other drink? *(If the past 4 months includes periods of abstinence and drinking, inquire about period(s) of drinking.)*

READ (Circle Answer)

- (0) Never
- (1) Several times
- (2) About once a month
- (3) Several times a month
- (4) 1-2 days a week
- (5) 3-4 days a week
- (6) 5-6 days a week
- (7) Everyday

There is no published information about the reliability and validity of this component of the ADIS.

Procedure

This study analyzed secondary data that have been collected previously since 2000 at the CHF. This researcher used scores from members of couples who attended therapy at the CHF and completed the standard pre-therapy assessment.

The assessment measures that were used in this study are the MMEA, the Anxious Arousal subscale of the TSI, and the item on the ADIS that assess the woman's amount of alcohol consumption. Those de-identified numerical data exist in a password-protected computer file in the CHF. Clients at the CHF give consent for the use of this information in research studies as part of their informed consent process before beginning the assessment and therapy. The sample of couple cases for this study were chosen based on the inclusion criteria described in the Sample section.

CHAPTER 4 RESULTS

Tests for Possible Control Variables

In order to determine whether any of the sample's demographic characteristics should be used as control variables in the tests of the hypotheses, their associations with the dependent variable TSI anxious arousal (AA) were computed. The Pearson correlation between personal yearly gross income and anxious arousal scores was $-.08$ ($p = .07$), the Pearson correlation between the individuals' years in their couple relationships and their anxious arousal scores was $.01$ ($p = .84$), and the correlation between the clients' age and anxious arousal was $-.01$ ($p = .88$). Therefore, none of those demographic characteristics were used as control variables.

The ADIS alcohol use item that includes eight categorical levels of usage was converted into a dichotomous variable, because many of the categories represented low levels of drinking; i.e., the response scale was skewed. Thus, the eight original response categories were condensed into *high* alcohol use and *low* alcohol use. The response options of (0) Never, (1) Several times, (2) About once a month, (3) Several times a month, and (4) 1-2 days a week, were classified as *low* alcohol consumption (coded as 1). Similarly, responses (5) 3-4 days a week, (6) 5-6 days a week, and (7) Everyday, were categorized as *high* levels of alcohol consumption (coded as 2). In the current sample, 83.6 % of participants engaged in low level alcohol consumption, while 9.7% of participants engaged in high levels of alcohol consumption, and 6.6% had missing data.

A one-way analysis of variance was used to compare the relationship status groups on their TSI Anxious Arousal scores. The original relationship status categories were collapsed into three categories. (1) Currently married, living together, (4) living

together, engaged, (6) dating living together, and (8) domestic partnership were grouped and coded as 1. Categories (2) currently married, separated, and (3) divorced, were grouped and coded as 2. Finally, categories (5) engaged, not living together and (7) dating, not living together, were grouped and coded as 3. The resulting ANOVA for TSI AA scores was not significant; $F(2, 554) = 1.98, p = .14$. Therefore, relationship status was not used as a control variable.

Another one-way analysis of variance was used to compare racial groups on TSI AA scores. The original set of racial categories was collapsed into a smaller number of categories. Initially, African American (2) was recoded as 1, White (5) recoded as 2, and all the other categories were coded as 3. The one-way ANOVA comparing these three groups on anxiety was significant. Because the mean difference for Whites was noticeably higher than the other groups, a further reduction was made into two groups of White participants and all of the other racial groups. The ANOVA comparing the two groups was significant; $F(1, 556) = 24.23, p < .001$. Consequently, race of the subject (White versus all other) was used as a control variable.

Finally, a one-way analysis of variance was conducted to compare level of education groups on their anxiety levels. The original set of categories was collapsed into a smaller number of categories. Some high school, high school diploma and trade school were grouped and coded as 1. Some college, associate's degree, and bachelor's degree were grouped and coded as 2. Some graduate education, master's degree, and doctorate degree were grouped and coded as 3. The ANOVA results were not significant: $F(2, 558) = 0.48, p = .62$, so level of education was not used as a control variable.

Tests of the Hypotheses

The hypotheses of the study were tested with five stepwise multiple regression analyses, one using the total MMEA score and four others using the individual MMEA subscale scores. In each multiple regression analysis, the control variable of race was entered in the first step. The two predictor variables of degree of psychological aggression victimization (assessed with the MMEA) and frequency of alcohol consumption were entered in the second step. That provided tests of the first two hypotheses, that greater psychological aggression victimization (H1) and greater alcohol use (H2) would be associated with greater anxiety symptoms. In the third step of each analysis, the interaction of psychological aggression victimization and alcohol consumption was entered, testing the third hypothesis (H3) that alcohol consumption would moderate the association between victimization and anxiety.

