AN ABSTRACT OF THE DISSERTATION OF

Roxanne G. George for the degree of Doctor of Philosophy in Human Development and Family Science presented on June 4, 2004.

Title: Exploring Intimate Violence Typologies for Women and Men: Implications for Research and Practice

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Redacted for Privacy

Samuel Vuchinich

Anisa M. Zvonkovic

Typologies of intimate violence are part of an emerging paradigm towards a multifaceted, multi-theoretical approach to understanding the causes and effects of intimate violence. For this new paradigm to be implemented into research and practice, there are several gaps in the knowledge base that must be addressed. In particular, there is a need: (a) to develop a more comprehensive typology of intimate violence that integrates characteristics of perpetrators with interactional characteristics of violence; (b) to evaluate the differential effects of this comprehensive typology for women and men; and (c) to develop of a clinical assessment approach that incorporates the most current knowledge on typologies of violence with the most current knowledge on assessment practices. Two studies were conducted to address these gaps. The first study is an empirical analysis testing Johnson's (1995; 2002) coercive control construct as an indicator of type and effects of intimate violence for women and men using secondary data analysis methods. The second manuscript is the development of a tiered intimate violence assessment approach that incorporates current knowledge on conjoint assessment with current knowledge on typologies of intimate violence. A conceptual clinical assessment approach is proposed that can be tested for its usefulness in assisting clinicians with assessing for intimate violence during conjoint sessions, and for determining whether conjoint treatment is indicated.

# Exploring Intimate Violence Typologies for Women and Men: Implications for Research and Practice

by

Roxanne G. George

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APPROVED:

Redacted for Privacy

Co-Major Professor, representing Human Development and Family Science

Redacted for Privacy

Co-Major Professor, representing Human Development and Family Science

Redacted for Privacy

Chair of the Department of Human Development and Family Science

Redacted for Privacy

Dean of Graduate School

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Roxanne G. George, Author

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# CONTRIBUTION OF AUTHORS

Dr. Sam Vuchinich and Dr. Anisa M. Zvonkovic assisted with the analysis design for Chapter 2, and provided multiple levels of feedback for all chapters of this dissertation.

Dr. Jeff Todahl provided the *Relational Confidentiality Agreement* (Figure 3.2), and assisted with the development of the integrated tiered assessment approach outlined in Chapter 3.

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# DEDICATION

This dissertation is dedicated to the memory of Jay Mallory George (1962 – 1975), whose violent and tragic death symbolized the end of a history of family violence, and created an opportunity for growth, healing, and change.

# PREFACE

"Core disagreements about the very nature of families characterizes our discipline.... Yet, few of us hold ourselves accountable for revealing how our ideas are rooted in or own history, experience, and values. As we give up the search for theoretical uniformity, we will have to work with and not gloss over the tensions in our disparate viewpoints. Family studies is an exciting location for intellectual discourse and social change when we can take on our own ideas critically and engage each other with respect, care, and rigor" (Allen, 2001, p. 40).

As a graduate student concurrently enrolled in a Marriage and Family Therapy program with an applied clinical approach founded in systems theory, and a Human Development and Family Science program with a focus on research and policy in family studies from an underlying feminist perspective, I became very aware of the controversial divide that exists between theorists, researchers, and clinicians around appropriate assessment and treatment of intimate violence (also referred to as partner violence throughout this paper). As a practicing marriage and family therapist, I have struggled with trying to maintain that delicate balance between creating a safe and trusted space for sharing, and the need to assess for violence early on due to the potential safety risk to all family members if violence is present. As a survivor of family violence, I appreciate the complex, and often misunderstood, interconnectedness between love, power, and violence in families, and the cost of this violence when it is not assessed and treated appropriately. And finally, as a clinical researcher, I am excited about the potential to contribute to an area of family studies that I feel very passionate about, and that, in my belief, contains many disparate viewpoints that need to be more fully explored.

When I first began exploring the literature on partner and family violence in the early 1980's, I would often come away feeling discouraged and unsatisfied. None of the definitions and characteristics captured the complex and interconnected qualities of my own experiences, and none of the voices spoke to the potential for growth, healing, and resiliency that I knew to be an integral part of the painful journey through intimate violence. Finally, in the 1990's, I came across a few voices offering a more

comprehensive and compassionate view. Cloe' Madanes'(1990) compassionate yet accountable strategic approach to treating family violence in therapy inspired me to test the current knowledge, understanding, and beliefs around this issue. The insightful and inspiring words of bell hooks (2000) helped me believe that I could pursue this issue through a feminist lens without compromising the perspective that the feminist movement has fought so hard to achieve. It is my hope that this project will contribute a much needed layer of complexity and breadth to our understanding of the assessment and treatment of intimate violence.

# Chapter 1: Introduction

## *Overview*

### *The Issue*

There are two longstanding debates between theorists, researchers, and clinicians around the assessment and treatment of intimate violence (also referred to as partner violence throughout this paper). One of the debates pertains to the issue of gender and partner violence. In particular, large-scale national studies tend to show that heterosexual partner violence is roughly gender symmetric[1] with only a small percentage of extreme cases of men and women unilaterally dominating and oppressing their partners (Johnson, 1995; Straus, 2000). Agency and shelter studies typically show a much higher percentage of this extreme violence by one partner over the other, and that it is perpetrated almost exclusively by men (Johnson, 1995; Johnson 2002). The second debate pertains to the conjoint (couples) assessment and treatment of intimate violence. Feminist theorists, researchers, and clinicians maintain that partner violence must be evaluated within the context of the underlying socially constructed dynamics of power and control. Therefore, the conjoint treatment of intimate violence has been highly criticized, due to its propensity to minimize, overlook, or support the underlying dynamics of power and control that sustain the violence. Systems theorists, researchers, and clinicians maintain that intimate violence must be evaluated and treated within the context of the interactional dynamics of the partner system, which is best accomplished through conjoint work. Intense debates around the nature of these issues has often led to polarization among well-intentioned researchers, theorists, and clinicians who share the common goal of stopping family violence.

### *The Emerging Paradigm: Typologies of Intimate Violence*

In the past two decades, there has been a move towards research on typologies of intimate violence, including typologies based on characteristics of the perpetrators, and typologies based on interactional characteristics of the violence. The findings from this research suggest that some types of partner violence are more gender symmetric, while others are not. In addition, the research indicates that some types of partner violence may cause considerably more physical and psychological harm to their victims than other

types of partner violence. And lastly, this research suggests that some types of partner violence (and perpetrators) may be amenable to conjoint treatment, while others may not.

One promising theoretical typology of partner violence that is gaining recognition in the field is Michael Johnson's (1995; 2002) typology, an interactional typology of partner violence grounded in the feminist principles of power and control. Johnson's typology makes distinctions between types of partner violence based on the absence or presence of a pattern of coercive control criteria, rather than on physical violence. No other typology makes this distinction. There are also a handful of promising typologies emerging that focus on the characteristics of both male and female perpetrators. This research on typologies has brought forth a new paradigm calling for a multi-faceted, multi-theoretical approach to understanding and evaluating intimate violence that may help to bridge the long-standing divide between theorists, researchers, and clinicians.

*Implications for Research and Practice*

The implications of this new paradigm for research and practice are many. From a research perspective, typologies of intimate violence add needed complexity to a phenomenon that is not well understood, which may improve the way we measure, predict, theorize, and make policy about intimate violence. From a clinical perspective, an assessment and treatment approach that makes distinctions between types of violence, and tailors the treatment to the particular needs of the client, may improve treatment effectiveness and client retention. This paradigm also opens the door for dialogue and investigation of the effective use of conjoint treatment for some types of violence. In addition, an assessment approach that makes distinctions between types of violence based on power and control dynamics (rather than on physical violence alone) may provide earlier detection of physical violence, as well as provide detection for individuals who experience psychological harm not accompanied by physical violence.

*Gaps in the Current Knowledge Base*

For this new paradigm to be successfully implemented into research and practice, there are several gaps in the knowledge base that must be addressed. In particular, a comparison of the existing typologies indicates that there may be similarities and overlaps between types of violence and types of perpetrators. There is a need to develop a

more comprehensive typology of intimate violence that integrates characteristics of perpetrators with interactional characteristics of violence, and to evaluate the differential effects of this comprehensive typology for women and men. Johnson's coercive control construct may prove to be a useful measure for making distinctions between types of intimate violence and understanding their characteristics and effects. There is a need to empirically test Johnson's hypotheses pertaining to the use of coercive control as an indicator of type and effects of intimate violence for women and men. In addition, the current clinical protocol for the assessment and treatment of intimate violence does not make distinctions between types of violence. There is a need for the development of an assessment approach that incorporates the most current knowledge on typologies of violence with the most current knowledge on assessment practices.

*The Goal of This Dissertation*

The goal of this dissertation is to extend the current knowledge base on intimate violence typologies to begin to address these gaps. To do this, two separate studies were conducted and have been presented in manuscript format for submission to journals. The first manuscript (Chapter 2) is an empirical analysis testing Johnson's hypotheses pertaining to the use of coercive control as an indicator of type and effects of intimate violence for women and men using secondary data analysis methods. The second manuscript (Chapter 3) is the development of a tiered clinical intimate violence assessment approach that incorporates current knowledge on conjoint assessment with current knowledge on typologies of intimate violence. A conceptual clinical assessment tool is proposed that can be tested for its usefulness in assisting clinicians with assessing for intimate violence during conjoint sessions, and for determining whether conjoint treatment is indicated.

## *Extended Literature Review: Background and Rationale*

### *Theoretical Perspectives: Systems, Feminist, and Psychobiological Theories on Intimate Violence: A Symmetrical, Complementary, or Parallel Union[1]?*

Post-modern systems theory has evolved considerably since the 1950's, when family systems theory, which originated from general systems theory, began to emerge (Whitchurch & Constantine, 1993). Many of these changes came about due to the

feminist critique of systems theory's approach to understanding and treating intimate violence (Carter & McGoldrick, 1999; Goldner, 1999; Salari & Baldwin, 2002). In recent years, due to advances in genetic and neurological research, the psychobiological perspectives have also contributed to the evolution of post-modern systems theory (Goldhaber, 2000; Sprenkle, 1994). When it comes to the assessment and treatment of intimate violence, however, there are still some disparities between these perspectives. Much of this controversy stems from the contrasting theoretical differences between each of these theories on the underlying causes of intimate violence. A brief review of these three perspectives as they pertain to intimate violence follows, along with the major critiques of each.

*Post-modern systems perspective.* An underlying premise of post-modern systems theory is that the family is a dynamic, self-regulating, organizational (hierarchical), interconnected structure that seeks to maintain itself in a steady state (homeostasis) as it experiences both internal system changes (e.g. life cycle, illness, disability, financial, developmental) and external system changes (social, economic, historical) over time (Becvar & Becvar, 2000; Carter et al. 1999). In many ways, post-modern systems theory parallels ecological theory (Bubolz & Sontag, 1993) and social-cognitive-behavioral theory (Crosbie-Burnett & Lewis, 1993), in that a family system is viewed as being comprised of individuals (with unique personality traits) who have a shared history (genetic, developmental, transgenerational) and a shared future that is influenced by extended family, the community, and the larger society and culture. The family is seen as an interactional system, and all behaviors are viewed as serving to maintain the interactional sequences and defining the nature of the relationships (i.e. all behavior makes sense, given the context). Causality is viewed as being reciprocal and circular (as opposed to linear cause-effect), and the focus of intervention is on changing the interactional system in the present (as opposed to understanding causal attributes from the past). Interventions focus on perturbing the existing system and alter the interactional patterns that organize the system in order to increase the potential for change (Becvar et al., 2000; Watzlawick, Weakland, & Fisch, 1974). Viewed through this lens, intimate violence is seen as an interactional problem in which the perpetrator and victim co-create

and maintain a pattern of violence through feedback, homeostasis, and recursive processes that can only be understood and treated conjointly within the context of the relationship (Lederer & Jackson, 1968; Sexton, 1994; Watzlawick et al., 1974).

*Feminist perspective*. Feminist theorist believe that issues of violence and power in relationships must be viewed within the context of gender, socio-demographic characteristics, minority status, family organization, isolation levels, cultural norms, and social structure and integration (Lawson, 2003; Osmond & Thorne, 1993; Salari et al., 2002). One of the main tenets of feminist theory is that gender roles are power-based, hierarchical systems that are created and maintained at the societal and historical level, and that provide men with the means and privilege to maintain power and control in relationships (Osmond et al., 1993). It is argued that these patriarchal societal attitudes and beliefs, as well as male control of resources, are encourage and support violence against women (Salari et al., 2002), and that abusive relationships are maintained because women typically lack the economic, political, and legal resources to extricate themselves (Lawson, 2003). The feminist approach to treatment of intimate violence involves separation of the couple, with individual and gender-specific group treatments focusing on patriarchal power and control re-socialization, as well as anger, conflict, and stress management (Feldman & Ridley, 1995) for men.

*Psychobiological perspective*. Another competing perspective on the understanding and treatment of intimate violence comes from the psychobiological theories. The basic premise of these theories is that psychological phenomena are viewed as the consequences of biological influences (i.e. genetic, neural) within a particular environmental (physical, social, cultural) context (Goldhaber, 2000). From this perspective, intimate violence is viewed as being caused by the complex interplay of individual biological (e.g. genetic, neurological, personality disorders, mental illness) and environmental (e.g. victim of childhood violence, lack of social skills, unemployment, substance abuse, social and cultural stressors, learned helplessness) factors (Chornesky, 2000; Goldhaber, 2000; Salari et al., 2002). Treatment for intimate violence from this perspective involves medical treatment for the biological imbalance combined with

individual psychoanalytical treatment for both partners to get at the environmental 'root' of the problem.

In summary, post-modern systems theories tend to focus on interactional characteristics of intimate violence rather than causal effects, while taking into account individual, couple, family, community, and societal influences on family systems. Feminist theories tend to focus causal explanations of intimate violence up to a broader societal/historical/cultural context. Psychological theories tend to focus causal explanations down to an individual level.

*Critiques of the theories.* The main feminist and psychobiological theory critiques of systems theory as it applies to intimate violence are that (a) it does not make a clear distinction between perpetrator and victim, and thereby places blame on the victim (typically the female) for the perpetrator's (typically the male) violence; (b) it shifts the focus away from the key issues of power, control, and violence towards improving relationships interactions, which encourages and maintains the underlying power imbalance; (c) it allows the violence to remain in-tact by not confronting it or assigning responsibility for it; (d) it can lead to escalation of violence outside the therapy room due to disclosures that may threaten the perpetrator; (e) it does not allow the victim's honest expression of thoughts and feelings due to fear of retribution; and (f) because women do not have equal status in our culture, the assumption that they are equal co-creators of violence is flawed (Goldner, 1999; Salari et al., 2002; Walker, 1995).

The main systems and psychological theory critiques of feminist theory as it applies to intimate violence are that: (a) the assumption that patriarchal attitudes and male privilege are the root cause of intimate partner violence does not explain women's use of violence against their partner; (b) it minimizes the emotional complexity of attachment, coercive control, and violence in relationships, which can add to the confusion of couples dealing with many intense and contradictory feelings about one another; (c) a singular focus on power and inequality minimizes the crucial role of the relational bond in creating change; (d) this approach does not take into account the positive aspects of the relational bond that may be supporting the victim's continued involvement with the perpetrator, which can lead to victim-blaming explanations that stigmatize the victim; and

(e) personal and psychological characteristics of both the victim and the perpetrator play an integral role in intimate violence, and can lead to serious safety issues for both partners if ignored (Babcock et al., 2003; Goldner, 1999; Salari et al., 2002).

The main systems and feminist critiques of the psychobiological theories as they apply to intimate violence are: (a) they minimize the role of society and structure in creating and maintaining power differences; (b) attributing violent behavior to a psychological disorder relieves the perpetrator of personal responsibility for the violence; (c) these theories keep us from investigating societal factors that can cause family violence; and (d) viewing domestic violence as a psychological abnormality or sickness keeps us from exploring the possibility that varying levels of violence may be a normative pattern of family relations (Goldner, 1999; Salari et al., 2002).

*The Emerging Paradigm: Towards a Parallel Union*[2]

The evolving paradigm is shifting towards the perspective that, while these theories capture crucial dimensions of the complex dynamics of intimate violence, each of them alone is inadequate for explaining the complex phenomenon of intimate violence (Chornesky, 2000; Goldner, 1999; Lawson, 2003; Rosenbaum & Maiuro, 1990). The current trend for understanding and treating intimate violence is an integrated theoretical and developmental approach that is adapted to meet the needs of the client, to the degree possible, and that accounts for the relationships between multiple factors at multiple levels (Chornesky, 2000; Lawson, 2003). Goldner (1999) proposed that effectively understanding and treating intimate violence requires a "feminist-informed, conjoint framework" that incorporates multiple perspectives and with multiple beliefs (p. 326). Carden (1994) proposed an approach that is both developmental (incorporates cognitive-behavioral, psychodynamic, and systemic concepts) and stratified (e.g. individual, couple, family, and group). Rosenbaum et al. (1990) suggest a more balanced approach in which "psychopathology variables should be viewed as vulnerability factors rather than causal entities" (p. 284). In summary, the emerging paradigm calls for a multifaceted multi-theoretical approach to the evaluation, assessment, and treatment of intimate violence.