Before computing the multiple regression analyses, the investigator centered the independent variable of psychological aggression victimization (both the total MMEA score and each of the four subscale scores). Centering involves computing the mean value for a variable and then the difference score between each subject's score on the variable and the mean. After the variables were centered, an interaction term was created for the psychological aggression victimization by alcohol use interaction, by computing the product of those two variables, for the total MMEA and for the four MMEA subscales. The alcohol use variable was not centered because it was dichotomous.

In the first stepwise multiple regression analysis, the dependent variable was subjects' TSI AA scores and the independent variables were the total MMEA score and the alcohol use score. In the first step the subjects' race was significantly related to

anxiety, with the multiple correlation $R = .206$. In the second step of the analysis, the total MMEA score and the alcohol use score were entered. The multiple correlation $R = .216$, $R^2 = .047$; and the F for change in R^2 was not significant; $F(2, 465) = 1.03, p = .36$. Thus, the analysis did not support Hypothesis 1 or Hypothesis 2. In the third step of the analysis, the psychological aggression victimization by alcohol use interaction variable was entered, and $R = .220$, with the $R^2 = .048$. The test for change in R^2 from step 2 to step 3 was not significant; $F(1, 464) = 0.84, p = .36$. Thus, the moderation Hypothesis 3 was not supported.

In the second stepwise multiple regression analysis, the dependent variable was subjects' TSI AA scores, and the independent variables were the MMEA denigration subscale scores and the alcohol use scores. In the first step, the subjects' race was significantly related to anxiety, with the multiple correlation $R = .207$, $R^2 = .043$, $F(1, 510) = 22.84, p < .001$. In the second step of the analysis, the MMEA denigration score and the alcohol use score were entered. The multiple correlation $R = .224$, $R^2 = .050$; $F(2, 508) = 1.91, p = .15$. The effect for alcohol consumption was not significant; $\beta = .02, t = 0.45, p = .65$. The effect for denigration was $\beta = -.085, t = -1.94, p = .053$, borderline significant. Thus, the borderline significant finding for denigration was opposite to the hypothesized effect, and the non-significant finding for alcohol use did not support Hypothesis 2. In the third step of the analysis, the denigration by alcohol use interaction variable was entered, and $R = .230$, with the $R^2 = .053$. The test for change in R^2 from step 2 to step 3 was not significant; $F(1, 507) = 1.49, p = .22$. Thus, the test for moderation did not support Hypothesis 3.

In the third stepwise multiple regression analysis, the dependent variable was subjects' TSI AA scores, and the independent variables were the MMEA domination/intimidation subscale scores and the alcohol use scores. In the first step, the subjects' race was significantly related to anxiety, the multiple correlation $R = .210$. In the second step of the analysis, the MMEA domination/intimidation score and the alcohol use score were entered. The multiple correlation $R = .228$, $R^2 = .052$; $F(2, 515) = 2.12$, $p = .121$. The effect for MMEA domination/intimidation was significant; $\beta = -.089$, $t = -2.046$, $p = .041$, such that greater victimization with domination/intimidation was associated with lower anxiety symptoms. The effect for alcohol consumption was not significant; $\beta = .017$, $t = .388$, $p = .698$. Thus, the significant finding for domination/intimidation was opposite to Hypothesis 1, and the non-significant finding for alcohol use did not support Hypothesis 2. In the third step of the analysis, the domination/intimidation by alcohol use interaction variable was entered, and $R = .230$, with the $R^2 = .053$. The test for change in R^2 from step 2 to step 3 was not significant; $F(1, 514) = 0.59$, $p = .443$. Thus, this analysis did not support moderation Hypothesis 3.

In the fourth stepwise multiple regression analysis, the dependent variable was subjects' TSI AA scores and the independent variables were the MMEA restrictive engulfment scores and the alcohol use scores. In the first step, the subjects' race was significantly related to anxiety, the multiple correlation $R = .206$. In the second step of the analysis, the MMEA restrictive engulfment score and the alcohol use score were entered. The multiple correlation $R = .211$, $R^2 = .045$; $F(2, 485) = .511$, $p = .60$. Thus, the findings did not support Hypothesis 1 or Hypothesis 2. In the third step of the analysis, the restrictive engulfment by alcohol use interaction variable was entered, and $R = .213$

and $R^2 = .046$. The test for change in R^2 was not significant; $F(1, 484) = 0.517, p = .473$. Thus, there was no support for moderation Hypothesis 3.