*Typologies of Intimate Violence: The Search for a Comprehensive Typology*

In the past two decades, several typologies of intimate violence have been proposed, and have begun to be empirically tested. Within the typology research, there are two distinct categories of typologies: those that make distinctions based on the interactional characteristics of the violence, and those that make distinctions based on characteristics of the perpetrator. Typologies based on the interactional characteristics of intimate violence have identified several important interactional factors associated with types of violence, including differences in escalation, reciprocity, intimacy, satisfaction, and power structure. Typologies based on characteristics of perpetrators have also identified several important psychobiological factors associated with types of perpetrators, including differences in attachment styles, social skills, cognitive processing, attitudes toward violence, generality of violence, psychopathology, and history of abuse. To date, however, no typology of intimate violence has been developed that integrates the characteristics of perpetrators with the characteristics of violence. In a review of the intimate violence research from the nineties, Johnson et al. (2001) proposed that "... major advances in our understanding of the origins of partner violence will come from bringing together and extending the work on types of violence and types of perpetrators" (p. 169).

*Johnson's Typology of Intimate Violence*

Michael Johnson's (1995; 2002) typology shows promise of being one of the most comprehensive typologies of intimate violence (Greene & Bogo, 2002; Johnson & Ferraro, 2001). Johnson has proposed that there are four types of intimate violence: *Situational Couple Violence* (intermittent minor to severe physical violence that is not embedded in a pattern of coercive control); *Intimate Terrorism* (prolonged pattern of minor to severe physical violence by one partner over the other, and embedded in a pattern of coercive control); *Violent Resistance* (minor to severe physical violence by the oppressed partner in retaliation to the oppressive partner's intimate terrorism); and *Mutual violent Control* (a prolonged pattern of minor to severe physical violence by both partners that is embedded in a pattern of coercive control). The underlying hypotheses behind Johnson's typology are that physical violence embedded in a pattern of coercive

control is distinctly different, and more harmful, than physical violence not embedded in a pattern of coercive control, regardless of severity of physical assault.

Johnson has developed a theoretical coercive control construct for his typology that includes the following components: inhibiting the will (e.g. psychological abuse, legitimization of control) and ability (e.g. economic control and social isolation) to resist; threats and intimidation (violence enacted to show there is an ability and will to impose punishment); surveillance (e.g. stalking and monitoring partner's behavior); and contingent punishment (violence enacted as punishment for a failure to comply with the explicit or implicit demands). Johnson's theoretical construct of coercive control is based on the Duluth Abuse Project's (2003) *Power and Control Wheel*, a widely accepted model that is used to describe the complex phenomenon of power and control in intimate violence. Johnson's construct of coercive control encompasses many of the established constructs typically used to measure non-physical violence (Dutton, 1995; Marshall, 1992; Straus, 2000; Tolman, 1989).

Johnson's typology has several advantages over other existing typologies. In particular, Johnson's typology incorporates both the interactional component of relationships and the underlying dynamics of power and control, and in fact makes distinctions between types of partner violence based on these criteria rather than on physical violence alone. In addition, Johnson's typology provides a theoretical framework from which to understand the different characteristics and motivation of women and men's violence within an interactional context of power and control.

*A multi-theoretical approach.* Johnson's typology provides a multi-theoretical framework for evaluating partner violence. From a systems perspective, Johnson's *Situational Couple Violence* and *Mutual Violent Control* types of violence capture the reciprocal and recursive interactional dynamics of conflicted relationships. From a feminist perspective, Johnson's *Intimate Terrorism* and *Violent Resistance* types of violence capture the underlying gendered and socialized constructs of power and control. No other existing typology simultaneously captures these often competing perspectives.

*Evaluates physical violence within a context of power and control.* Johnson's typology is unique in its underlying hypothesis that it is not the severity of physical acts

that defines the type of violence, but rather the presence of these acts embedded in a pattern of coercive control. Using non-physical violence to make distinctions between types of violence is supported in the literature in three ways. First, perceived power in relationships has been shown to be positively associated with the type and number of influence strategies used during conflict for both women and men (Gordon, 2000; Greene et al., 2002; Rosen & Bird, 1996; Sagrastano, 1992). In addition, non-physical violence typically occurs in conjunction with physical violence, and often precedes and predicts physical violence (Feld et al., 1992; Gordon, 2000; Jory, 2004; O'Leary, 1993; Stets, 1990; Straus & Sweet, 1992; Vivian & Malone, 1997). There is also evidence that the long-term effects of non-physical violence may be more harmful than the long-term effects of physical violence (Gleason, 1993; Vitanza, Vogel, & Marshall, 1995). And finally, for extreme cases of abuse, the underlying power and control dynamics have been shown to play an integral part in creating and maintaining the cycle of violence that can lead to the *battered woman syndrome* (Dutton, 1995).

*Addresses issues of gender and intimate violence*. One of the most controversial debates around intimate violence is that of women's violence towards their partners. There is a growing body of evidence indicating that women employ a wide range of physical and non-physical violence against their male partners, and that they are often the first to engage in these violent acts (Anderson, 2002; Dutton, 1995; Lawson, 2003; McFarlane & Willson, 2000; Schafer & Caetano, 1998; Shackelford, 2001; Stets, 1990; Tjaden, 2000; Verburg, 1994). Empirical studies exploring the motivation, extent, and effects of types of women's violence against their partners have only recently begun to emerge (Babcock, Miller, & Siard, 2003; Olson, 2002; Swan & Snow, 2002). Johnson's typology provides a theoretical framework from which to understand the motivation and characteristics of women and men's violence within an interactional context of power and control. For example, *Violent Resistance* is one type of violence in which women are physically violent in retaliation to their male partner's *Intimate Terrorism*. The motivation and characteristics of this type of violence are very different than *Situational Couple Violence*, where women may employ minor to severe acts of physical violence in a particular situation, or *Mutual Violent Control*, where women may employ a wide range

of physical and non-physical violence over time with the intent to control the relationship or her partner. Because Johnson's typology makes distinctions based on power and control dynamics rather than on gender, it also allows for the exploration of alternative explanations for men's violence (such as the possibility that some men's violence may be in response to *Intimate Terrorism* by their female partner) and same sex partner violence.

*Empirical support of Johnson's typology.* Only two studies could be found that empirically tested Johnson's typology and hypotheses. Johnson and Leone (2000) used the *National Violence Against Women* (NVAW) survey (Tjaden & Thoennes, 1999) to evaluate differences in physical violence (frequency and severity), psychological well-being (depression and post-traumatic stress disorder), injuries sustained, drug use (prescription and recreational), interference with everyday activities (days of work lost due to violence), and leaving and help-seeking behaviors between married women who experienced low levels of coercive control versus high levels of control (based on a seven item non-physical control construct). Johnson et al. found that women in the high control group were physically attacked more often, were more likely to be injured, exhibited more symptoms of post-traumatic stress disorder, missed more work, and were more likely to leave their husbands.

Leone, Johnson, Cohan, and Lloyd (2001) used data from the *Effects of Violence on Work and Family Study* (as cited in Lloyd, 1996) to evaluate differences in physical, psychological, and economic well-being for poor ethnic minority women who experienced emotional abuse (based on an eight item construct) and threats (based on a three item construct) by their male partners. The authors found that women who experienced high levels of emotional abuse and threats also experienced significantly more frequent, severe, and debilitating physical violence, and scored significantly lower across all three well-being measures than women who experienced low levels of emotional abuse and threats.

The existing studies support Johnson's hypotheses that partner violence embedded in a pattern of control is distinctly different and more harmful than partner violence that is not embedded in a pattern of control. However, there are several issues these studies do not address. For example, neither of these studies used all four

components of Johnson's coercive control construct to identify types and effects of intimate violence. There is a need to empirically test Johnson's full coercive control construct as an indicator of type and effects of intimate violence. Secondly, Johnson's typology includes only those individuals who experience physical violence in their relationship. Because non-physical violence has been shown to have harmful psychological effects even when not accompanied by physical violence, there is a need to evaluate the psychological effects of coercive control when not accompanied by physical violence, and to explore the possibility of expanding Johnson's typology to include this group of individuals. Thirdly, none of these studies evaluated the characteristics and differential effects of intimate violence experienced by men. And finally, none of these studies explored Johnson's hypothesis that the type of violence depends on the absence or presence of a pattern of coercive control, irrespective of severity of the physical violence.

*Limitations of Johnson's typology.* One limitation to Johnson's typology is that does not include the important psychobiological components shown to exist for some types of extreme violence. Another limitation to Johnson's typology is that it does not include couples that experience a pattern of coercive control not accompanied by physical violence. The existing literature indicates that non-physical violence has been shown to cause mental health dysfunction and subjective distress, even when no physical violence is present (Straus et al., 1992; Tolman, 1989). Identifying the presence of a pattern of coercive control even when no signs of physical violence are present may not only identify couples at risk for psychological harm, but it may also identify couples at risk for future physical violence. There is a need to expand Johnson's typology to include characteristics of perpetrators, and to include men and women who experience coercive control without physical violence.

*Other Typologies of Intimate Violence*

Several typologies of intimate violence have been proposed within the past two decades that range in scope from interactional characteristics of violence (Table 1.1) to characteristics of male and female perpetrators (Table 1.2). A summary of these typologies and their similarities to Johnson's typology follows.

Table 1.1
*A Comparison of Johnson's Typology With Current Typologies Based on Interactional Characteristics of Intimate Violence*

| Source | Type and percentage found within each | | | |
|---|---|---|---|---|
| Johnson (1995; 2002) | *Situational Couple Violence (65%)*<br>Most common form of partner violence<br>More likely to be gender symmetric<br>Typically captured in large-scale national surveys<br>Context and situation specific<br>Rarely escalates into severe physical assault<br>Social, emotional, and physical well-being not affected | *Intimate Terrorism (35%)*<br>Less common form of partner violence<br>More likely to be perpetrated by men<br>Typically captured in public agency& shelter studies<br>Embedded in a prolonged pattern of power and control<br>More likely to escalate over time and to cause injury<br>Associated w/declines in all levels of well-being | *Mutual Violent Control*<br>Prevalence not known<br>More likely to be gender symmetric<br>Embedded in pattern of power and control | *Violent Resistance*<br>Prevalence not known<br>More likely perpetrated by women<br>Violence in retaliation to IT |
| Neidig et al. (1984) | *Expressive* Couple Violence<br>Heightened emotional arousal<br>High potential for sequential, gradual, escalation<br>Mutual and reciprocal violence by both<br>Followed by remorse by both<br>High potential for accidental injury<br>Relatively low psychological consequences<br>Amenable to conjoint therapy | *Instrumental* Couple Violence<br>Lower emotional arousal<br>Relatively sudden and rapid escalation<br>Unilateral violence w/intent to punish or control<br>Followed by little to no remorse<br>High potential for violent retaliation, homicide, suicide<br>Serious psychological consequences<br>Not amenable to conjoint therapy | | |
| Olson (2002) | *Aggressive* Couples<br>Shared power<br>Gender symmetric initiation, reciprocity, and kind<br>Low to medium verbal and non-contact physical | *Abusive* Couples<br>Power controlled by one partner<br>Unilateral violence by dominant partner<br>Medium to severe verbal and physical violence | *Violent* Couples<br>Shared power<br>Gender symmetric initiation, reciprocity, kind<br>Medium to severe acts of verbal and physical | |
| Whitchurch (2000) | *Agreeable-Intimate* Couples (58%)<br>Moderate to high verbal/symbolic violence<br>High level of minor physical violence<br>Low level of severe physical violence<br>High level of escalation, low level of de-escalation<br>Low level of reasoning<br>High marital satisfaction<br>High reported intimacy level<br>Infrequent and short duration of conflict | *Conflictive-Intimate* Couples (6%)<br>High level of verbal/symbolic violence;<br>Moderate level of minor physical violence<br>High level of severe physical violence (highest of all)<br>High level of escalation, low-level of de-escalation<br>Exhibited husband-dominant roles/power structure<br>Were less likely to separate<br>Had the second highest reported intimacy level<br>Highest levels of perceived stress for the wives<br>Highest level of alcohol abuse for the husbands | *Detached* Couples 17%)<br>High level of symbolic/emotional violence<br>High level of minor physical violence<br>Low level of severe physical violence<br>High escalation, low de-escalation<br>High perceived role overload<br>Low level of reasoning<br>Highest levels of marital dissatisfaction<br>Least distressed men; distressed wives<br>Second highest alcohol abuse | *Diffident* Couples (19%)<br>Low/mod level emotional/symbolic violence<br>High level of minor physical violence<br>High level of severe physical violence<br>High level escalation, low level de-escalation<br>Highest level of reasoning<br>Second highest level marital satisfaction<br>Lowest perceived stress<br>Least likely to abuse alcohol |
| Swan & Snow (2002) | *Mixed-Male Coercive (32%)*<br>Woman committed more severe physical assault<br>Partner committed more coercive control behaviors<br><br>*Mixed-Female Coercive (18%)*<br>Partner committed more severe physical assault<br>Woman committed more coercive control behaviors | *Women as Aggressor: Type A (7%)*<br>Woman committed more severe physical assault<br>Woman committed more coercive control behaviors<br>Woman committed more minor physical & emotional<br><br>*Women as Victims: Type A (19%)*<br>Partner committed more severe physical assault<br>Partner committed more coercive control behaviors<br>Partner committed more minor physical & emotional | *Women as Aggressor: Type B (5%)*<br>Woman committed more severe physical assault<br>Woman committed more coercive control behaviors<br>Partner committed more minor physical & emotional<br><br>*Women as Victims: Type B (15%)*<br>Partner committed more severe physical assault<br>Partner committed more coercive control behaviors<br>Woman committed more minor physical & emotional | |

Table 1.2

*A Comparison of Johnson's Typology With Current Typologies Based on Characteristics of Perpetrators*

| Source | Type and percentage found within each | | | |
|---|---|---|---|---|
| Johnson (1995; 2002) | *Situational Couple Violence (65%)* | *Intimate Terrorism (35%)* | *Mutual Violent Control* | *Violent Resistance* |
| | Most common form of partner violence | Less common form of partner violence | Prevalence not known | Prevalence not known |
| | More likely to be gender symmetric | More likely to be perpetrated by men | More likely to be gender symmetric | More likely perpetrated by women |
| | Typically captured in large-scale national surveys | Typically captured in public agency& shelter studies | Embedded in pattern of power and control | Violence in retaliation to IT |
| | Context and situation specific | Embedded in a prolonged pattern of power and control | | |
| Johnson et al., 2000; | Rarely escalates into severe physical assault | More likely to escalate over time and to cause injury | | |
| Leone et al., 2001 | Social, emotional, and physical well-being not affected | Associated w/declines in all levels of well-being | | |
| Gottman (1999) | *Type II Husbands (80%)* | *Type I Husbands (20%)* | | |
| | More likely to use their fists | More likely to use a knife or gun | | |
| | Not typically violent outside the home | History of violence outside the home | | |
| | Tended to have slow predictable buildup of anger | Belligerent, defensive, contemptuous, & intimidating | | |
| | Showed increased heart rates during conflict | Showed decreased heart rates during conflict | | |
| | Generally encouraged wives to be independent | Tended to isolate their wives socially | | |
| | More likely to get divorced | Less likely to get divorced | | |
| Berns et al. (1999) | Less likely to meet psychopathology criteria | More likely to have Antisocial Personality Disorder | | |
| | Less likely to be dependent on illegal drugs | More likely to be dependent on illegal drugs | | |
| | Less likely to demand | More likely to demand | | |
| | Wives less likely to exhibit extreme fear of | Wives exhibited extreme fear and sadness | | |
| | Wives less likely to withdraw | Wives more likely to withdraw | | |
| Chase et al. (2001) | *Reactive* Violence by Men (63%) | *Proactive* Violence by Men (38%) | | |
| | High affective-physiological arousal | Min/decreasing emotional and physiological arousal | | |
| | Low cognitive processing response to threats | Planned, methodical, goal-oriented response to threats | | |
| | More likely to have Dependent Personality Disorder | Anti-social, aggressive-sadistic, or psychopathic | | |
| | Tended to have higher anger scores | Tended to have lower anger scores | | |
| | Tended to have lower dominance scores | Tended to have higher dominance scores | | |
| Holtzworth-Munroe et al. (1994); Holtzworth-Munroe et al. (2000); | *Family Only Violent Men* (23-37%) | *Generally Violent-Antisocial Men (10-17%)* | *Borderline-Dysphoric Men 9-16%)* | |
| | None to low severity of violence | Moderate to high severity of violence | Moderate to high severity of violence | |
| | None to low generality of violence | High generality of violence | Low to moderate generality of violence | |
| | None or passive/dependent personality disorder | Anti-social Psychopathology | Borderline personality disorder | |
| | Low to moderate alcohol/drug use | High alcohol/drug use | Moderate alcohol/drug use | |
| | Low to moderate depression and anger | Low depression and moderate anger | High depression and anger | |
| Waltz et al. (2000) | Low distal-historical correlates | Moderate to high distal-historical correlates | Moderate to high distal-historical correlates | |
| | Secure attachment styles | Dismissing attachment style | Preoccupied attachment style | |
| | Moderate dependency | Low dependency | High dependency | |
| | Low to moderate impulsivity | High impulsivity | Moderate impulsivity | |
| | Low to moderate social skills | Low social skills | Low to moderate social skills | |
| | Low hostility towards women | High hostility towards women | Moderate to high hostility towards women | |
| | Low support of violence | High support of violence | Moderate to high support of violence | |
| Babcock et al.(2003) | *Partner-Only* Violent Women (50%) | *Generally-Violent* Women (50%) | | |
| | Less likely to use violence to control partner | Used *Instrumental Violence* to control their partners | | |
| | Used less severe physical and emotional violence | Used more severe physical & emotional violence | | |
| | Lower frequency of physical assault against partner | Higher frequency of physical assault against partner | | |
| | Had less extensive rationales/reasons for violence | Had extensive rationales/reasons for their violence | | |
| | Less likely to externalize blame for their violence | Externalized blame for their violence | | |
| | Reported less trauma symptoms | Reported more trauma symptoms | | |
| | Inflicted injury less often | Inflicted injury on partner more often | | |
| | Less likely to witness mother's aggression to father | More likely to witness mothers aggression to father | | |
| | Equally likely to report using violence in self-defense | Equally likely to report using violence in self-defense | | |

*Typologies based on interactional characteristics of intimate violence.* Neidig and Friedman (1984) proposed a typology of *Expressive* and *Instrumental* partner violence. *Expressive* violence was defined as a heightened emotional arousal that tends to occur in a sequential, gradual, predictable, escalating manner, with mutual and reciprocal violence being used by both partners in the escalation process, followed by remorse by both partners. This type of violence was typically unpredictable, had a high potential for escalation and accidental injury, and relatively low psychological consequences. Neidig et al. found that this type of violence was amenable to conjoint treatment (with a focus on skill building) due to both partners' high motivation to change and the acceptance of personal responsibility. *Instrumental* violence was defined as a relatively sudden and rapid escalation of unilateral violence by one partner (typically men with a family history of violence and neglect) with the intention of controlling and/or punishing their partner, followed by little to no remorse. This type of violence had serious psychological consequences for the victim (e.g. helplessness, depression, low self-esteem, external locus of control) and a high potential for violent retaliation, homicide, or suicide. Neidig et al. found this type of violence was not amenable to conjoint treatment due to the lack of empathy and low motivation to change by the abuser. These types of violence align with Johnson's typology very closely, with *Expressive* violence most likely being the type of violence found within *Situational Couple Violence*, and *Instrumental* violence most likely being the type of violence found within *Intimate Terrorism*.