In the fifth stepwise multiple regression analysis, the dependent variable was subjects' TSI AA scores and the independent variables were the MMEA hostile withdrawal scores and the alcohol use scores. In the first step, the subjects' race was significantly related to anxiety, with the multiple correlation $R = .204$. In the second step of the analysis, the MMEA hostile withdrawal score and the alcohol use score were entered. The multiple correlation $R = .209, R^2 = .044; F(2, 515) = .534, p = .587$. Thus, the findings did not support Hypothesis 1 or Hypothesis 2. In the third step of the analysis, the hostile withdrawal by alcohol use interaction variable was entered, and $R = .211$ and $R^2 = .044$. The test for change in R^2 was not significant; $F(1, 514) = 0.337, p = .562$. Thus, the moderation Hypothesis 3 was not supported.

CHAPTER 5: DISCUSSION

Summary of Findings

This study's aim was to examine the association between psychological aggression victimization in couple relationships and female victims' anxiety symptoms. Given prior research indicating that individuals commonly use alcohol as one strategy for coping with life stressors, this study also tested whether alcohol consumption by female victims of psychological partner aggression moderated the association between degree of victimization and females' experience of anxiety symptoms. It was hypothesized that women who were subjected to psychological aggression in their couple relationships and who consumed more alcohol would exhibit a stronger association between degree of victimization and the strength of their anxiety symptoms. However, the results from the study did not support the hypotheses. There was no significant association between two of the types of psychological aggression received (hostile withdrawal and restrictive engulfment) and victims' level of anxiety, and with two other types of psychological aggression there in fact were significant negative associations between psychological aggression and anxiety (greater victimization associated with less anxiety). The hypothesized positive association between females' alcohol use and their anxiety also was not found. Finally, the hypothesized moderation effect of alcohol use in worsening the association between victimization and anxiety symptoms was not supported by the findings. Consequently, the findings of this study raise more questions than they answered.

Specific Findings in Regard to the Hypotheses

Regarding the first hypothesis, there was no significant association between psychological aggression victimization on the total MMEA or on the restrictive engulfment and hostile withdrawal subscales and women's anxiety symptoms. When it came to the other two subscales on the MMEA (denigration, and domination/intimidation), there was a negative association between the two variables indicating that psychological aggression, within the context of these two subscales, was associated with lower anxiety levels among female partners. This finding is not consistent with prior research literature describing how victims of psychological aggression, similar to those experiencing physical violence, are likely to experience a variety of poor mental health outcomes, including anxiety, depression and even PTSD (Começanhaa, Pereira, & Maia, 2017; Pico-Alfonso et al., 2006). The present results suggest that the psychological aggression that is experienced by women in their couple relationships within this clinic sample was not related to the anxiety that they report experiencing in their daily lives. There are several possible explanations for these findings that were contradictory to the hypothesis and prior research findings linking victimization and aspects of poor mental health.

One interpretation of this finding is that it may be that the anxiety that is being experienced and reported by women attending the CHF and completing the Trauma Symptoms Inventory (TSI) is due to a variety of other life stressors and issues, rather than specifically associated with the psychological aggression received from their male partners. Couples seek assistance at the CHF for multiple reasons that may elicit symptoms of emotional distress. For this sample, even if some psychological aggression

is present, it may not be the root of the issue for which many of the women have sought couple therapy. Therefore, variance in levels of anxiety symptoms assessed by the TSI may be accounted for by other issues in the clients' lives rather than partner aggression. Because this study did not assess other sources of stress in the women's lives, it is not possible to determine what other variables may have been associated with their TSI Anxious Arousal scores.

Also, the emotional distress, and anxiety in specific, that is experienced from partner aggression may include other types of symptoms that are not measured by the Anxious Arousal subscale of the TSI. Women who are experiencing anxiety from the distress of their victimization may not be thinking about it in terms of what is going on physically in their body, which the AA items primarily assess. It is possible that within the context of relationships in which partner aggression occurs sporadically, those anxiety symptoms that are experienced within the scope of an abusive encounter in the moment may subside after the abusive interaction has ended and are not tapped well by an overall anxiety scale. In Walker's (1979) description of the "cycle of violence," victims commonly experience periods of relative peace and calm between their partners' violent episodes, and during those periods they may experience little emotional distress such as the jumpiness assessed by the TSI. To address more pervasive feelings of anxiety that may occur in relationships with intermittent and perhaps mild to moderate rather than severe psychological aggression, a broader range of anxiety assessment items relating to thoughts associated with overall security in the relationship may be needed.

There is still a high likelihood that the women in the sample who had experienced partner aggression had felt some types of anxiety symptoms, especially as an abusive

interaction with a partner was developing. However, when the females completed the TSI during their pre-therapy assessment, reporting on typical symptoms during the past six months, there may not be any immediate cause for concern about partner aggression, and they may have under-reported feelings of unease (jumpiness, nervousness, danger). Thus, the timing of the assessment and the limited scope of the TSI Anxious Arousal items may have failed to capture the negative effects that psychological partner aggression had on the female victims.

The two MMEA subscales that produced significant associations between psychological aggression victimization and less anxiety may represent similar aspects of negative couple interaction. Denigration is characterized by acts that involve purposefully demeaning and insulting another individual. Hypothetically, if this type of behavior occurs frequently in a relationship, to the extent that it is “normalized” as how one or both partners behave when arguing, it may be possible that anxiety or fear would not be the resulting emotion felt by the recipient. Rather, the recipient might be more likely to experience frustration and anger toward the partner who expressed such insults. Domination/intimidation can also fall into this category, resulting in more anger (as opposed to more vulnerable emotions such as anxiety) given that the victim may become agitated by their partner’s efforts to control their life and create added fear in the relationship. Each of these two types of psychological aggression is characterized by a perpetrator’s aggressive confrontation, marked by actions that aim to belittle, control, restrain, and cause obvious direct harm to the other person. Rather than an *absence* of interaction (as with hostile withdrawal or restrictive engulfment) the other forms psychological abuse require the perpetrator to be more active in their attempts to control

and hurt their partner. Hostile withdrawal and restrictive engulfment takes a more passive and neglectful approach, aiming to hurt an individual with a lack of communication, attention or regard and strip them of resources. With repeated exposure to such types of aggression, it seems possible that the victim might be more subject to anger as a more appropriate and immediate response. Even if the recipient does experience some anxiety, she may cope with it by focusing on the more powerful emotion of anger, consistent with the core assumption in emotion-focused couple therapy (Johnson, 1996) that individuals cover underlying “primary emotions” such as anxiety with “secondary emotions” such as anger. Given that the overall level of aggression in this clinic sample was relatively mild (the Center for Healthy Families staff screen out severe partner aggression cases from use of couple therapy), the recipient may be minimizing any experienced anxiety, as she is not being terrorized. Because this study did not assess the women’s levels of anger toward their partners, this possibility that they experienced anger rather than anxiety cannot be verified.

Another possible explanation for the unexpected finding may be that chronic exposure to psychological partner aggression could lead the women to develop “learned helplessness” that reduces anxiety responses. Thus, the female partners may have become habituated to this type of partner aggression and believe that they have no control over it. Perhaps at one time it caused them a significant amount of distress, yet over time they have developed an emotional exhaustion or numbing. In fact, Iverson et al. (2013) found that victims of partner aggression may dissociate or withdraw in order to cope with some of the harmful effects of their abuse, often keeping them at risk for further re-victimization. Provided that these women have learned this as an “effective” coping

strategy, it may be that the female partner is immediately resorting to this method of coping, mentally tuning out some of the aversive partner aggression. That being the case, she therefore would actually be subconsciously be protecting herself from experiencing anxiety, which could account for the present study's findings.

Contrary to the second hypothesis, there was no association found between the frequency of alcohol being consumed and the anxiety symptoms experienced by the women in this clinic sample. There are alternative possible interpretations for this finding that in this particular sample the women's frequency of drinking per week was unrelated to their anxiety symptoms as assessed by the TSI. This can be related back to prior research showing that small amounts of alcohol can actually reduce anxiety, improve mood, and increase positive couple interaction (Testa et al., 2014). This being said, it is possible that the alcohol that women in this sample consume has little or no negative effect on their overall psychological functioning. The alcohol may be doing just enough to help control anxiety, or possibly even distort the victimized women's perceptions about their couple interactions. The one ADIS item used to measure alcohol consumption in this study did not ask about the functions that the drinking serves for the individual (e.g., social drinking, regular accompaniment to meals, daily stress reduction).

Additionally, it may be important to note that because this is a clinical sample of couples who actively sought therapy, they may use more active ways of coping with relationship issues such as partner aggression. These couples may be taking a more active role in the betterment of their relationship, so their drinking is not a significant way of coping with problems.

Lastly, the final hypothesis was not supported. There was no moderation effect found for drinking on the association between psychological aggression victimization and female anxiety symptoms. This finding is also inconsistent with prior research findings that show that alcohol consumption as a coping strategy in relationships with partner aggression can result in negative consequences for the drinker (Keller, El-Sheikh, Keiley, & Liao 2009; Fairbairn & Cranford, 2016). Much of the prior research indicated that the anxiety that is experienced by victims of abuse is often numbed through consumption of alcohol. For those other clinical samples, it seems as if coping in that way resulted in continual issues with not only prolonged partner aggression, but also further alcohol consumption and negative mental health outcomes.