Olson (2002) qualitatively evaluated 31 individuals who had experienced either physical or psychological aggression in their relationship over the previous year, and identified three types of violent couples: *Aggressive* (gender symmetric initiation and reciprocity, shared power, equally likely to use low to medium verbal and non-contact physical aggression); *Violent* (gender symmetric initiation and reciprocity, shared power, equally likely to use medium to severe acts of verbal or physical violence; and (c) *Abusive* (not gender symmetric with regard to initiation and reciprocity, power controlled by one partner who is most likely to use medium to severe acts of verbal or physical violence). Olson compared her findings to Johnson's (1995) typology, and concluded that the *Abusive* type of violence most closely matched Johnson's *Intimate Terrorism* type,

however it was unclear to what extent the *Aggressive* and *Violent* type fit with Johnson's *Situational Couple Violence*, and that perhaps this category was too narrowly defined. (It should be noted that at the time of Olson's study, Johnson had not yet developed his typology of *Mutual Violent Control*, and that Olson's identified *Violent* type may well have been representing this type of violence).

Whitchurch (2000) identified four types of couple violence for respondents from the 1975 *National Survey of Family Violence* ($N = 247$) who reported experiencing physical violence from their current spouse in the previous year. The four types of violent couples included *Agreeable-Intimate* (58%), *Conflictive-Intimate* (6%), *Detached* (17%), and *Diffident* (19%). *Agreeable-Intimate* couples tended to have moderate to high verbal/symbolic violence, high levels of minor physical violence, low levels of severe physical violence, high levels of escalation with low level of de-escalation, low levels of reasoning, high marital satisfaction, low levels of perceived conflict, and the highest level of reported intimacy. *Conflictive-Intimate* couples tended to have high levels of verbal/symbolic violence, moderate levels of minor physical violence, high levels of severe physical violence, high levels of escalation combined with low-levels of de-escalation, the highest level of perceived conflict, exhibited husband-dominant roles and power structure, were less likely to separate, had the second highest reported intimacy level, and had the highest levels of perceived stress for the wives and alcohol abuse for the husbands. *Detached* couples tended to have high levels of symbolic/ emotional violence, high levels of minor physical violence, low levels of severe physical violence, low levels of reasoning, high levels of escalation combined with low levels of de-escalation, had the lowest levels of reported intimacy and highest levels of marital dissatisfaction, had high perceived husband-dominant roles, had the least distressed husbands with second highest distressed wives, and had the second highest alcohol abuse rates. *Diffident* couples showed low to moderate levels of emotional/symbolic violence, high levels of minor physical violence, high levels of severe physical violence, high levels of reasoning, high levels of escalation combined with low level of de-escalation, were least likely to abuse alcohol, second lowest perceived conflict levels, second highest level of marital satisfaction, lowest perceived stress, and were generally lacking in

confidence in ability, worth, or fitness. In comparison to Johnson's typology, the *Agreeable-Intimate* and possibly the *Detached* couples would most likely fall within *Situational Couple Violence*, and the *Conflict-Intimate, Detached,* and *Diffident* couples would most likely fall within the *Intimate Terrorism* and *Mutual Violent Control* groups.

*Typologies based on characteristics of male perpetrators.* Gottman (1999) and his colleagues (Berns, Jacobson, & Gottman, 1999) developed a typology of violent husbands based on their work with married couples. The authors found two distinct types of violent husbands. *Type I* husbands (20%) were more likely to use a knife or gun when threatening their wives, were more likely to be violent with other members of the family and outside of the home, tended to be belligerent, defensive, contemptuous, and intimidating during arguments, tended to strike quickly and fiercely, showed decreased heart rates during conflict, and tended to isolate their wives socially. *Type II* (80%) husbands were more likely to use their fists when threatening their wives, were not typically violent with other members of the family or outside the home, tended to have a slow-buildup of anger, showed increased heart rates during conflict, and generally encouraged their wives to be independent. In addition, *Type II* husbands were more likely to get divorced than *Type I* husbands. Later studies by Berns et al. (1999) indicated that *Type I* husbands had higher demand patterns, and *Type I* wives had higher withdrawal patterns than the *Type II* husbands and wives, respectively. *Type II* husbands were also less likely to be responsive to their wives demands than *Type I* husbands as well. Based on these characteristics, *Type I* husbands would most likely fall within Johnson's *Intimate Terrorism* type of violence due to the fact that many of these behaviors (e.g. social isolation, intimidation) indicate a pattern of coercive control. The *Type II* husbands would most likely fall within *Situational Couple Violence*.

Holtzworth-Munroe and Stuart (1994) conducted a review of the domestic violence literature prior to 1990 and found three consistent dimensions of violence by men: severity (physical, psychological, and sexual abuse), generality (violence outside the family, criminal behavior, and legal involvement), and psychopathology/personality disorders (personality disorder, alcohol/drug abuse, depression, and anger). These dimensions were used to develop a typology of male batterers that consisted of (a) *Family*

*Only* (none to low severity of violence, none to low generality of violence, and none or passive/dependent personality disorder typically associated with low to moderate alcohol/drug use, depression, and anger); (b) *Borderline-Dysphoric* (moderate to high severity of violence, low to moderate generality of violence, and borderline personality disorder typically associated with moderate alcohol/drug use, and high rates of depression and anger), and (c) *Generally Violent-Antisocial* (moderate to high severity of violence, high generality of violence, and anti-social psychopathology typically associated with high alcohol/drug use, low depression, and moderate anger).

Later empirical studies conducted by Holtzworth-Munroe and colleagues (Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000; Waltz, Babcock, Jacobson, & Gottman, 2000) confirmed these typologies and further evaluated theoretical correlates for these typologies including distal-historical correlates (parental violence, child abuse or neglect, association with deviant peers) and proximal correlates (attachment style, dependency, impulsivity, social skills, and attitudes of hostility towards women and support of violence). They found that *Family Only* batterers (23-37%) had low distal-historical correlates, secure attachment styles, moderate dependency, low to moderate impulsivity, low to moderate social skills, and low attitudes of hostility towards women and support of violence. *Borderline-Dysphoric* batterers (9-16%) had moderate to high distal-historical correlates, preoccupied attachment style, high dependency, moderate impulsivity, low to moderate social skills, and moderate to high attitudes of hostility towards women and support of violence. *Generally Violent-Antisocial* batterers (10-17%) had moderate to high distal-historical correlates, dismissing attachment styles, low dependency, high impulsivity, low social skills, and high attitudes of hostility towards women and support of violence. Based on these characteristics, it could be hypothesized that the *Family Only* violent men would fall within Johnson's *Situational Couple Violence*, and the other two would most likely fall within Johnson's *Intimate Terrorism* or *Mutual Violent Control* types of violence.

Chase, O'Leary, and Heyman (2001) identified two types of violence among 60 maritally-violent men. *Reactive* violence (63%) was defined as high affective-physiological arousal and low cognitive processing response to perceived threats or

frustrations, and *Proactive* violence (38%) was defined as minimal-to-decreasing emotional and physiological arousal response that is planned, methodical, and goal-oriented. Chase et al. found that men who used *Reactive* violence were significantly more likely to be diagnosed as having a dependent personality disorder, significantly less likely to be diagnosed as having antisocial, aggressive-sadistic, or psychopathic disorders, and tended to have higher anger and lower dominance scores than the *Proactive* violence group. Chase et al. proposed that Gottman's (1999) *Type 2* batterers and Hotzwork-Munroe et al.'s (1994; 2000) *Family-Only* and *Borderline-Dysphoric* batterers appeared to be using *Reactive* (and *Expressive*) violence, whereas the *Type 1* and *Violent-Antisocial* batterers appear to be using *Proactive* (and *Instrumental*) violence. Based on these findings, it could be hypothesized that men (and possibly women) within Johnson's *Situational Couple Violence* may use *Reactive* violence, whereas individuals within the *Intimate Terrorism* and *Mutual Violent Control* groups may use *Proactive* violence.

*Typologies based on characteristics of female perpetrators.* Only two authors could be found that specifically evaluated women's violence within the context of typologies. Babcock et al. (2003) used a modified version of Holtzworth-Munroe et al.'s (1994) intimate violence typology, and Neidig et al.'s (1994) *Instrumental/Expressive* types of violence to evaluate 52 women referred to a treatment agency for abusive behavior. They found that *Generally Violent* women (50%) reported using *Instrumental* violence more often to control their partners, used violence more broadly and in a variety of situations, had more extensive rationales and reasons for their use of violence, externalized blame for their own violence by blaming their partner or claiming a lack of control, reported more trauma symptoms (psychological or physical distress, e.g. feeling tense, memory problems, urges to harm themselves), and were more likely to have witnessed their mothers being aggressive toward their fathers than *Partner Only Violent* women (50%). One interesting finding was that *Generally Violent* and *Partner Only Violent* women were equally likely to report using violence in self-defense, however the authors point out that there is no way to validate this finding without the other partner's report of the violence. Similar to the Holtzworth-Munroe et al. (1994; 2000) typology, it is hypothesized that *Partner-Only* women would most likely fall within Johnson's

*Situational Couple Violence* or *Violent Resistance* groups, whereas *Generally Violent* women would most likely fall within the *Intimate Terrorism* or *Mutual Violent Control groups*.

Swan et al. (2002) evaluated self-reports of 108 women who had used physical violence against a male partner within a six-month period, and identified four types of violent relationships based on severity and frequency of physical assault using Straus' (2000) *Modified Conflict Tactics Scale* and coercive control using Tolman's (1989) *Psychological Maltreatment of Women Inventory*. The *Women as Victims* group (34%) included women whose male partners committed more severe physical assault and more coercive control behaviors than they did, with *Type A* women committing less minor physical violence and/or emotional abuse than her partner, and *Type B* committing equal or greater minor physical violence and/or emotional abuse than her partner. The *Women as Aggressor's* group (12%) included women who committed more severe physical assault and more coercive control behaviors than her partner, with *Type A* women committing equal or greater minor physical violence and/or emotional abuse than her partner, and *Type B* committing less minor physical violence and/or emotional abuse than her partner. The *Mixed-Male Coercive* group included women who were equally or more physical violent with their male partner, however their male partner used more coercive control behaviors. *The Mixed-Female Coercive* group included women whose partner was more physically violent, however the women used more coercive control behaviors. Because this typology does not identify a pattern of coercive control, or quantify levels of coercive control, it is difficult to draw comparisons to Johnson's typology. However, it is loosely hypothesized that the *Women as Victims* group most closely resembles Johnson's *Violent Resistance* group, with the partners of these women displaying signs of *Intimate Terrorism* behaviors. The *Women as Aggressor* group could either be classified within the *Intimate Terrorism* group (Type A) or the *Mutual Violent Control* group (Type B). The *Mixed-Coercive* groups could either fall within the *Situational Couple Violence* group, or the *Violent Resistance* and *Mutual Violent Control* groups, depending on whether there was an absence or presence of coercive control, respectively.

*A Need to Extend the Knowledge Base on Intimate Violence Typologies*

The existing typologies each offer important contributions towards understanding intimate violence. These typologies share some common themes, but the extent to which these overlap is difficult to estimate because of the differences in characteristics measured. There is clearly a need to expand the current knowledge base on intimate violence typologies by integrating Johnson's (and others) typologies of violence with the typologies of perpetrators, and to empirically evaluate the differential characteristics and effects of these expanded types of violence. Using Johnson's coercive control construct to identify these types of violence is appealing from both a feminist and systems perspective, however, it has not been widely tested. There is a need to empirically test Johnson's coercive control construct as an indicator of type and effects of intimate violence. In addition, from a clinical perspective, there is a need to incorporate current knowledge on types of violence with current knowledge on assessment and treatment of violence, as the existing assessment and treatment protocols do not yet make these distinctions.

*A need to integrate typologies of violence with typologies of perpetrators.* Johnson's typology of violence shows promise of being one of the most comprehensive typologies that currently exists. However, it also has several limitations. There is a need to integrate Johnson's and others' typologies based on interactional characteristics of intimate violence with typologies based on characteristics of perpetrators in order to develop a more comprehensive typology of violence. A comparison of the existing typologies identified two common themes.

One common theme among the existing typologies is the presence of a type of violence that has low levels of control, low levels of severe physical violence, tends to be reciprocal and gender symmetric in nature, and in which the perpetrators show low to no rates of unresolved psychopathology and substance abuse. These types of violence include Johnson's (1995; 2002) *Situational Couple Violence*, Neidig et al.'s (1984) *Expressive* violence, Chase et al.'s (2001) *Reactive* violence, Whitchurch's (2000) *Agreeable-Intimate* violence, Gottman's (1999) *Type II* husbands, Holtzworth-Munroe et al.'s (1994) *Family-Only* violent men, and Babcock et al.'s (2003) *Partner-Only* Violent

women. These types of violence appear to have a relatively low potential for long-term physical or psychological harm, and show promise of being amenable to conjoint treatment.

Another common theme among the existing typologies is the presence of a type of violence perpetrated by one or both partner that involves high levels of control, high levels of severe physical violence, low levels of remorse, and high levels of unresolved psychopathology and substance abuse. These types of violence include Johnson's (1995; 2002) *Intimate Terrorism* and *Mutual Violent Control*, Neidig et al.'s (1984) *Instrumental* violence, Chase et al.'s (2001) *Proactive* violence, Whitchurch's (2000) *Conflictive-Intimate* violence, Gottman's (1999) *Type I* husbands, Holtzworth-Munroe et al.'s (1994) *Generally Violent-Antisocial* and *Borderline-Dysphoric* men, and Babcock et al.'s (2003) *Generally Violent* women. These types of violence show a high potential for long-term physical and psychological harm, as well as a high potential for retaliation.

In summary, there are clearly similarities and overlaps between Johnson's typology and other existing typologies of violence and typologies of perpetrators, but the extent of this overlap is unknown. There is a need to develop a comprehensive intimate violence typology that integrates Johnson's (and other's) typology of violence with the typologies of perpetrators, and to empirically evaluate the differential characteristics and effects of these expanded types of violence.

*A need to empirically test Johnson's coercive control construct as an indicator of type and effects of intimate violence for women and men.* In order to integrate typologies of violence with typologies of perpetrators, a common criterion must be established for making distinctions between types of intimate violence. Using Johnson's coercive control construct to differentiate between types of intimate violence is appealing from both a feminist and systems perspective, as discussed previously. One of the biggest advantages of using Johnson's coercive control construct to differentiate between types of violence is the evidence that suggests that non-physical violence often precedes and predicts physical violence, and that the long term effects of non-physical violence may be greater than those associated with physical violence. In addition, because coercive control has been shown to be an integral factor in the cycle of violence for extreme batterers, a typology

that makes distinctions based on this criterion would be sure to capture this type of violence. In addition, a typology of violence that makes distinctions between types of violence that are more harmful than others would be very usefulness for the clinical assessment and treatment of intimate violence.

Several studies have found that depression, posttraumatic stress disorder, and fear of one's partner are significant predictors of physical and non-physical violence in intimate partner relationships (Anderson, 2002; Cascardi, O'Leary, Lawrence, & Schlee, 1995; Cascardi, O'Leary, & Schlee, 1999; DeMaris & Swinford, 1996; Gordon, 2000; Stets & Straus, 1992; Straus, 2000; Straus et al., 1992). Cascardi et al., (1999) found a positive correlation between depression, post-traumatic stress disorder (PTSD), and fear of partner in abused women, with PTSD being predicted by male dominance/isolation tactics and severity of physical aggression, and depression being predicted by marital discord and severity of physical aggression. Cascardi et al. (1995) found high levels of fearfulness of partners, depression, and symptoms of post-traumatic stress disorder in physically abused married women as compared to non-abused but distressed married women. DeMaris et al. (1996) found that for women in abusive relationships, fear of their partner was related to severity of past physical violence, initiation of the physical violence, sexual assault by the partner, and fear of retaliation.

The existing literature also suggests that there are several psychobiological risk factors associated with intimate violence, including: a history of violence (either domestic or outside the home); the availability and use of weapons during violence; threats to retaliate, hurt, or kill one's partner or self; obsession with one's partner (jealousy, accusations, stalking); bizarre forms of violence (sadistic or depersonalized); and unresolved substance abuse by either partner; stressors associated with unemployment, poverty, and economic dependency; and childhood emotional abuse of both partners (Anderson, 2002; Bograd & Mederos, 1999; Brannon & Rubin, 1996; Cascardi et al., 1995; Clark & Foy, 2000; Dutton, 1995; Gordon, 2000; Gottman, 1999; Stets, 1990; Stith, Rosen, & McCollum, 2002; Tolman & Bennet, 1990; van Wormer, 1998). O'Leary (1993) found a progressively increasing relationship between type and severity of violence and risk factors for men. In particular, factors such as the need to control, misuse

of power, jealousy, and marital discord were associated with the use of verbal aggression. These factors plus the acceptance of violence as a means of control, modeling physical aggression, being abused as a child, having an aggressive personality style, and abusing alcohol were associated with the use of minor to severe physical violence. These factors plus personality disorders, emotional disturbance, and poor self-esteem were associated with the use of severe physical violence in men.

Because typologies of intimate violence are relatively new, most of the existing literature on the characteristics and effects of intimate violence has not been evaluated within the context of typologies. The data that is available almost exclusively evaluates the effects of men's violence on their female partners. This data suggests that extreme types of violence characterized by high levels of control and severe physical violence are typically associated with high levels of physical injury, mental health dysfunction (depression, PTSD), impairment of daily functioning (social, work), subjective stress (fear), and unresolved substance abuse for female victims (Babcock et al., 2003; Berns et al., 1999; Johnson et al., 2000; Leone et al., 2001; Neidig et al., 1984). Types of violence characterized by low levels of control typically show much lower levels of these factors, however the results vary depending on what measure was used to make the distinction between types of violence. In order to establish Johnson's coercive control construct as valid and reliable indicator of types and effects of intimate violence, there is a need to empirically evaluate differences in characteristics (e.g. psychopathology, history of violence, education level, economic status) and well-being (e.g. psychological, social, and economic) of women and men who experience varying levels of coercive control in their relationships.

*A need to incorporate typologies into clinical assessment and treatment protocols.* Because the identification of intimate violence typologies is relatively new, only a handful of articles could be found pertaining to the clinical assessment and treatment of intimate violence within the context of typologies (Greene et al., 2002; Gondolf, 1997; Langhinrichsen-Rohling, Huss, & Ramsey, 2000; Saunders, 1996; Walker, 1995). Current accepted clinical practices and policies for the assessment and treatment of partner violence do not yet make distinctions between types of violence (Bograd et al.,

1999; Greene et al., 2002; Johnson et al., 2001). There is a need to incorporate existing knowledge on typologies into the current intimate violence assessment and treatment protocol.

The existing literature suggests that conjoint treatment has been effective for couples with low levels and limited incidents of physical violence by male partners, or couples that had individually completed gender-specific group treatments first (Brannen et al., 1996; Geller, 1998; Geller & Wasserstrom, 1984; Hamby, 1998; Heyman & Neidig, 1997; Johannson & Tutty, 1998; Neidig et al., 1984). Other research has shown that men who use only minor physical aggression against their wives have a significant likelihood of stopping future violence with minimal intervention (Feld et al., 1992; Quigley & Leonard, 1996). In addition, conjoint treatment has been shown to be effective in identifying the reciprocal and recursive nature of the interpersonal dynamics between couples, which has been found to be a critical factor in preventing future violence (Murphy & O'Leary, 1989; Neidig et al., 1984). These dynamics typically do not get addressed in current accepted treatment modalities of individual or gender-specific groups (Geffner & Rosenbaum, 1990). This research suggests that the types of violence characterized by low levels of control, physical violence and unresolved psychopathology, such as Johnson's *Situational Couple Violence*, may be effectively treated using conjoint methods. Further research is needed to explore the use of conjoint treatment for these types of violence.

The existing literature also suggests that conjoint treatment may NOT be effective for treating some types of intimate violence (Gondolf, 1997; Holtzworth-Munroe et al., 1994; Neidig et al., 1984). The existing research on male batterers indicates that some types of extreme male batterers show clear signs of unresolved psychopathology, often accompanied by unresolved substance abuse issues. This type of batterer typically uses a wide range of physical, psychological, social, and economic violence against their female partners. The recent research on women's violence indicates that some female batterers may share similar characteristics. These types of batterers would most likely fall within Johnson's *Intimate Terrorism* or *Mutual Violent Control* types of violence. Attempting to treat these individuals using conjoint methods will most likely not be effective due to the

high level of control dynamics entrenched within the relationship. In addition, due to the high potential for retaliation associated with this type of violence, attempting to treat these couples conjointly may cause additional harm to the individuals and their families. The development of an assessment and treatment protocol that makes clear distinctions between types of violence may assist clinicians in making better decisions about appropriate treatment modalities.

Current accepted clinical practices and policies for the assessment and treatment of intimate violence do not yet make distinctions between types of violence. In essence, we are still using a "one type fits all" model to address a complex phenomenon that is clearly not uni-dimensional. This is not consistent with findings that suggest that therapeutic treatment effectiveness is optimized by tailoring treatment approaches to match the needs of the client and the particular phenomenon being treated (American Psychological Association, 1995; Hubble, Duncan, & Miller, 1999). The integration of typologies of intimate violence into current clinical assessment and treatment protocols may allow clinicians to more accurately identify appropriate treatment modalities for different types of violence, which may improve treatment effectiveness (Bograd et al., 2002; Gondolf, 1997; Johnson et al., 2001).

These are critical issues to consider given that existing statistics on intimate violence indicate that from 12% to 51% of couples in the United States have experienced at least one incident of physical assault over the course of their relationship (Lawson, 2003; Straus, 2000), and that roughly 50% to 65% of family therapy client populations have reported at least one incident of physical violence in their relationship history (Lawson, 2003; O'Leary, Vivian, & Malone, 1992). In addition, once physical violence begins, it is likely to continue and escalate without some type of intervention (O'Leary, K. D., Barling, J., Arias, I., Rosenbaum, A., Malone, J., & Tyree, A., 1989). Couples counseling may be the first line of defense in the assessment and treatment of intimate violence (Bograd et al., 1999; Greene et al., 2002). Therefore, it is imperative that clinicians be prepared to make appropriate assessment and treatment decisions that incorporate the most current information on typologies and assessment criteria for intimate violence. As Greene et al. (2002) pointed out, "Current assessment and treatment

practices that focus almost exclusively on patriarchal male violence against women may not reflect an understanding of the lived experiences of many couples and ultimately may deny them the type of help they seek" (p. 456).

In summary, there is a need to extend the current knowledge base on intimate violence typologies by developing a comprehensive typology of violence that integrates characteristics of violence with characteristics of perpetrators, and empirically evaluating the differential characteristics and effects of this comprehensive. There is also a need to empirical test Johnson's coercive control construct as an indicator of types and effects of intimate violence. And finally, there is a need to incorporate this information into current assessment and treatment protocols for intimate violence.

### *Overview of Methods Used*

In order to address the needs identified above, two separate studies were undertaken. The first study (Chapter 2) is an empirical analysis testing Johnson's hypotheses pertaining to coercive control as an indicator of type and effects of intimate violence using secondary data analysis methods. These analyses were conducted separately for women and men. The second manuscript (Chapter 3) is the development of a tiered intimate violence assessment approach that incorporates current knowledge on conjoint assessment with current knowledge on typologies of intimate violence. A conceptual clinical assessment tool is proposed that can be tested for its usefulness in assisting clinicians with assessing for intimate violence during conjoint sessions, and for determining whether conjoint treatment is indicated.

#### *Article #1: Testing Coercive Control as an Indicator of Type and Effects of Intimate Violence for Women and Men*

A sub-sample from the *National Violence Against Women* (NVAW) Survey (Tjaden et al., 1999) was used to test Johnson's hypotheses pertaining to coercive control as an indicator of type and effects of intimate violence. The NVAW survey is a cross-sectional national random sample of data from telephone interviews, fielded between November 1995 and May 1996, containing a wide range of information on types and characteristics of intimate violence experienced by men and women across the United States. The subset used for this study consisted of women (N = 4,772) and men (N =

5868) currently living with a partner at the time of the interview. Demographic characteristics of the respondents can be found in Tables A.1 and A.2. A comparison of the demographic characteristics of the NVAW study sample with the 2000 Census data (U.S. Department of Commerce, 2000) can be found in Table A.3.

The NVAW survey was chosen for this study for several reasons. Based on a review of the existing available secondary data sets, the NVAW survey was the only data set that contained a comprehensive evaluation of physical and non-physical violence for both women and men. In addition, the NVAW survey contained 26 items that closely matched Johnson's coercive control criteria. This data set also contained three measures of psychological harm known to be associated with intimate violence, including depression, post-traumatic stress disorder, and perceived fear of partner.

The fundamental hypotheses of Johnson's typology are that physical violence embedded in a pattern of control (i.e. *Intimate Terrorism, Mutual Violent Control,* and *Violent Resistance*) is distinctly different, and more harmful, than physical violence not embedded in a pattern of control, regardless of the severity of the physical violence. To test Johnson's underlying hypotheses, a coercive control construct was created from the 26 coercive control behaviors. Hierarchical regression analyses were conducted to establish a relationship between coercive control and the three psychological well-being measures. Once this relationship was established, K-means cluster analyses were conducted for both women and men separately to identify groups that experienced no intimate violence, low levels of coercive control, and high levels of coercive control. Differences between these groups were then explored with regard to severity of physical assault and psychological well-being (depression, PTSD, and perceived fear of partner), while holding background variables constant (education, income, general health, and number of years lived together).

*Article #2: Integrating Typologies of Intimate Violence with Conjoint Assessment: A Tiered Clinical Assessment Tool*

This study incorporates the current knowledge on typologies of intimate violence with current assessment and treatment protocols. Based on this information, an integrated tiered clinical assessment approach is proposed, along with a conceptual intimate

violence assessment tool that can be tested for its usefulness in assisting clinicians with assessing for intimate violence during conjoint sessions, and for determining whether conjoint treatment is indicated.

*Footnotes*

[1]Gender symmetry with regards to intimate violence is defined in this paper as meaning that the characteristics (i.e. type, frequency, severity, and range) of women's and men's violence are similar. This term can also be used to describe intimate violence within a couple system in which the characteristics of each partner's violence matches the other's.

[2]In systems language (Becvar et al., 2000), a symmetrical relationship is one that involves a high frequency of escalating exchanges of similar kinds of communications (e.g. the more one yells, the more the other yells; the more one belittles, the more the other belittles, etc.). Complementary relationships are marked by a high frequency of opposite kinds of communications (e.g. when one is passive, the other is aggressive, when one is dominant, the other is submissive, etc.). Parallel relationships include both types of communication, however, there exists a certain amount of role flexibility in which both members are able to accept responsibility where appropriate, which allows for compromise, growth, and change.

# CHAPTER 2: TESTING COERCIVE CONTROL AS AN INDICATOR OF TYPE AND EFFECTS OF INTIMATE VIOLENCE FOR WOMEN AND MEN

Roxanne G. George
Samuel Vuchinich
Anisa M. Zvonkovic

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Marc Drucker, Manuscript Coordinator
Department of Psychology
University of Miami
P.O. Box 249229
Coral Gables, FL 33124-0751
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# Chapter 2: Testing Coercive Control as an Indicator of Type and Effects of Intimate Violence for Women and Men

The identification of typologies of intimate violence is part of an emerging paradigm towards a multifaceted, multi-theoretical approach to understanding the causes and effects of intimate violence (Chase, O'Leary, & Heyman, 2001; Greene & Bogo, 2002; Johnson & Ferraro, 2001; Stith, Rosen, & McCollum, 2002). In a review of the 1990's literature on intimate violence, Johnson et al. (2001) concluded that "...partner violence cannot be understood without acknowledging important distinctions among types of violence... Our ability to draw firm conclusions and to develop effective policies is broadly handicapped by a failure to make distinctions among types of partner violence" (p. 178). This movement towards typologies of partner violence has stemmed largely from the differences in findings between large-scale national studies and public agency and shelter research on partner violence. Large-scale national studies typically find that heterosexual partner violence is perpetrated by men and women equally, with only a small percentage of extreme cases of men (and sometimes women) unilaterally dominating and oppressing their partners (Johnson, 1995; Straus, 2000). Agency and shelter studies typically show a much higher percentage of this extreme violence perpetrated almost exclusively by men (Johnson, 1995; Johnson 2002; NIJCDC, 1998). Intense debates about the nature of these differences has often led to polarization among well-intentioned researchers, theorists, and clinicians who share the common goal of stopping family violence.

One promising intimate violence typology that may help to bridge this divide is Michael Johnson's (1995; 2002) typology, an interactional typology grounded in the feminist principles of power and control. Johnson has proposed that large-scale national studies typically capture *Situational Couple Violence* (previously termed *Common Couple Violence*), and public agency and shelter studies typically capture *Intimate Terrorism* (previously termed *Patriarchal Terrorism*). Johnson defines *Situational Couple Violence* as intermittent outbursts of minor to severe physical violence by one or both partners, motivated by a need to control the specific situation rather than from a general intent to control one's partner. Johnson defines *Intimate Terrorism* as a prolonged

pattern of minor to severe physical violence by one partner over the other, embedded in a pattern of control. Johnson has proposed that *Situational Couple Violence* is the most common type of violence among couples, and that it is more likely to be gender symmetric and rarely escalates into severe physical violence, whereas *Intimate Terrorism* is less common among couples, and is most often perpetrated by men against women and is more likely to escalate over time and to involve serious injury. Johnson has recently added two additional types of partner violence that include *Violent Resistance* (minor to severe physical violence by one partner in retaliation to *Intimate Terrorism*), and *Mutual Violent Control* (minor to severe physical violence by both partners embedded in a pattern of control).

Johnson (2002) has developed a theoretical coercive control construct for his typology that includes the following four components: inhibiting the will (psychological abuse, legitimization of control) and ability (economic control and social isolation) to resist; threats and intimidation (violence enacted to show there is an ability and will to impose punishment); surveillance (stalking and monitoring partner's behavior); and contingent punishment (violence enacted as punishment for a failure to comply with the explicit or implicit demands). Johnson's coercive control construct is based on the Duluth Abuse Project's (2003) *Power and Control Wheel*, a widely accepted model used to describe the complex role of power and control in intimate violence. Johnson's construct of coercive control also encompasses many of the established constructs used to measure non-physical violence (Dutton, 1995; Gordon, 2000; Marshall, 1992; Straus, 2000; Tolman, 1989). The fundamental hypotheses of Johnson's typology are that physical violence embedded in a pattern of control (i.e. *Intimate Terrorism, Mutual Violent Control,* and *Violent Resistance*) is distinctly different, and more harmful, than physical violence not embedded in a pattern of control, regardless of the severity of the physical violence.

The use of a non-physical construct to make distinctions between types of intimate violence is supported in the intimate violence literature. For example, the use of physical violence as an influence strategy has been shown to be positively associated with the amount of perceived power in relationships for both women and men (Gordon,

2000; Greene et al., 2002; Rosen & Bird, 1996; Sagrastano, 1992). The literature also shows that non-physical violence typically occurs in conjunction with physical violence, and that non-physical violence often precedes and predicts physical violence (Feld & Straus, 1992; Gordon, 2000; Jory, 2004; Stets, 1990; Straus & Sweet, 1992; Vivian & Malone, 1997). There is also evidence that the long-term psychological effects of non-physical violence may be more harmful than the long-term psychological effects of physical violence (Gleason, 1993; Vitanza, Vogel, & Marshall, 1995). In particular, depression, post-traumatic stress disorder, and perceived fear of partner have all been shown to be separate but distinct factors associated with both physical and non-physical violence (Anderson, 2002; Campbell & Sullivan, 1995; Cascardi, O'Leary, Lawrence, & Schlee, 1995; Cascardi, O'Leary, & Schlee, 1999; DeMaris & Swinford, 1996; Gordon, 2000; Stets & Straus, 1992; Straus, 2000; Straus et al., 1992; Vivian et al., 1997). In addition, for extreme cases of intimate violence, such as those found in public shelters and agencies, the underlying dynamics of power and control have been shown to create and maintain the cycle of violence that can lead to the *battered woman syndrome* (Dutton, 1995).

Johnson's typology provides a comprehensive multi-theoretical framework for evaluating the complex interactional characteristics and motivation behind women and men's violence within a context of power and control. From a feminist perspective, Johnson's *Intimate Terrorism* and *Violent Resistance* types of violence capture the underlying gendered and socialized constructs of power and control known to exist in conflicted relationships (Osmond & Thorne, 1993; Salari & Baldwin, 2002; Walker, 1995). From a systems perspective, Johnson's *Situational Couple Violence* and *Mutual Violent Control* types of violence capture the reciprocal and recursive interactional dynamics of relationships also known to exist in conflicted relationships (Becvar & Becvar, 2000; Lederer & Jackson, 1968; Watzlawick, Weakland, & Fisch, 1974). No other existing typologies simultaneously capture these often competing perspectives.