In contrast, in the present sample it could be possible that there are several other things that victims of psychological aggression may be doing to alleviate anxiety they are experiencing, such as: fighting back, venting to others, and accessing resources such as mental health professionals. As noted earlier, another interpretation for this finding could be that the victims of psychological partner aggression in this sample may not be defining the behavior as highly inappropriate in their relationships. According to Arriaga and Schkeryantz (2015), psychological aggression is much less recognized or seen as an issue in relationships as compared to more overt forms of abusive behavior, such as physical violence. It is possible that there has been a habituation that has occurred, in which victims of mild to moderate psychological aggression may evaluate their situation as “normal” or “typical” couple conflict, and have even begun to become accustomed to it over time. To the extent that this normalization or habituation has occurred, victims of psychological partner aggression may perceive no reason to engage in alcohol use as a

way to cope, given that they may be more distressed about unresolved areas of disagreement (e.g., regarding money management, child-rearing) and unmet needs with their partner than by the partner's particular negative ways of behaving toward them when arguing.

Another explanation for these findings may involve the specific sample that makes up the clientele at the Center for Healthy Families. As mentioned, the CHF offers a broad array of services for its individuals, couples, and families. The sample for this study was taken from a larger pool of couples that sought services at the CHF for various reasons, with no requirement that they had to be couples who have experienced partner aggression. The CHF is not known in the neighboring community specifically for addressing partner aggression, and as noted earlier, couples who have engaged in severe physical aggression within a certain period of time are screened out and are not provided couple therapy services. Due to safety concerns, high violence couples are referred to other services.

That being said, many of the couples that were in the sample presented with mild to moderate psychological aggression. Although they may be unhappy with their relationships' circumstances, there is little evidence that suggests that they are interpreting the aggression in their relationship as abusive or dangerous. Epstein, Werlinich, and LaTaillade (2015), state that many of the couples that fall in this mild/moderate range often engage in "common couple violence" which encompasses more "normal" and expected types of aggressive behaviors that rarely inflict harm. It is probable that most of the aggression that is occurring in this sample may not fall into areas such as *intimate partner terrorism*, or *resistant violence*, which often make up a

large portion of IPV cases (especially those with physical abuse). Further, this type of common aggression is often mutual and occurs bidirectional between both partners in the relationship. That being said, there is little reason to believe that either partner perceives the couple encounters as anything more than a fight/argument, rather than an experience of abuse. In the context of anxiety symptomatology, it would be necessary for some level of danger to be perceived in order to elicit anxiety symptoms. In much of the literature that covers mental health complications as part of the negative aftermath of partner aggression, the samples usually involve severe violence, especially physical. When studying this topic, many of the samples are exclusively couples or individuals who fall into this category of violence. This was not the case for the sample used in this study, which may be a significant contributor to the findings.

When the hypothesis regarding an association between psychological aggression victimization and anxiety symptoms was tested, not only with the overall MMEA score but also explored separately with the four subscales, some differences were found by type of psychological aggression. There were significant inverse associations between both denigration, and domination/intimidation and level of anxious arousal, which were in the opposite direction as hypothesized, whereas hostile withdrawal and restrictive engulfment were unrelated to anxiety symptoms. The variation in findings across MMEA subscales suggests that it is important to differentiate types of psychological aggression and to tailor therapeutic interventions based on an assessment of the pattern observed in each couple. As noted, regarding the surprising finding that receiving denigration, and domination/intimidation was associated with female partners' lower anxiety, it is important to consider that types of aggression such as these may yield significant

emotions other than just anxiety. Alternative emotional products of victimization, such as anger, apathy, or even helplessness, may play a part in the lower levels of anxiety experienced by these participants. These emotions may accompany, substitute for, or even overpower the experiences of anxiety felt by victims of partner aggression, and therefore need to be taken into consideration.

Limitations of the Study

There were a number of limitations to this study that may have altered its results. First, there were limitations in regard to some of the measures that were used to assess the variables. On the one hand, the MMEA seemed to be an adequate and appropriate measure of psychological aggression, given that it measures four major types of psychological aggression, asks about both one's own and the partner's behavior, and has good evidence of established reliability and validity. Nevertheless, the topic of psychological aggression is a sensitive one, and it is not clear how honest the clients may have been when completing the MMEA during their initial visit to the clinic, when they had no established relationship with a therapist. In contrast, the simplicity of the alcohol measure, involving only one item asking about frequency of drinking alcohol on a weekly basis and relying on the honesty of the women's self-reports, easily may have limited its value as the index of the moderator variable. That question alone may not provide an adequate measure of a person's alcohol consumption, or an adequate reflection of the pattern and dynamics of an individual's alcohol use (especially as a coping pattern). A more thorough assessment would need to include more questions about the nature of someone's alcohol use, addressing not only how many times a week they drink but also

how many drinks in a given setting, the purpose for drinking, and the effects of the drinking on the person's functioning.

Additionally, the TSI may not have been an adequate measure of the anxiety experiences of women in response to psychological partner aggression. As mentioned, although there is the chance that the anxiety is indeed being felt by the female partner at a given moment of abuse, it may not mirror the state of anxiety she experienced at the time she was asked to report about it for the study. Because there may not be any anxiety being experienced in the moment of filling out the questionnaire, perception of severity of this variable may go unnoticed. The TSI subscale used for this study may not factor in the "cool down" periods that follow instances of aggressive behavior. Further, although the TSI has specific items that are dedicated to anxious symptomology, it may not have been an accurate measure of the types of anxiety responses among individuals who have experienced or presently are experiencing partner aggression. Because the study used only the "anxious arousal" subscale of the TSI, the set of items was limited in its coverage of the range of anxiety symptoms. The items on this subscale primarily addressed physiological symptoms of anxiety, such as "jumpiness" and "being easily startled." However, living with a partner who may intermittently behave aggressively may elicit other cognitive and emotional symptoms of anxiety, such as hyper-alertness for cues that the partner may be building toward an aggressive outburst, or rumination and worry about the overall future of the relationship, as well as insecurity about a partner's hostile withdrawal. Those types of symptoms may not have been captured adequately with the TSI Anxious Arousal subscale, limiting the study's ability to test the hypotheses. It can also be argued that some people have a difficult time noticing and

acknowledging physical symptoms of their anxiety, as they may be more focused on their thoughts or their behavioral attempts to avoid a psychologically aggressive partner, or even to retaliate against him. Perhaps, in some cases it may take more self-reflection to identify some of one's bodily symptoms of anxiety, especially when symptoms are recurrent and pervasive. Had this study used a measure for anxiety that addressed more cognitive and behavioral aspects of anxiety in relation to fear, worry and safety, the results may have been very different.

Lastly, only the female's own self-reports of alcohol consumption, psychological aggression victimization, and anxiety symptoms were used for this study. Using one member of the couple's account of each of these variables leaves room for reporting bias. For some of these variables, it would have been helpful to look at the perceptions of the male partner in addition to the female, particularly regarding the female's alcohol consumption. Originally female scores were only included because it was believed that they would have the best awareness and insight in regard to the aggression that they were experiencing from their partner, as well as the amount of anxiety they were experiencing as a result. As noted, this may not be the case.

Additionally, there may have been several limitations when it came to the alcohol measure of the study and the assumption that the drinking engagement by the female partner was directly connected to coping with their victimization. The reported number of days during the week that an individual consumes alcohol does not indicate the function that the drinking serves, including coping with partner aggression. The women in this sample could have been drinking for several other reasons that may not be connected to the partner aggression they were experiencing. The single question on the alcohol

measure does not give a detailed depiction of the individual's alcohol consumption. Although it provides information about how many days a week the individual may consume alcohol, there is no information provided as to why they are drinking, and how much they are drinking on a given day. Additionally, the only aspect of alcohol use that was addressed in this study was frequency of usage, only inquiring as to the general number of days during the week that an individual had *any* type of alcohol. Much of the overarching literature that examines behavioral patterns in relation to alcohol use looks at frequency AND severity. More information about the number of drinks consumed on a given occasion, binge drinking behaviors, and possibly types of alcohol, would give more insight as to the severity of which participants are engaging in problematic levels of alcohol use. Other studies derived more accurate results by looking at this telling aspect of alcohol engagement. Furthermore, as noted earlier, this in-person interview (with a clinician the respondent has just met) may result in some hesitancy or reluctance to be honest with one's answers. Social desirability may account for the sample's reporting fairly low overall rates of drinking.

As previously noted, the sample that used for this study most likely contributed to the overall limitations of the study. This clinic sample primarily included couples with mild to moderate psychological and physical aggression. Additionally, the sample for this study included couples seeking services at the CHF for a wide variety of presenting concerns, many of which had nothing to do with partner aggression. To the extent that a many couples were not experiencing partner aggression, the ability of this study to tap into the consequences of psychological partner aggression may have been limited.

Recommendations for Future Research

To start, it would be beneficial to replicate this study with more appropriate and reliable measures that would create a better test of the hypotheses. The TSI and the alcohol consumption question did not seem very well suited as measures of the key variables in the study. A more well-rounded assessment that includes several items addressing the cognitions, feelings, behaviors, and physiology of anxiety would have given a more accurate picture of how these feelings of distress or worry are being experienced. Being that people experience their anxiety in different ways, it would be important to include an assessment that better represents these various characteristics. Additionally, having one question as a basis for measuring alcohol use does not provide enough information about the degree of alcohol consumption and its effects on the individual. More questions need to be used regarding intent to drink, and outcomes of drinking. Additionally, this might be an assessment that is not conducted through the form of an interview, where people are required to admit to these behaviors to someone with whom they are unfamiliar. It also should be emphasized to participants that their responses will be kept strictly confidential, to attempt to reduce social desirability responding. Furthermore, given that alcohol is just one substance that people are capable of consuming as a coping process, more research could extend the assessment to other types of substances as well.