Only two studies could be found that empirically tested Johnson's typology and hypotheses. Johnson and Leone (2000) used the *National Violence Against Women* (NVAW) survey (Tjaden & Thoennes, 1999) to evaluate differences in physical violence

(frequency and severity), psychological well-being (depression and post-traumatic stress disorder), injuries sustained, drug use (prescription and recreational), interference with everyday activities (days of work lost due to violence), and leaving and help-seeking behaviors between married women who experienced low levels of coercive control versus high levels of control (based on a seven item non-physical control construct). Johnson et al. found that women in the high control group were physically attacked more often, were more likely to be injured, exhibited more symptoms of post-traumatic stress disorder, missed more work, and were more likely to leave their husbands.

Leone, Johnson, Cohan, and Lloyd (2001) used data from the *Effects of Violence on Work and Family Study* (as cited in Lloyd, 1996) to evaluate differences in physical, psychological, and economic well-being for poor ethnic minority women who experienced emotional abuse (based on an eight item construct) and threats (based on a three item construct) by their male partners. The authors found that women who experienced high levels of emotional abuse and threats also experienced significantly more frequent, severe, and debilitating physical violence, and scored significantly lower across all three well-being measures than women who experienced low levels of emotional abuse and threats.

The existing studies support Johnson's hypotheses that partner violence embedded in a pattern of control is distinctly different and more harmful than partner violence that is not embedded in a pattern of control. However, there are several issues these studies do not address. For example, neither of these studies used all four components of Johnson's coercive control construct to identify types and effects of intimate violence. There is a need to empirically test Johnson's full coercive control construct as an indicator of type and effects of intimate violence. Secondly, Johnson's typology includes only those individuals who experience physical violence in their relationship. Because non-physical violence has been shown to have harmful psychological effects even when not accompanied by physical violence, there is a need to evaluate the psychological effects of coercive control when not accompanied by physical violence, and to explore the possibility of expanding Johnson's typology to include this group of individuals. Thirdly, none of these studies evaluated the characteristics and

differential effects of intimate violence experienced by men. And finally, none of these studies explored Johnson's hypothesis that the type of violence depends on the absence or presence of a pattern of coercive control, irrespective of severity of the physical violence.

The purpose of this study was to empirically address these issues. In particular, this study included two sets of analyses, conducted independently for women and men: (a) hierarchical regression analyses were conducted on a 26 item coercive control measure (based on Johnson's criteria) to establish a relationship between coercive control and psychological health (depression, post-traumatic stress disorder, and perceived fear of partner) while holding background variables (age, education, income, general health, and number of years living together) constant; (c) k-means cluster analyses were conducted on the coercive control construct to identify no control, low control, and high control groups, and General Linear Model (GLM) and chi-square analyses were conducted to evaluate differences in the psychological health measures across nine coercive control-by-severity groups.

## *Methods*

### *Sample*

Data for this analysis was taken from the *National Violence Against Women* (NVAW) Survey (Tjaden et al., 1999), a cross-sectional national random sample telephone interview, jointly sponsored by the National Institute of Justice (NIJ), the National Center for Injury Prevention and Control (NCIPC), and the Centers for Disease Control and Prevention (CDC), to further the understanding of violence against women. Completed interviews were fielded in a series of replicate waves from November 1995 through May 1996 for 8,000 women and 8,000 men, 18 years of age or older, residing in households throughout the United States, stratified by U.S. Census region. A subset from this data set was used for these analyses that included female ($N$ = 4772) and male ($N$ = 5868) respondents currently living with an intimate partner at the time of the interview.

Respondents in the subset ranged in age from 18 to 88 ($M$ = 43.46, $SD$ = 13.94) for women and from 18 to 93 ($M$ = 43.46, $SD$ = 13.94) for men (Table A.1). Respondent education level (0 = no school, 1 = 1$^{st}$ thru 8$^{th}$ grade, 2 = some high school, 3 = high school graduate, 4 = some college, 5 = four year college degree, 6 = post graduate work)

ranged from no school to post-graduate school for both women ($M$ = 3.80, $SD$ = 1.16) and men ($M$ = 3.96, $SD$ = 1.25). The average personal income of respondents ranged from none to $100,000 or more for both women ($M$ = $22,809, $SD$ = $21,010) and men ($M$ = $40,355, $SD$ = $25,069). General overall health (1 = *poor*, 2 = *fair*, 3 = *good*, 4 = *very good*, and 5 = *excellent*) ranged from poor to excellent for both women ($M$ = 3.79, $SD$ = 1.05) and men ($M$ = 3.78, $SD$ = 1.04). The number of years respondents had lived with their current partner ranged from less than 1 year to 74 years for women ($M$ = 18.77, $SD$ = 14.58), and from less than 1 year to 69 years for men ($M$ = 17.42, $SD$ = 14.29).

Approximately 90% ($N_{women}$ = 4316, $N_{Men}$ = 5284) of the respondents were married or in common-law marriages (Table A.2), 4% ($N_{women}$ = 181, $N_{Men}$ = 228) were divorced or separated, 6% ($N_{women}$ = 254, $N_{Men}$ = 339) were single and never married, and less than one percent ($N_{women}$ = 20, $N_{Men}$ = 16) were widowed. Less than one percent of the respondents ($N_{women}$ = 26, $N_{Men}$ = 29) reported living with a same-sex partner. Approximately 84% ($N_{women}$ = 4009, $N_{Men}$ = 4887) of the respondents were White, 6% ($N_{women}$ = 299, $N_{Men}$ = 381) African American, 2% ($N_{women}$ = 79, $N_{Men}$ = 98) Asian or Pacific Islander, 1% ($N_{women}$ = 49, $N_{Men}$ = 65) American Indian or Alaskan Native, 5% ($N_{women}$ = 244, $N_{Men}$ = 264) were mixed or other, with roughly 8% ($N_{women}$ = 395, $N_{Men}$ = 387) reporting being of Hispanic origin. Approximately 47% ($N$ = 2256) of the female respondents were employed full-time, 14% ($N$ = 681) were employed part-time, 3% ($N$ = 122) were unemployed, 11% ($N$ = 523) were retired, 20% ($N$ = 934) were homemakers, and the remaining 5% ($N$ = 230) were students or doing something else. Approximately 74% ($N$ = 4347) of the male respondents were employed full-time, 3% ($N$ = 188) were employed part-time, 2% ($N$ = 139) were unemployed, 14% ($N$ = 817) were retired, .2% ($N$ = 10) were homemakers, and the remaining 6% ($N$ = 350) were students or doing something else.

*Measures of Intimate Violence*

Intimate violence was defined for this study as any form of physical (including sexual) or non-physical aggression used against an intimate (emotional/sexual) partner without consent. A measure for non-physical aggression was created using Johnson's

theoretical coercive control criteria. Measures for physical aggression were created based on Straus' (2000) *Revised Conflict Tactics Scale* (CTS-2) criteria.

*Coercive control.* The NVAW survey contained 26 Yes-No items for female ($\alpha$ = .72, $N$ = 2696) and male ($\alpha$ = .72, $N$ = 2911) respondents that fell within Johnson's theoretical coercive control construct (Table A.4). Eleven of these items were adopted from the *Canadian Violence Against Women Survey* (Statistics Canada, 1994), and included behaviors related to inhibiting the will and ability to resist (e.g. psychological abuse, legitimization of control, economic and social isolation). The NVAW survey also contained eleven items describing surveillance and contingent punishment behaviors (e.g. stalking, attempts to see or communicate against respondent's will, harm to property or pets), and four items describing threatening behaviors (e.g. threats to harm or kill self or others, threatened with a knife or gun). Respondents were asked if they had ever experienced any of these behaviors by their current partner.

An exploratory factor analysis was conducted on all 26 variables using a principal component extraction method with varimax rotation for all factors with eigenvalues greater than one. Six distinct factors were identified for women (Table A.5) that fell within Johnson's theoretical coercive control construct including: inhibiting the will to resist (psychological abuse), inhibiting the ability to resist (social isolation & economic control), surveillance, threats, and intimidation. There were also six factors with eigenvalues greater than one for men (Table A.6), however the grouping of the items within each factor was much less distinct. One factor consisted of psychological abuse and social isolation items combined. The other five factors consisted of surveillance, threats, and intimidation, however no clear pattern could be identified. When the number of factors was reduced to three (Table A.7), there were two distinct themes for both women and men: Inhibiting the will and ability to resist (psychological, social, economic), and surveillance, intimidation, and threats.

All 26 items were recoded as dichotomous variables (0 = no, 1 = yes) variables and summed together to create a continuous coercive control variable indicating the total number of coercive control tactics used by the respondent's partner. Approximately 37% ($N$ = 1781) of the female respondents experienced from 1 to 17 ($M$ = 2.18, $SD$ = 1.82)

coercive control behaviors by their partners, and 38% ($N$ = 2208) of the male respondents experienced from 1 to 16 ($M$ = 2.18, $SD$ = 1.77) coercive control behaviors by their partners (Table A.13).

*Severity of physical assault.* The NVAW survey contained 14 Yes-No items for female ($\alpha$ = .86, $N$ = 4661) and male ($\alpha$ = .83, $N$ = 5711) respondents adapted from Straus' (2000) *Physical Assault* and *Sexual Coercion* scales (Table A.8). Four of these items fell within Straus' minor physical assault behaviors (e.g. pushed, grabbed, shoved, slapped, threw something at, pulled hair), and ten of these items fell within Straus' severe physical assault (e.g. kicked, bit, choked, attempted to drown, hit with object, beat up, used a knife, gun, or other object) and severe sexual coercion (forced sexual behaviors against respondent's will) behaviors. Respondent were asked if they had ever experienced any of these behaviors by their current partner.

The severe physical and sexual assault items were combined together based on existing evidence that sexual abuse has been found to be highly associated with physical abuse, and therefore can be considered another form of physical abuse (Gordon, 2000). All 14 items were used to create both a continuous (0 = no intimate violence, 1 = no physical assault, 2 = minor physical assault, 3 = severe physical assault) and dichotomous (0 = minor, 1 = severe) severity of physical assault variable, with respondents who experienced both minor and severe physical assault being coded as severe. Of the female ($N$ = 245) and male ($N$ = 136) respondents who experienced physical assault, approximately 64% ($N$ = 157) of the female respondents and 57% ($N$ = 77) of the male respondents experienced minor physical assault, with the remainder of the respondents experiencing severe physical assault (Table A.13).

*Measures of Psychological Harm*

Depression, post-traumatic stress disorder, and perceived fear of partner were used to measure harmful psychological effects of intimate violence for women and men.

*Depression.* The NVAW survey contained an eight-item depression scale for female ($\alpha$ = .77, $N$ = 4661) and male ($\alpha$ = .75, $N$ = 5705) respondents adapted from the *SF-36 Health Survey, U.S. Acute Version, 1.0* (Medical Outcomes Trust, 1993). Respondents were asked to rate on a four-point likert scale (1= never, 2 = rarely, 3 =

some of the time, 4 = most of the time) the extent to which they had experienced any of the listed feelings or behaviors in the previous week (Table A.9). The items were recoded so that a higher score indicated a higher depression level, and a total depression score was created by taking the average of those items answered. Total depression scores ranged from one to four for female ($M$ = 1.94, $SD$ = .51) and male ($M$ = 1.81, $SD$ = .48) respondents.

*Post-traumatic stress disorder (PTSD).* The NVAW survey contained a 21-item PTSD scale adapted from the *Impact of Event Scale* (Weiss & Marmar, 1997) for female ($\alpha$ = .95, $N$ = 183) and male ($\alpha$ = .95, $N$ = 133) respondents who had experienced physical (including sexual) assault in their current relationship. Respondents were asked to think about the most recent experience of physical assault in their relationship, and to rate on a four-point likert scale (1= not at all, 2 = a little bit, 3 = moderately, 4 = quite a bit) how much the listed difficulties (intrusion, hyper-arousal, and avoidance related) had bothered them in the past week (Table A.10). Consistent with the *Impact of Event Scale* (IES) scoring method, a total PTSD score was computed by summing the averages of the intrusion, hyper-arousal, and avoidance scores. PTSD scores ranged from 1 to 12 for female respondents ($M$ = 4.54, $SD$ = 2.04), and from 3 to 10 for male respondents ($M$ = 4.10, $SD$ = 1.67) respondents. As noted above, data were only available for those respondents who had experienced physical assault in their current relationship.

*Perceived fear of partner.* Respondents perceived fear of their partner was measured using a single Yes-No item question within the power, control, and abuse section of the NVAW survey that asked: "Thinking about your current husband (wife)/partner, would you say he/she frightens you?" Approximately one percent ($N$ = 59) of the female and male ($N$ = 36) respondents reported being afraid of their partner.

*Background Variables*

The effects of respondent education level, personal income level, general overall health, and number of years living with current partner were controlled for in the analyses. Existing studies indicate that income, education levels, and general health are often associated with intimate violence, depression, and PTSD (Anderson, 2002; Babcock, Waltz, Jacobson, & Gottman, 1993; Lorant & Eaton, 2003; Sagrastano, 1992;

Taylor & Barusch). Number of years living together was included in the analysis based on evidence of an association (both positive and negative) between duration of relationship and intimate violence (Johnson et al., 2001). There is some evidence to suggest that cohabitating couples engage in more violence than married or dating couples (Stets et al. 1992), however, Johnson et al. (2001) found that this only holds true for couples who have been together for three years or less, and only for couples with reciprocal violence occurring. Because the majority of the couples in this sample had lived together on average more than 17 years, and due to the fact that marital status was significantly correlated to number of years lived together (Table A.14) for both women ($r = .28$, $p < .001$) and men ($r = .40$, $p < .001$), marital status was not included in the analyses. Age of respondents was also not included in the analyses due to its strong correlation with number of years lived together for both women ($r = .83$, $p < .001$) and men ($r = .83$, $p < .001$).

*Development of Coercive Control Groups*

The key distinction between Johnson's *Situational Couple Violence* and the other three types of intimate violence (i.e. *Intimate Terrorism, Violent Resistance,* and *Mutual Violent Control*) is the absence or presence of a pattern of coercive control. To establish a pattern of coercive control, exploratory full and split-half K-Means cluster analyses were conducted on the coercive control measure for women and men who experienced at least one coercive control behavior by their current partner. Respondents who experienced no intimate violence (i.e. no coercive control and no physical assault) by their partner were used as a comparison group ($N_{women} = 2246$; $N_{men} = 2380$), and were therefore not included in the cluster analysis. Respondents who experienced intimate violence by someone other than their intimate partner were also excluded from all analyses in order to avoid the confounding effects of this violence with violence in the current relationship. This reduced the total cluster analysis sample size to 1,141 women and 1,160 men who experienced coercive control by their partner.

The four-cluster full analysis for both women (Table A.11) and men (Table A.12) did not provide sufficient counts in the highest coercive control group, and therefore the split-half analyses were abandoned for this analysis. The three-cluster solution for both

women and men found a low coercive control cut point of 3 or less behaviors and a high coercive control cut point of 8 behaviors for women, and 8 to 11 behaviors for men. A cut point of four or less behaviors was found for both of the two-cluster analyses for both women and men. Distances from the cluster centers were less than one for all cases in the two-cluster and three-cluster solutions. Because the three cluster solutions varied in the high coercive control cut-point for both women and men, the two-cluster solution was used. Therefore, respondents who experienced four or less coercive control behaviors by their partner were placed in the low coercive control group, and respondents who experienced five or more coercive control behaviors were placed in the high coercive control group. Roughly 90% of the women ($N = 1072$) and men ($N = 1080$) who experienced coercive control by their intimate partner experienced low coercive control, with the remaining 10% experiencing high coercive control (Table A.13).

*Development of Coercive Control-by-Severity of Physical Assault Groups*

To explore the relationship between coercive control and severity of physical assault and their combined psychological effects, nine coercive control-by-severity of physical assault groups were created (Table 2.1): *No Intimate Violence*, *No Coercive Control Minor Physical Assault*, *No Coercive Control Severe Physical Assault*, *Low Coercive Control No Physical Assault*, *Low Coercive Control Minor Physical Assault*, *Low Coercive Control Severe Physical Assault*, *High Coercive Control No Physical Assault*, *High Coercive Control Minor Physical Assault*, and *High Coercive Control Severe Physical Assault*. It should be noted that sample sizes within each coercive control category were reduced from their original size due to removal of those respondents who experienced coercive control (or physical assault) by their partner, but experienced physical assault (or coercive control) by someone other than their partner, in order to avoid the confounding effects of violence by someone other than their intimate partner. In addition, respondents who had a missing value (i.e. did not respond or did not know) for either coercive control or physical assault were also removed from the analyses in order to avoid misclassification.

Table 2.1

*Group Sizes for Level of Coercive Control by Severity of Physical Assault*

| | | Severity of physical/sexual assault[a] | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | None | | Minor | | Severe | | Total[c] | |
| Control[b] | Gender | *N* | % | *N* | % | *N* | % | *N* | % |
| None | Women | 2246 | 65.7 | 30 | .9 | 10 | .3 | 2286 | 66.9 |
| | Men | 2380 | 67.0 | 18 | .5 | 4 | .1 | 2402 | 67.6 |
| Low | Women | 884 | 25.9 | 93 | 2.7 | 38 | 1.1 | 1015 | 29.7 |
| | Men | 976 | 27.5 | 42 | 1.2 | 25 | .7 | 1043 | 29.4 |
| High | Women | 41 | 1.2 | 34 | 1.0 | 40 | 1.2 | 115 | 3.4 |
| | Men | 61 | 1.7 | 17 | .5 | 30 | .8 | 108 | 3.0 |
| Total[c] | Women | 3171 | 92.8 | 157 | 4.6 | 88 | 2.6 | 3416 | 100.0 |
| | Men | 3417 | 96.2 | 77 | 2.2 | 59 | 1.7 | 3553 | 100.0 |

*Note.* [a]Coercive control levels determined by cluster analysis of total coercive control behaviors. [b]Severity of physical assault based on Straus' (2000) criteria. [c]Analysis totals and percentages. Missing values included 28% women ($N$ = 1337) and 39% ($N$ = 2299) men who experienced violence by others, and .4% women ($N$ = 19) and .3% men ($N$ = 16) who refused or did not know.

## Analyses

### *Establishing a Relationship Between Coercive Control and Psychological Harm*

Hierarchical linear regression analyses (controlling for the background variables) were conducted to establish a relationship between total number of coercive control behaviors and severity of physical assault on depression and PTSD for both women and men. A hierarchical logistic regression analysis (controlling for the background variables) was conducted to evaluate the relationship between number of coercive control behaviors and severity of physical assault on perceived fear of partner.

In preliminary analyses, it was found that the number of coercive control behaviors was strongly correlated with severity of physical assault (Table A.14) for both women ($r$ = .82, $p$ < .001) and men ($r$ = .82, $p$ < .001). Therefore, coercive control was

evaluated independently of severity of physical assault for all regression analyses in order to avoid the effects of multicollinearity. Four models were evaluated for each psychological outcome variable (i.e. depression, PTSD, and perceived fear of partner): (a) coercive control; (b) coercive control combined with the effects of the control variables; (c) severity of physical assault; and (d) severity of physical assault combined with the effects of the control variables.

*Comparison of Coercive Control-by-Severity of Physical Assault Groups*

To explore the relationship between coercive control and severity of physical assault and their effects on psychological health, General Linear Models (GLM) with Scheffe post-hoc comparisons (with significant background variables entered as covariates in the model) were conducted to evaluate differences in mean depression and PTSD scores for the nine coercive control-by-severity of physical assault groups. Planned contrasts were also conducted for the three coercive control (e.g. none, low, and high) and severity of physical assault (e.g. none, minor, and severe) categories. Chi-square analyses were conducted to evaluate differences in number of respondents who were afraid of their partner for each of the three coercive control and physical assault categories, and for the nine coercive control-by-severity of physical assault groups.

## *Results*

*Establishing a Relationship Between Coercive Control and Psychological Harm*

*Depression.* Total number of coercive control behaviors experienced was a significant positive predictor of depression (Table A.15) for both women ($t = 15.44$, $p < .001$) and men ($t = 13.35$, $p < .001$), and accounted for approximately eight percent of the variance in depression for the women ($R^2 = .08$, $F_{(1,2604)} = 238.41$) and six percent for the men ($R^2 = .06$, $F_{(1,2863)} = 178.34$). Adding the background variables significantly increased the amount of variance accounted for in the model by 10% for the women ($R^2 = .18$, $F_{change\ (4,2604)} = 80.18$) and 8% for the men ($R^2 = .14$, $F_{change\ (4,2863)} = 66.84$). Years lived together ($t = -5.43$, $p < .001$) and general health ($t = -16.58$, $p < .001$) were significant background predictors of depression for women, and years lived together ($t = -2.06$, $p = .04$), general health ($t = -14.62$, $p < .001$), and income ($t = -3.09$, $p = .002$) were significant background predictors of depression for men.

Severity of physical assault was also a significant positive predictor of depression for both women ($t$ = 13.78, $p$ < .001) and men ($t$ = 11.20, $p$ < .001), and accounted for approximately seven percent of the variance in depression for the women ($R^2$ = .07, $F_{(1,2590)}$ = 189.92) and four percent for the men ($R^2$ = .04, $F_{(1,2582)}$ = 125.48). Adding the background variables significantly increased the amount of variance accounted for in the model by 10% for the women ($R^2$ = .17, $F_{change\ (4,2590)}$ = 82.31) and 8% for the men ($R^2$ = .12, $F_{change\ (4,2582)}$ = 66.68). Years lived together ($t$ = -5.62, $p$ < .001) and general health ($t$ = -16.72, $p$ < .001) were the only significant background predictors of depression for women and men, and years lived together ($t$ = -2.38, $p$ = .02), general health ($t_{men}$ = -14.39, $p$ < .001), and education level ($t$ = -3.32, $p$ =.001) were significant background predictors of depression for men.

*PTSD.* Coercive control was a significant positive predictor of PTSD for both women ($t$ = 7.62, $p$ < .001) and men ($t$ = 7.18, $p$ < .001), and accounted for approximately 21% of the variance in PTSD (Table A.16) for women ($R^2$ = .21, $F_{(1,217)}$ = 58.06) and 29% for the men ($R^2$ = .29, $F_{(1,127)}$ = 51.60). None of the background variables were significant predictors of PTSD for the women. Education level was a significant of PTSD for men ($t$ = -2.07, $p$ = .04), however it did not significantly improve the overall model.

Severity of physical assault was also a significant positive predictor of PTSD for both women ($t$ = 3.95, $p$ < .001) and men ($t$ = 6.00, $p$ < .001), and accounted for approximately 7% of the variance in depression for the women ($R^2$ = .07, $F_{(1,207)}$ = 15.95) and 23% for the men ($R^2$ = .23, $F_{(1,121)}$ = 36.03). None of the background variables were significant predictors of PTSD for the women, and only education level was a significant predictor of PTSD for men ($t$ = -2.31, $p$ = .02), significantly increasing the amount of variance accounted for in the model by seven percent ($R^2$ = .30, $F_{change\ (4,121)}$ = 2.77).

*Perceived fear of partner.* Coercive control was a significant predictor of perceived fear of partner (Table A.17) for both women ($\chi^2_{wald}$ = 143.89, $p$ < .001) and men ($\chi^2_{wald}$ = 89.36, $p$ < .001), with each additional coercive control behavior increasing the likelihood of a respondent being afraid of their partner by almost twice as much for both women ($e^{\beta}$ = 1.86) and men ($e^{\beta}$ = 1.69). None of the background variables were significant predictors of fear of partner for women, and general health was the only

significant predictor of fear of partner for men ($\chi^2_{wald}$ = 3.90, $p$ = .05), with each one unit increase in health category decreasing the likelihood of a male respondent being afraid of his partner by approximately 30% ($e^{\beta}$ = .67).

Severity of physical assault was also a significant predictor of perceived fear of partner for both women ($\chi^2_{wald}$ = 108.19, $p$ < .001) and men ($\chi^2_{wald}$ = 72.46, $p$ < .001). Women ($e^{\beta}$ = 4.28) and men ($e^{\beta}$ = 4.31) who experienced severe physical assault were approximately four times more likely to be afraid of their partners than respondents who experienced minor physical assault. When the background variables were added to the model, only income was a significant predictor of fear of partner for women ($\chi^2_{wald}$ = 6.91, $p$ = .009), however it did not account for a substantial change in the likelihood of a woman being afraid of her partner ($e^{\beta}$ = 1.00). General health was the only significant background predictor of fear of partner for men ($\chi^2_{wald}$ = 4.28, $p$ = .04), with each one unit increase in health category decreasing the likelihood of a male respondent being afraid of his partner by approximately 30% ($e^{\beta}$ = .68).

*Comparison of Coercive Control-by-Severity of Physical Assault Groups*

*Depression.* Results from the General Linear Model analysis for depression indicated that number of years lived together ($t$ = -5.53, $p$ < .001) and general overall health ($t$ = -16.62, $p$ < .001) were significant background predictors of women's depression, and number of years lived together ($t$ = -2.22, $p$ = .027), general overall health ($t$ = -14.50, $p$ < .001), and income level ($t$ = -3.21, $p$ = .001) were significant background predictors of men's depression. Therefore, depression scores were adjusted for these significant background variables, and Scheffe post-hoc comparisons were conducted on adjusted means for the nine coercive control-by-severity groups (Table 2.2). Planned comparisons were also conducted to compare mean depression scores for the three coercive control groups (i.e. none, low, and high) and for the three severity of physical assault groups (i.e. none, minor, and severe).

Table 2.2

*Adjusted Mean Depression*[a] *Scores for Coercive Control-by-Severity Groups*

| | | *Severity of physical/sexual assault*[b] | | | |
|---|---|---|---|---|---|
| | | None | Minor | Severe | |
| Control[c] | Gender | Adjusted Mean | Adjusted Mean | Adjusted Mean | Total |
| None | Women | 1.82 $_{d.e.f.g.h.i.j.k}$ | 2.10 $_{d.l}$ | 2.16 $_{e}$ | 2.03$_{t}$ |
| | Men | 1.72 $_{w.x.y.z.aa.bb}$ | 1.85 $_{cc}$ | 1.87 | 1.81$_{ll}$ |
| Low | Women | 2.01 $_{f.m.n.o.p}$ | 2.08 $_{g.q.r.s}$ | 2.18 $_{h.m}$ | 2.09$_{u}$ |
| | Men | 1.86 $_{w.dd.ee.ff}$ | 2.02 $_{x.dd.gg}$ | 1.91 $_{y.hh}$ | 1.93$_{mm}$ |
| High | Women | 2.33 $_{i.l.n.q}$ | 2.26 $_{j.o.r}$ | 2.28 $_{k.p.s}$ | 2.29$_{t.u}$ |
| | Men | 2.04 $_{z.ee.jj}$ | 1.98 $_{aa.kk}$ | 2.25 $_{bb.cc.ff.gg.hh.jj.kk}$ | 2.09$_{ll.mm}$ |
| Total | Women | 2.05$_{v}$ | 2.15 | 2.21$_{v}$ | 2.14 |
| | Men | 1.87 | 1.95 | 2.01 | 1.95 |

*Note.* [a]Depression: 8-item likert scale (1 = *never*, 2 = *rarely*, 3 = *some of the time*, 4 = *most of the time*) adapted from the *SF-36 Health Survey, Acute Version, 1.0* (Medical Outcomes Trust, 1993). [b]Severity of physical assault based on Straus' (2000) criteria. [c]Level of coercive control determined by cluster analysis of total number of coercive control behaviors. Means with a common subscript differed significantly based on General Linear Model pairwise Scheffe comparisons and planned contrasts (totals). Means shown are adjusted for average years lived together ($M$ = 21.39) and general health ($M$ = 3.82) for women, and average years lived together ($M$ = 18.71), respondent income (M = 40.445), and general health ($M$ = 3.77) for men.

In general, women and men's depression scores increased across both coercive control and severity of physical assault levels, with women's scores averaging slightly higher than men's scores (Figure 2.1). Women in the *No Intimate Violence* group had significantly lower average depression scores than any of the other eight groups. Women in the *No Coercive Control Minor Physical Assault* group had significantly lower depression scores than women in the *High Coercive Control No Physical Assault* group. Women in the *Low Coercive Control No Physical Assault* group had significantly lower

depression scores than women in the *Low Coercive Control Severe Physical Assault* group. Women in both the *Low Coercive Control No Physical Assault* and the *Low Coercive Control Minor Physical Assault* groups had significantly lower depression scores than women in any of the three *High Coercive Control* groups, regardless of the presence or severity of physical assault.

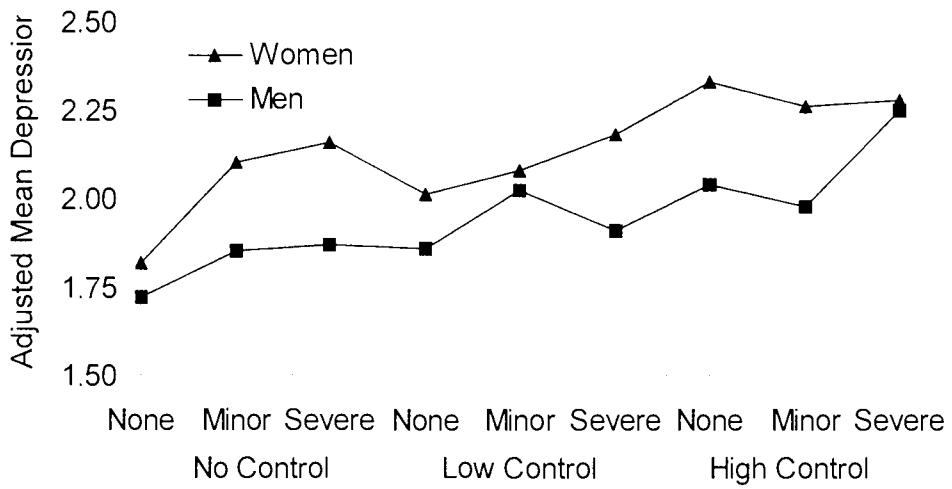



*Figure 2.1.* Adjusted Mean Depression Scores for Coercive Control-by-Severity Groups.

Men's trends were slightly different. Men in the *No Intimate Violence* group had significantly lower depression scores than all of the other groups with the exception of the *No Coercive Control Minor Physical Assault* group and the *No Coercive Control Severe Physical Assault* group. Men in the *Low Coercive Control No Physical Assault* group had significantly lower depression scores than men in the *Low Coercive Control Minor Physical Assault, High Coercive Control No Physical Assault,* and the *High Coercive Control Severe Physical Assault* groups. The only other significant difference found between groups for men was that depression scores for men in the *High Coercive Control Severe Physical Assault* group were significantly higher than all of the other groups except for the *No Coercive Control Severe Physical Assault* group.

Planned contrasts for the combined coercive control groups indicated that depression scores for the high coercive control groups were significantly higher than

depression scores for the no coercive control groups for both women ($t = 4.40$, $p < .001$) and men ($t = 3.37$, $p = .001$). Depression scores for the high coercive control groups were also significantly higher than depression scores for the low coercive control groups for both women ($t = 4.35$, $p < .001$) and men ($t = 2.66$, $p = .008$). There were no significant differences in depression scores between the no coercive control and low coercive control groups for women or men.

Planned contrasts for the combined severity of physical assault groups indicated that depression scores for women in the severe physical assault groups were significantly higher than depression scores for women who experienced no physical assault ($t = 3.10$, $p = .002$), however there were no significant differences in depression scores between these groups for men. Interestingly, there were also no significant differences in depression scores between the minor and severe physical assault groups for either women or men.

*PTSD.* Results of the General Linear Model analysis for PTSD indicated that there were no significant background predictors of PTSD for women, and only general overall health ($t = -2.05$, $p < .001$) was a significant background predictor of men's PTSD scores. Therefore, PTSD scores for men were adjusted for general health only, and Scheffe post-hoc comparisons were conducted on adjusted means for the nine coercive control-by-severity groups (Table 2.3). Planned comparisons were also conducted to compare mean PTSD scores for the three coercive control groups (i.e. none, low, and high) and for the three severity of physical assault groups (i.e. none, minor, and severe).

In general, women and men's PTSD scores increased across both coercive control and severity of physical assault levels, with women's scores averaging slightly higher than men's scores (Figure 2.2). Both women and men in the *High Coercive Control Severe Physical Assault* group had significantly higher PTSD scores than any of the other groups eight groups. In addition, women in the *High Coercive Control Minor Physical Assault* group had significantly higher PTSD scores than women in the *Low Coercive Control Minor Physical Assault* group. The only other significant finding for the women was that respondents in the *High Coercive Control Severe Physical Assault* group had significantly higher PTSD scores than any of the other groups. No other significant differences were found for women or men.

Table 2.3

*Adjusted Mean PTSD[a] Scores for Coercive Control-by-Severity Groups*

| | | *Severity of physical/sexual assault*[b] | | | |
|---|---|---|---|---|---|
| | | None | Minor | Severe | |
| Control[c] | Gender | - | *Adjusted Mean* | *Adjusted Mean* | Total |
| None | Women | - | $3.56_{d, e}$ | $4.18_{f}$ | $3.87_{j}$ |
| | Men | - | $3.34_{m}$ | $4.24_{n}$ | $3.79_{r}$ |
| Low | Women | - | $3.98_{g}$ | $4.41_{h}$ | $4.20_{k}$ |
| | Men | - | $3.32_{o}$ | $3.87_{p}$ | $3.60_{s}$ |
| High | Women | - | $4.92_{d, i}$ | $6.45_{e, f, g, h, l}$ | $5.68_{j, k}$ |
| | Men | - | $3.89_{q}$ | $6.09_{m, n, o, p, q}$ | $4.99_{r, s}$ |
| Total | Women | - | $4.15_{l}$ | $5.01_{l}$ | 4.58 |
| | Men | - | $3.52_{t}$ | $4.73_{t}$ | 4.13 |

*Note*. [a]Post-traumatic stress disorder: 21-item likert scale (1 = *not at all*, 2 = *a little bit*, 3 = *moderately*, 4 = *quite a bit*), adapted from the *Impact of Event Scale* (Weiss & Marmar, 1997). Only asked to respondents who reported experiencing physical/sexual assault. [b]Severity of physical assault based on Straus' (2000) criteria. [c]Level of coercive control determined by cluster analysis of total number of coercive control behaviors. Means with a common subscript differed significantly based on General Linear Model pairwise Scheffe comparisons and planned contrasts (totals). Means shown were not adjusted for women (no significant covariates), and were adjusted for average general health ($M = 3.85$) for men.