One of the biggest questions that still exists in regard to this topic is whether victims of psychological aggression view the psychologically aggressive behavior as problematic. Whether it is accompanied by physical aggression or not, individuals may be less aware of the harmful effects of psychological aggression on their mental and

physical health. It would be important to get more information about how victims interpret their own victimization and at what level it becomes an issue for them. If not anxiety, it would be beneficial to see what areas of life victims believe are affected by psychological partner aggression. If members of couples were more aware of the psychological aggression that is present in their relationships and evaluated such behavior as problematic, there may be a foundation set as to how they perceive the reasons for their anxiety.

Another important consideration concerns the topic of victim responsiveness. Being that many studies indicate that partner aggression is bidirectional, it is likely that a victim may be reacting or retaliating to the initial abuse to which they are being subjected. Responding to the aggression in this way may leave little room for anxiety symptomology. Thus, rather than experiencing concern or distress with an experience of partner aggression, victims may match the perpetrator's bids with aggression of their own. Future work in this area may wish to look at some of the retaliatory behavioral responses that are a result of partner aggression victimization and inquire more about the role of fear or anxiety in this process at all. Instead, the focus could be on the reciprocated aggression from the victim and their emotional state.

Given prior evidence that psychological aggression in a relationship causes individual and couple problems, more research needs to be done to examine ways that people who are experiencing this form of aversive behavior cope with the distress that accompanies it. This may take the form of a direct interview (using qualitative research methods), and could examine different ways that victims view the behavior and how they address it as an issue. In-depth examination of each of these variables would give more

insight into the nature of how they might interact. For example, in relation to anxiety, a qualitative researcher could ask more questions about some of the individual's thoughts and emotions related to their anxious symptomology, and if those responses tend to follow instances of partner aggression. Investigators could also get more information about what other emotions victims experience, how they typically cope with their distress, and if they ever use alcohol as a means to combat difficult thoughts/feelings, as well as when. Such qualitative data could enhance understanding of the connections among partner aggression victimization, alcohol use, and anxiety, as well as related responses.

Similarly, because there were some differences in associations of the four types of psychological aggression and victim anxiety, it would be beneficial for research to focus on each one of the forms (restrictive engulfment, domination/intimidation, hostile withdrawal, and denigration) to see which types have the most harmful effects on victims and what those effects are. Research should examine which factors (e.g., the meanings that victims attach to the forms of aggressive partner behavior) may contribute to one type of psychological aggression having more negative effects than another, and how that might vary from couple to couple.

Future research also could explore other contextual factors that may influence effects that partner aggression have on victims' well-being. The current sample was fairly diverse in demographic characteristics, but more could be done in terms of examining cultural differences in the degree to which partner aggression is perceived as inappropriate. In addition, cultural differences in coping strategies could be explored. As noted earlier, the unclear findings from this study raise many questions, but they do not

detract from the original question of how individuals cope with partner aggression. Hopefully, future studies will address the limitations of the present work and increase understanding of this important topic.

Clinical Implications

Based on the results from this study, there are several implications for future work in clinical practice. As mentioned, it is possible that victims of psychological aggression may not be aware of the prolonged and harmful affects of this form of abuse. More psycho-education from therapists can help guide couples to the insight they need in regard to the severity of the aggression present in their relationships. This can help give clients, and especially victims, more of an idea of the connection between their symptomology and its etiology. Not stopping there, this additional awareness will encourage and facilitate the implementation of intervention strategies and prevention. Therapists can not only provide couples with tools to assist with the reduction of aggression in their relationships, but also active tools to help them cope with the thoughts and feelings that may follow.

Furthermore, the results from this study indicate that more information is needed regarding the conditions in which people might engage in drinking as a way of coping with partner aggression. Although there was a low to moderate amount of alcohol consumed within this sample, there was little information to indicate that it was used specifically as a method of coping. Although therapists might conduct interviews and assessments regarding prevalence and severity of alcohol consumption, there may be gaps in knowledge regarding the intent behind usage, and what therapists then can do

with that information. Connecting back to Lazarus and Folkman's (1984) stress and coping theory, drinking alcohol is an emotionally focused coping strategy and can be used as a means of avoidance in efforts to suppress the negative feelings caused by an aversive stimulus (Lazarus & Folkman, 1984). Knowing that a client is engaging in alcohol use, especially for this purpose of avoidance, can help give therapists more of an idea about why they might not have high levels of anxiety in abusive relationships, or how the alcohol use might even exacerbate the anxiety further.

Conclusion

Although this study yielded minimal significant findings, and none in support of the hypotheses, the study's topic still stands as an important and relevant area for exploration. Intimate partner aggression remains a serious concern in couple relationships. The lack of knowledge and recognition regarding the impacts of psychological aggression alone needs to be illuminated and more adequately addressed by clients, therapists, and researchers. Much of the available prior research seems to indicate that victim anxiety is one of many negative products of partner aggression and that alcohol remains one of the many ways that victims of aggression cope with their abuse. Given those trends, it is still worth pursuing additional research on associations among the three variables.

Regardless of this study's limitations, the findings provide further context for understanding the nature of the psychological aggression and also highlight important differences among its various forms. Additionally, the study raises important questions about the manner in which victims of aggression perceive and interpret their abuse, their subsequent emotional reactions, and the possible roles of coping in regard to these

processes. Expanding on relevant knowledge pertaining to this topic, researchers should aim to delve deeper into the “how?” and “why?” regarding associations between psychological aggression and anxiety symptoms, while simultaneously examining alcohol use and victim drinking intentionality, as they relate to coping.

Appendices

Appendix A: Trauma Symptom Inventory



TSI-A (ASSESSMENT)

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

Instructions: The items that follow describe a number of things that may or may not have happened to you. Read each one carefully, and then indicate on the answer sheet how often it has happened in the last **6 months** by circling the correct number. Circling a 0 means it hasn't happened at all in the last 6 months. Circling a 3 means it has happened often in the last **6 months**. Circling a 1 or 2 means it has happened in the last 6 months, but has not happened often.

Never
Often
0
1
2
3

Please answer each item as honestly as you can. **Be sure to answer every item.**

*In the last **6 months**, how often have you experienced:*

		Never			Often
1/1.	Nightmares or bad dreams	0	1	2	3
2/2.	Trying to forget about a bad time in your life	0	1	2	3
3/3.	Irritability	0	1	2	3
4/4.	Stopping yourself from thinking about the past	0	1	2	3
5/8.	Flashbacks (sudden memories or images of upsetting things)	0	1	2	3
6/10.	Feeling like you were outside your body	0	1	2	3
7/12.	Sudden disturbing memories when you were not expecting them	0	1	2	3
8/15.	Becoming angry for little or no reason	0	1	2	3
9/20.	Your mind going blank	0	1	2	3
10/22.	Periods of trembling or shaking	0	1	2	3
11/23.	Pushing painful memories out of your mind	0	1	2	3
12/26.	Feeling like you were watching yourself from far away	0	1	2	3
13/27.	Feeling tense or "on edge"	0	1	2	3
14/29.	Not feeling like your real self	0	1	2	3
15/31.	Worrying about things	0	1	2	3
16/34.	Being easily annoyed by other people	0	1	2	3
17/35.	Starting arguments or picking fights to get your anger out	0	1	2	3
18/37.	Getting angry when you didn't want to	0	1	2	3
19/38.	Not being able to feel your emotions	0	1	2	3
20/41.	Feeling jumpy	0	1	2	3
21/42.	Absent-mindedness	0	1	2	3
22/45.	Yelling or telling people off when you felt you shouldn't have	0	1	2	3
23/51.	High anxiety	0	1	2	3
24/54.	Nervousness	0	1	2	3
25/57.	Feeling mad or angry inside	0	1	2	3
26/59.	Staying away from certain people or places because they reminded you of something	0	1	2	3

*In the last **6 months**, how often have you experienced:*

		Never			Often
27/62.	Suddenly remembering something upsetting from your past	0	1	2	3
28/63.	Wanting to hit someone or something	0	1	2	3
29/66.	Suddenly being reminded of something bad	0	1	2	3
30/67.	Trying to block out certain memories	0	1	2	3
31/70.	Violent dreams	0	1	2	3
32/72.	Just for a moment, seeing or hearing something upsetting that happened earlier in your life	0	1	2	3
33/74.	Frightening or upsetting thoughts popping into your mind	0	1	2	3
34/83.	Not letting yourself feel bad about the past	0	1	2	3
35/84.	Feeling like things weren't real	0	1	2	3
36/85.	Feeling like you were in a dream	0	1	2	3
37/87.	Trying not to have any feelings about something that once hurt you	0	1	2	3
38/88.	Daydreaming	0	1	2	3
39/89.	Trying not to think or talk about things in your life that were painful	0	1	2	3
40/91.	Being startled or frightened by sudden noises	0	1	2	3
41/93.	Trouble controlling your temper	0	1	2	3
42/97.	Feeling afraid you might die or be injured	0	1	2	3

Appendix B: Multidimensional Measure of Emotional Abuse



MMEAS (DAY 1)

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.

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

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

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