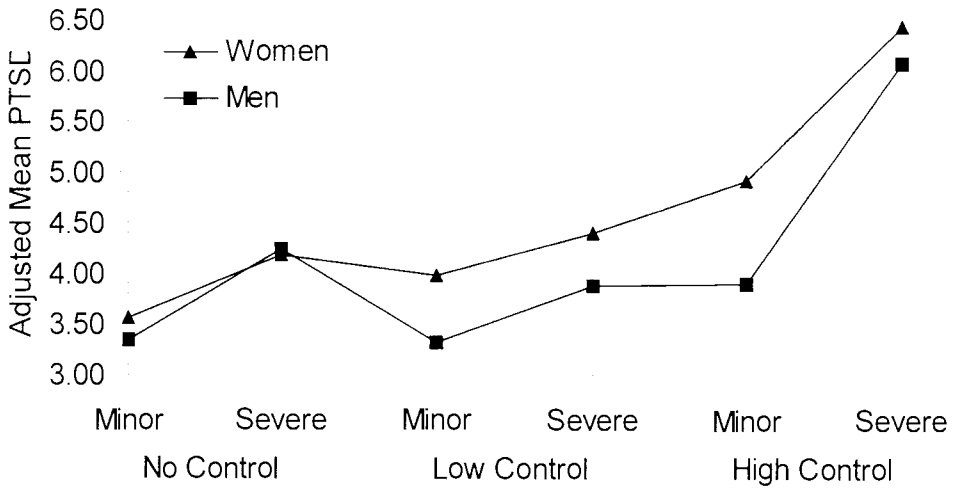



*Figure 2.2.* Adjusted Mean PTSD Scores for Coercive Control-by-Severity Groups.

Planned contrasts for the coercive control groups indicated that PTSD scores for the high coercive control groups were significantly higher than PTSD scores for the no coercive control groups for both women ($t = 4.48$, $p < .001$) and men ($t = 3.15$, $p = .002$). PTSD scores for the high coercive control groups were also significantly higher than PTSD scores for the low coercive control groups for both women ($t = 5.35$, $p < .001$) and men ($t = 5.50$, $p < .001$). There were no significant differences in PTSD scores between the no coercive control and low coercive control groups for either women or men. Planned contrasts for the severity of physical assault groups indicated that PTSD scores for the severe physical assault groups were significantly higher than PTSD scores for the no physical assault groups for both women ($t = 2.95$, $p = .003$) and men ($t = 4.07$, $p < .001$). No other significant differences in PTSD scores were found.

*Perceived fear of partner.* In general, the percentage of respondents afraid of their partner increased across coercive control groups, and was generally higher for women than men across all groups except for the *High Coercive Control Minor Physical Assault* group (Table 2.4, Figure 2.3). In the *No Coercive Control* groups the percentage of respondents afraid of their partner was less than one percent for both women and men. In the low coercive control groups, the percentage of female respondents afraid of their partner did increase across severity levels, however the total percentages were relatively

small (less than 10%). For men, the number of respondents afraid of their partner in the low coercive control groups was virtually non-existent for all levels of severity of physical assault. There were, however, substantially greater percentages of respondents afraid of their partner in the high coercive control groups than in either the low coercive control or no coercive control groups, with the largest percentage of respondents afraid of their partners within the *High Coercive Control Severe Physical Assault* group for both women and men. Chi-square analyses for the nine groups indicated that there were significant differences in number of respondents afraid of their partner across groups for both women ($\chi 2 = 579.48$, $p < .001$) and men ($\chi 2 = 420.18$, $p < .001$). Chi-square analyses for the three coercive control groups (i.e. no, low, and high) indicated that there were significant differences in number of respondents afraid of their partner across these groups for both women ($\chi 2 = 137.27$, $p < .001$) and men ($\chi 2 = 124.14$, $p < .001$). Chi-square analyses for the three severity of physical assault groups (i.e. no, minor, and severe) indicated that there were also significant differences in number of respondents afraid of their partner across these groups for both women ($\chi 2 = 79.09$, $p < .001$) and men ($\chi 2 = 47.23$, $p < .001$).

Table 2.4

*Perceived Fear of Partner*[a] *for Coercive Control-by-Severity Group*

| | | Severity of physical/sexual assault[b] | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | None | | Minor | | Severe | | Total[d] | |
| Control[c] | Gender | *N* | % | *N* | % | *N* | % | *N* | % |
| None (NC) | Women | 4 | .2 | 0 | .0 | 0 | .0 | 4 | .2 |
| | Men | 6 | .2 | 1 | 5.6 | 0 | .0 | 7 | .3 |
| Low (LC) | Women | 12 | 1.4 | 8 | 8.6 | 4 | 10.5 | 24 | 2.4 |
| | Men | 9 | .9 | 0 | .0 | 0 | .0 | 9 | .9 |
| High (HC) | Women | 10 | 24.4 | 5 | 15.2 | 16 | 40.0 | 31 | 27.2 |
| | Men | 7 | 11.5 | 4 | 23.5 | 9 | 30.0 | 20 | 18.5 |
| Total[d] | Women | 26 | .8 | 13 | 8.3 | 20 | 22.7 | 59 | 1.7 |
| | Men | 22 | .6 | 5 | 6.5 | 9 | 15.2 | 36 | 1.0 |

*Note.* [a]Perceived fear of partner: 0 = *no*, 1 = *yes*. Counts shown are for those respondents who reported being afraid of their partner. Percentages are based on the total number of respondents who answered within each group. [b]Severity of physical assault based on Straus' (2000) criteria. [c]Level of coercive control determined by cluster analysis of total number of coercive control behaviors. [d]Percentages based on total number of respondents who answered within each row or column.

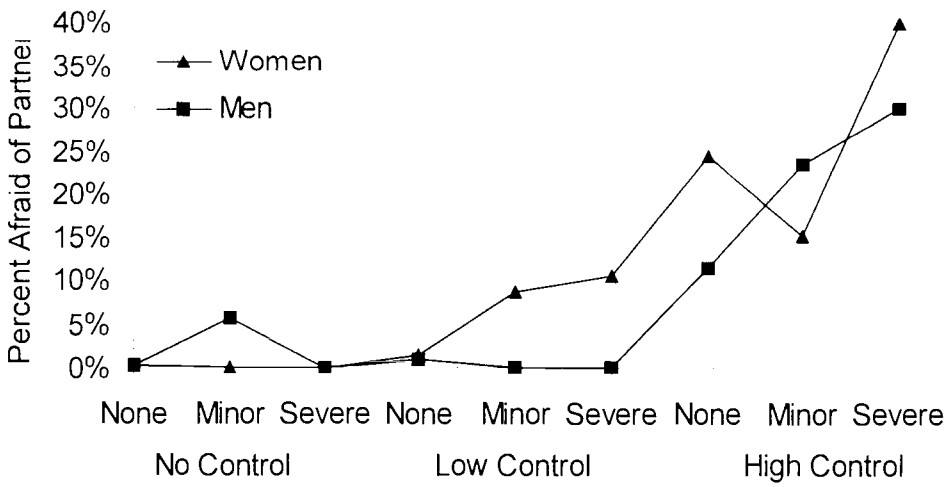



*Figure 2.3.* Perceived Fear of Partner for Coercive Control-by-Severity Group.

It should be noted that the significance findings for the chi-square analyses may be due to the large differences in total counts between the groups, as well the large differences between number of respondents who were afraid of their partners versus those who were not across all groups. While the statistical significance of these findings may be questionable, there were some very noticeable trends in the data that should not be overlooked. In particular, there were substantially greater percentages of respondents afraid of their partner in the high coercive control groups than in either the low coercive control or the no coercive control groups, regardless of severity of physical assault. In addition, there were virtually no respondents that were afraid of their partner in the no coercive control groups, even when severe physical assault was experienced. When a logistic regression analysis was conducted using a dichotomous low/high coercive control variable based on the cluster analyses (holding severity of physical assault constant) it was found that women in the high control group were 14 times more likely to be afraid of their partner than women in the low control group ($\chi^2_{wald} = 51.37$, $p < .001$), and men in the high control group were 20 times more likely ($\chi^2_{wald} = 47.94$, $p < .001$) to be afraid of their partner.

*Discussion*

The purpose of this study was to empirically test Johnson's hypotheses pertaining to coercive control as an indicator of type and effects of intimate violence for women and men by (a) establishing a relationship between coercive control and psychological harm; (b) testing Johnson's hypotheses that physical violence embedded in a pattern of coercive control is distinctly different, and more harmful, than physical violence not embedded in a pattern of coercive control, regardless of the severity of the physical violence; and (c) exploring the psychological effects of coercive control without the presence of physical violence.

*Establishing a Relationship Between Coercive Control and Psychological Harm*

The results from the hierarchical regression analyses indicate that there was a significant positive linear relationship between coercive control and depression and PTSD for both women and men. In addition, coercive control consistently accounted for as much or more of the explained variance in psychological health measures than severity

of physical assault for both women and men. For men, coercive control typically accounted for roughly the same percentage of variance as severity of physical assault for both depression and PTSD. For women, coercive control accounted for three times as much of the variance in PTSD as severity of physical assault did. These findings support existing findings that non-physical violence has psychological consequences as or more harmful than physical violence (Gleason et al., 1995).

Coercive control was also a significant predictor of perceived fear of partner for both women and men, with each additional coercive control behavior increasing the likelihood of fear of partner by roughly twice as much. These finding supports Cascardi et al.'s (1999) finding that PTSD was predicted by male dominance and isolation tactics, as well as severity of physical assault. One of the most pronounced findings from this study was that, holding severity of physical assault constant, women and men in the high coercive control group were 14 and 20 times more likely to be afraid of their partner as women and men in the low coercive control group, respectively. Coercive control is clearly associated with perceived fear of partner for both women and men.

*Testing Johnson's Hypotheses*

The results from the regression analyses, GLM analyses, and chi-square analyses support Johnson's hypothesis that there are distinct differences in psychological harm between women and men who experienced low levels of coercive control versus high levels. In particular, women and men who experienced high levels of coercive control by their partner had significantly higher depression and PTSD scores, and were significantly more likely to be afraid of their partner than women and men who experienced low levels of coercive control.

There was also some evidence to support Johnson's second hypothesis pertaining to severity of physical assault for low levels of coercive control. In particular, there were no significant differences in depression scores between the minor and severe physical assault groups for women and men who experienced no coercive control or low coercive control. There were, however, significant differences in depression scores for men, and PTSD scores for both women and men between the minor and severe physical assault groups for respondents who experienced high levels of coercive control by their partner.

A similar trend was found for perceived fear of partner for both women and men. These results imply that, for no to low levels of coercive control, severity of physical assault may not be a significant predictor of psychological harm. At high levels of coercive control, however, this hypothesis does not necessarily hold true. These findings suggest that a high level of coercive control combined with severe physical aggression was significantly more psychologically harmful than any other combination of intimate violence.

The results of this study also support Johnson's hypotheses that *Situational Couple Violence* is the most common type of violence among couples, and that it rarely escalates into severe physical violence. Following Johnson's definition, if we assume that, of the women ($N$ = 245) and men ($N$ = 136) who experienced physical assault, those who experienced low levels of coercive control represent Johnson's *Situational Couple Violence*, then 70% of the women ($N$ = 171) and 65% of the men ($N$ = 89) experienced *Situational Couple Violence* (Table 2.1), with the remainder of the respondents experiencing one of the other three types of violence associated with a pattern of coercive control. In addition, only 28% of the women ($N$ = 48) and 33% of the men ($N$ = 29) within the *Situational Couple Violence* category experienced severe physical assault as compared to 54% women ($N$ = 40) and 64% men ($N$ = 30) in the high control violence types. While no distinctions can be made between the types of violence within the high control groups without having information about both partner's behaviors, these results do support Johnson's hypothesis that types of violence associated with high levels of coercive control are distinctly different, and are more likely to cause harm, than *Situational Couple Violence*.

*Testing Johnson's Typologies Across Gender*

A statistical comparison of women's findings versus men's findings was beyond the scope of this study, however some general trends were observed that are worth noting. For example, the percentages of women and men within each of the coercive control and severity of physical assault groups were very similar for all analyses. This finding is consistent with other national data set findings for partner violence (Johnson, 1995; Straus, 2000). It should be emphasized, that while there were roughly the same

percentage of women and men in each coercive control group, this does not necessarily imply that the violence within these groups is gender symmetric. Information about the characteristics and motivations of both partner's behaviors would be needed to address the gender symmetry issue.

Interestingly, the percentage of men who experienced coercive control with no physical assault was higher than for women across all levels of coercive control, and the percentage of women who experienced physical assault was higher than men across all levels of coercive control. These finding suggests that women may be more inclined to use coercive control tactics against their partners, and men may tend to use more physical assault tactics. It is likely, however, that perceived power in the relationship is the mediating factor, rather than gender (Sagrastano, 1992).

Average depression, PTSD, and perceived fear of partner scores and percentages were slightly higher for women than men across all intimate violence groups, however the rate of increase across groups was similar for women and men. Women and men also differed on several of the background variables associated with intimate violence. For example, income was a significant predictor of depression and PTSD for men but not for women. Perceived fear of partner was significantly associated with income for women and general health for men. Gender differences were also found in the exploratory factor analysis results. For example, six distinct factors were identified for women that very closely matched the categories identified by Johnson's (i.e. psychological, social, economic, surveillance, threats, and intimidation). For men, only two factors emerged: a combined psychological and social control factor; and a combined threats, intimidation, and surveillance factor.

These results suggest that, while women and men may experience intimate violence at roughly the same rates, the characteristics and motivations of the violence may vary across type and gender. One finding that cannot be overlooked is the fact that men are experiencing psychological harm due to intimate violence at similar rates and levels as women. One of the central themes in response to women's physical violence has been that women do not have the physical size, and do not possess the range of social and

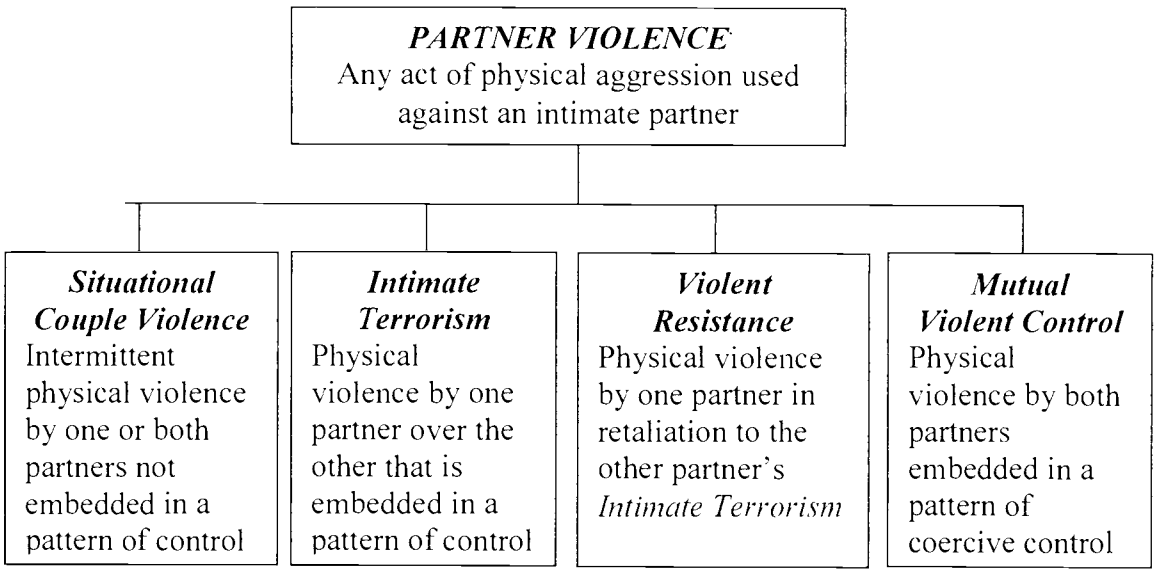
economic power as men do, and therefore, the consequences of women's violence are far less serious. The results from this study indicate that this hypothesis may not be true.

*Expanding Johnson's Typology*

Based on the results of this study, two modifications were made to Johnson's typology (Figure 3.1). The first modification involves the addition of an *Intimate Violent Control* category that encompasses the three types of intimate violence embedded in a pattern of coercive control (i.e. *Intimate Terrorism, Violent Resistance,* and *Mutual Violent Control*). The reason for this modification is that, in order to make distinctions between these three types of violence, one must have access to information about both partners' behaviors. A review of the available data sets pertaining to intimate violence indicates that most of these do not contain this information. Johnson et al. (2001) made the assumption that women who experienced high coercive control most likely fell within the *Intimate Terrorism* category, however, this assumption cannot be validated without information about both partners behaviors. This modification allows for the ability to empirically evaluate existing intimate violence data sets for the presence of two types of violence that are distinctly different, without negating the important interactional and gender components of Johnson's typology.

A second modification to Johnson's typology is the inclusion of individuals who experience coercive control that is not accompanied by physical violence. As noted previously, Johnson's typology only includes individuals who experience physical violence, making distinctions between these individuals based on the absence of presence of a pattern of coercive control. This would have excluded approximately 27% ($N = 925$) of the women and 29% ($N = 1037$) of the men from this study. PTSD scores were not available for respondents who did not experience physical assault, however, depression scores for women and men who experienced high coercive control with no physical assault were significantly higher than respondents who experienced low coercive control with no physical assault. More importantly, women and men who experienced high coercive control with no physical assault had depression scores that were statistically similar to women and men who experienced low levels of coercive control combined with severe physical assault, and high levels of coercive control combined with minor

Johnson's Typology of Partner Violence




George's Proposed Modifications to Johnson's Typology

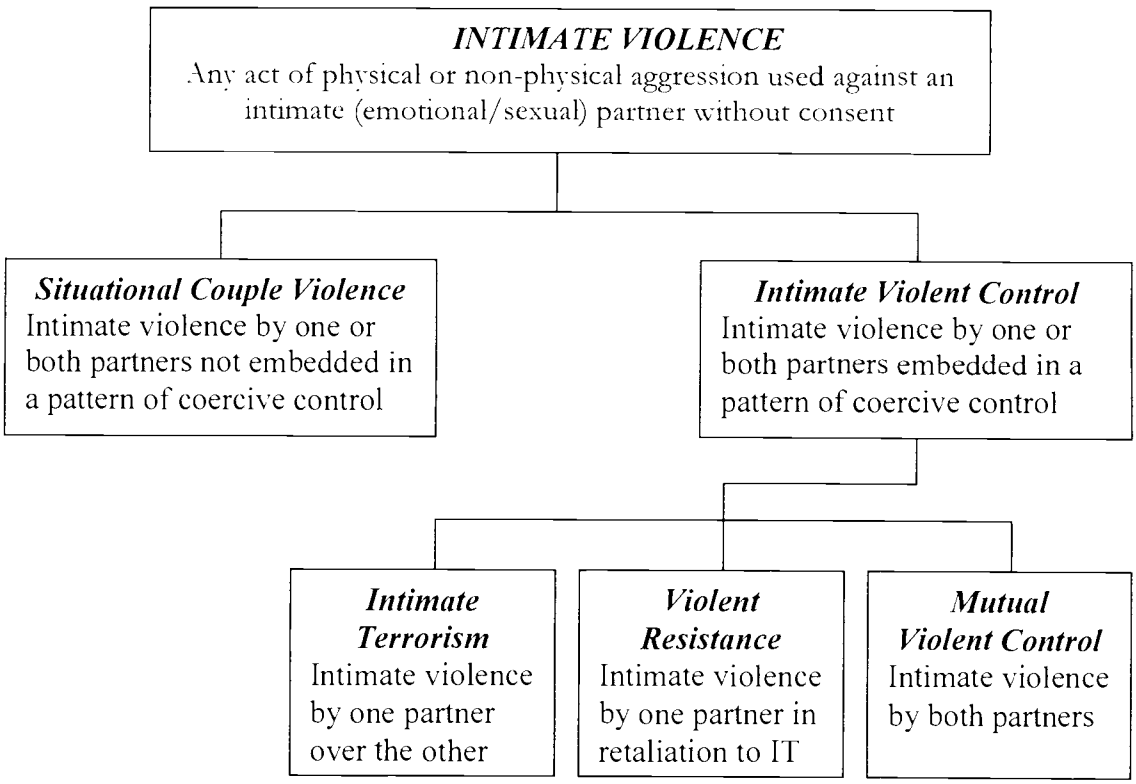



*Figure 2.4.* Johnson's Typology of Violence and George's Proposed Modifications.

physical assault. This trend was also noticeable within the perceived fear of partner analysis. These finding are consistent with existing research that indicates that non-physical aggression is psychologically harmful, even without the presence of physical violence (Straus et al., 1992; Tolman, 1989). In addition, existing research suggests that physical and non-physical aggression exist on a continuum, with non-physical aggression often being a precursor to physical aggression (Feld et al., 1992; Gordon, 2000; Stets, 1990; Straus et al., 1992; Vivian et al., 1997). Identifying the presence of a pattern of coercive control even when no signs of physical violence are present may not only identify individuals at risk for psychological harm, but it may also identify individuals at risk for future physical violence. These modifications allow for a more inclusive evaluation of types of intimate violence without compromising Johnson's fundamental hypotheses.

*Limitations and Directions for Future Research*

Johnson's typology is limited in that it does not include individuals who experience coercive control not accompanied by physical assault. The modifications proposed herein allow for a more inclusive typology of intimate violence. Future research into the characteristics, effects, and motivation behind these modified types of intimate violence is needed for both women and men. In particular, there is a need to empirically explore the characteristics and motivation behind the three types of violence embedded in a pattern of coercive control for both women and men. Ideally, this data should contain information on both partner's behaviors collected from self and partner reports of both partners in order to eliminate reporting biases. In addition, because national surveys tend to miss extreme cases of intimate violence, and agency/shelter data tend to capture these cases for women only, future research on intimate violence must utilize a wide range of sources in order to get a more accurate representation of intimate violence within the population.

There are several questions pertaining to Johnson's coercive control construct that have not been adequately answered by this study or by other studies that have evaluated Johnson's typology. In particular, it may be possible that some coercive control behaviors are more harmful than others. There is a need to explore how much and what type of

coercive control behaviors are required to identify the breakpoint between the less harmful *Situational Couple Violence* and the more harmful types of violence embedded in a pattern of coercive control. In addition, further empirical testing of Johnson's coercive control construct is needed in order to establish its validity and reliability for use with both women and men.

One limitation to this study was that both the depression and PTSD scales were modified from their original source, making it impossible to identify a baseline threshold, or to compare the NVAW respondents' scores to other studies using these same measures. In addition, there was only one question in the NVAW survey that accessed respondent's perceived fear of partner. Using a single item construct to capture the complex phenomenon of perceived fear of partner limits the validity of these results. Future research on intimate violence needs to consistently assess psychological health using validated multiple item measures that can be compared across studies. And lastly, it should be noted that removing respondents from the sample who experienced intimate violence in a previous relationship but not in their current one removed an important group of individuals from the comparison group that may have affected the results.

In summary, Johnson's typology, with the modifications suggested herein, provides a comprehensive multi-theoretical framework for evaluating the motivation, characteristics, and effects of intimate violence for both women and men. Johnson's typology incorporates the complex interactional dynamics of power, control, and gender, and identifies types of violence based on these criteria rather than on characteristics of the abuser or characteristics of the physical violence. No other typologies of intimate violence simultaneously capture these criteria. Future research is needed to test the validity and usefulness of Johnson's modified typology and coercive control construct.

*Other noted limitations of this study.* There were several other limitations to this study that should be addressed that will not be included in the manuscript sent for publication due to the page limit requirements. The first limitation was that no information was available on the frequency of coercive control behaviors experienced over time. Therefore, the only means for establishing a pattern of coercive control was by evaluating the number of coercive control behaviors used, and to assume that a higher

number of coercive control behaviors indicated a pattern of coercive control. It should be noted that Johnson et al. (2000), and Leone et al. (2001) used a similar measure of coercive control based on this assumption.

Another limitation to this study was the fact that coercive control and severity of physical assault were highly correlated, making it difficult to evaluate the combined effects of these phenomena without violating the fundamental assumptions of the statistical techniques used. For example, due to the high correlation between coercive control and severity of physical assault, a regression analysis using both variables simultaneously could not be conducted without inducing errors associated with multicollinearity effects. Therefore, a General Linear Model (GLM) technique was used to compare and contrast mean scores across coercive control and severity levels. However, one of the fundamental assumptions of the GLM technique is random selection and assignment to groups, with group sizes being approximately equal. These assumptions were violated in this analysis. Therefore, neither causal nor population inferences can be drawn from this study. The results of this study, however, can be used to draw attention to the significant trends and findings that are worthy of future research.

Another potential limitation of this study is the evidence that suggests that national surveys typically do not capture the high control, severe physical violence groups typical of the *Intimate Violent Control* types of violence (Johnson, 1995). The consequence of having this group under-represented for this study is that the cluster analysis breakpoint between low and high coercive control would most likely be higher if the high control group was fully represented. In addition, physical assault characteristics, average depression and PTSD scores, and percentage of respondents afraid of their partner within each group would most likely be higher. However, from an assessment perspective, this actually provides a more conservative result. For example, this study found that five or more coercive control behaviors placed a respondent in the *High Coercive Control* group. If the *High Coercive Control* group had been adequately represented, the cut-off point between the low control and high control groups would most likely have been higher, and some of individuals that fell within the *High Coercive Control* group would have become part of the *Low Coercive Control* group.

References

Anderson, K. (2002). Perpetrator or victim: Relationships between intimate partner violence and well-being. *Journal of Marriage and Family, 64(4),* 851 - 863.

Babcock, J. C., Waltz, J., Jacobson, N. S., & Gottman, J. M. (1993). Power and violence: The relation between communication patterns, power discrepancies, and domestic violence. *Journal of Consulting and Clinical Psychology, 61(1),* 40 - 49.

Becvar, D.S., & Becvar, R.J. (2000). *Family therapy: A systemic integration,* 4th ed. MA: Allyn and Bacon.

Campbell, R. S., & Sullivan, C. M. (1995). Women who use domestic violence shelters. *Psychology of Women Quarterly, 19(2),* 237 – 255.

Cascardi, M., O'Leary, K. D., Lawrence, E. E., & Schlee, K. A. (1995). Characteristics of women physically abused by their spouses and who seek treatment regarding marital conflict. *Journal of Consulting and Clinical Psychology, 63(4),* 616 - 623.

Cascardi, M., O'Leary, K.D., Schlee, K. A. (1999). Co-occurrence and correlates of posttraumatic stress disorder and major depression in physically abused women. *Journal of Family Violence, 14(3),* 227 – 249.

Chase, K. A., O'Leary, K. D., & Heyman, R. E. (2001). Categorizing partner-violent men within the reactive-proactive typology model. *Journal of Consulting and Clinical Psychology, 69(3),* 567 – 572.

DeMaris, A., & Swinford, S. (1996) Female victims of spousal violence: Factors influencing their level of fearfulness. *Family Relations, 45,* 98 - 106.

Duluth Abuse Project (2003). *Duluth Domestic Abuse Intervention Project,* 206 West Fourth Street, Duluth, Minnesota 55806, http://domesticviolence.org/wheel.html.

Dutton, D. G. (1995). *The domestic assault of women: Psychological and criminal justice perspectives.* Vancouver BC: UBC Press.

Feld, S. L., and Straus, M. A. (1992). Escalation and desistance from wife assault in marriage. In M. A. Straus and R. J. Gelles (Eds.), *Physical violence in American families* (pp. 489 - 506). New Brunswick, NJ: Transaction.

Gleason, W. (1993). Mental disorders in battered women: An empirical study. *Violence and Victims, 8*, 53 – 68.

Gordon, M. (2000). Definitional issues in violence against women. *Violence Against Women, 6(7)*, 747 – 783.

Greene, K., & Bogo, M. (2002). The different faces of intimate violence: Implications for assessment and treatment. *Journal of Marital and Family Therapy, 28(4)*, 455 – 466.

Johnson, M. P. (1995). Patriarchal terrorism and common couple violence: Two forms of violence against women. *Journal of Marriage and the Family, 57*, 283 – 294.

Johnson, M. P. (2002, In progress). *Violence and control in intimate relationships: Intimate terrorism and other types of domestic violence.*

Johnson, M. P., & Ferraro, K. J. (2001). Research on domestic violence in the 1990's: Making distinctions. In Milardo, R. M. (Ed.), *Understanding families into the new millennium: A decade in review* (pp. 38 – 51). MN: National Council on Family Relations.

Johnson, M. P., & Leone, J. M. (2000, July). *The differential effects of intimate terrorism and situational couple violence: Findings from the National Violence Against Women survey.* Presented at the Tenth International Conference on Personal Relationships, Brisbane, Australia.

Jory, B. (2004). The intimate justice scale: An instrument to screen for psychological abuse and physical violence in clinical practice. *Journal of Marital and Family Therapy, 9(1)*, 29 – 43.

Lederer, W. J., & Jackson, D. D. (1968). *The mirages of marriage*. New York: Norton.

Leone, J. M., Johnson, M. P., Cohan, & C. L., Lloyd, S., (2001, June). Consequences of different types of domestic violence for low-income, ethnic women: A control-based typology of male-partner violence. Presented at the International Network on Personal Relationships, Prescott, Arizona.

Lloyd, S. A. (1996, November). The effects of violence on women's employment. Paper presented at the Association for Public Policy Analysis and Management (APPAM).

Lorant, V., & Eaton, W. (2003). Review: There is marked socioeconomic inequality in persistent depression. *Evidence-Based Mental Health, 6(3)*, 75 – 76.

Marshall, L. L. (1992). Development of the Severity of Violence Against Women Scales. *Journal of Family Violence, 7*, 103 - 121.

Medical Outcomes Trust (1993). *SF-36 Health Survey, U.S. Acute Version, 1.0*. MA: P.O. Box 1917, Boston, MA 02205.

NIJCDC (National Institute of Justice Centers for Disease Control and Prevention) (1998). *Prevalence, incidence, and consequences of violence against women: Findings from the national violence against women survey*. U.S. Department of Justice.

Olson, L. N. (2000). Exploring common couple violence in heterosexual romantic relationships. *Western Journal of Communications, 66(1)*, 104 – 128.

Osmond, M. W. & Thorne, B. (1993). Feminist theories: The social construction of gender in families and society. In Boss, P. G., Doherty, W. J., Larossa, R., Shumm, W. R., and Steinmetz, S. K. (Eds.), *Sourcebook of family theories and methods: A Contextual Approach* (pp. 591 - 622). New York, NY: Plenum Press.

Rosen, K. H., & Bird, K. (1996). A case of woman abuse. *Violence Against Women*, 2(3), 302 – 321.

Sagrestano, L. M. (1992). Power strategies in interpersonal relationships: The effects of expertise and gender. *Psychology of Women Quarterly, 16*, 481 - 495.

Salari, S. M., & Baldwin, B. M. (2002). Verbal, physical, and injurious aggression among intimate couples over time. *Journal of Family Issues, 23(4)*, 523 –550.

Statistics Canada (1994). *Canadian Violence Against Women Survey*. Canada: Housing, Family and Social Statistics Division.

Stets, J. E. (1990). Verbal and physical aggression in marriage. *Journal of Marriage and the Family, 52*, 501 - 514.

Stets, J. E., & Straus, M. A. (1992). Gender differences in reporting marital violence and its medical and psychological consequences. In M. A. Straus and R. J. Gelles (Eds.), *Physical violence in American families* (pp. 151 - 165). New Brunswick, NJ: Transaction Books.

Stith, S. M., Rosen, K. H., McCollum, E. E. (2002). Domestic violence. In Sprenkle, D. H. (Ed.), *Effectiveness research in marriage and family therapy* (pp. 223 – 254). Alexandria, VA: AAMFT.

Straus, M. A. (2000). *Handbook for the conflict tactics scales (CTS) including revised versions CTS2 and CTSPC*. NH: Family Research Laboratory, University of New Hampshire.

Straus, M. A., & Sweet, S. (1992). Verbal/symbolic aggression in couples: Incidence rates and relationships to personal characteristics. *Journal of Marriage and the Family, 54(2),* 346 – 357.

Taylor, M. J., & Barusch, A. S. (2004). Personal, family, and multiple barriers of long-term welfare recipients. Social Work, 49(2), 175 – 183.

Tjaden, P., & Thoennes, N. (1999). *Violence and threats of violence against women and men in the United States, 1994-1996.* Washington, D.C.: National Institute of Justice/Centers for Disease Control and Prevention.

Tolman, R. M. (1989). The development of a measure of psychological maltreatment of women by their male partners. *Violence and Victims, 4,* 159 - 177.

Vitanza, S., Vogel, L., & Marshall, L. (1995). Distress and symptoms of post-traumatic stress disorder in abused women. *Violence and Victims, 10,* 23 – 24.

Vivian, D., & Malone, J. (1997). Relationship factors and depressive symptomology associated with mild and severe husband-to-wife physical aggression. *Violence and Victims, 12,* 3 - 18.

Walker, L. (1995). Current perspectives on men who batter women – Implications for intervention and treatment to stop violence against women: Comment on Gottman et al. (1995). *Journal of Family Psychology, 9(3),* 264 – 271.

Watzlawick, P., Weakland, J., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution.* NY: Norton and Company.

Weiss, D. S., & Marmar, C. R. (1997). The Impact of Event Scale revised. In J.P. Wilson and T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399 - 411). NY: Guilford.

# CHAPTER 3: INTEGRATING TYPOLOGIES OF INTIMATE VIOLENCE WITH CONJOINT ASSESSMENT: A TIERED CLINICAL ASSESSMENT APPROACH

Roxanne G. George
Jeffrey Todahl
Samuel Vuchinich
Anisa Zvonkovic

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Karen S. Wampler, PhD, Editor
Marriage and Family Therapy Program
Texas Tech University
P.O. Box 41162
Lubbock, TX 79409-1162
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# Chapter 3: Integrating Typologies of Intimate Violence with Conjoint Assessment: A Tiered Clinical Assessment Approach

The identification of typologies of partner violence is part of an emerging paradigm towards a multifaceted multi-theoretical approach to understanding the causes and effects of intimate violence (Chase, O'Leary, & Heyman, 2001; Greene & Bogo, 2002; Johnson & Ferraro, 2001). In the past two decades, several intimate violence typologies have been proposed and are beginning to be empirically tested. These typologies range in scope from interactional characteristics of intimate violence (Johnson, 1995; Johnson, 2002; Neidig & Friedman, 1984; Olson, 2002; Whitchurch, 2000), to characteristics of male batterers (Berns, Jacobson, & Gottman, 1999; Chase et al., 2001; Gottman, 1999; Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000; Holtzworth-Munroe, & Stuart, 1994; Waltz, Babcock, Jacobson, & Gottman, 2000). More recently, promising work has evolved on characteristics of female batterers (Babcock, Miller, & Siard, 2003; Swan & Snow, 2002; Whitchurch, 2000). Findings from this research suggest that the characteristics, motivation, and effects of intimate violence vary widely, and that some types of intimate violence may cause considerable physical and psychological harm, while others may not.

This research on typologies of intimate violence has brought about a resurgence of research evaluating the efficacy of using conjoint (couples) treatment for some types of intimate violence (Bograd & Mederos, 1999; Greene et al., 2002; Stith, Rosen, & McCollum, 2002). The existing literature suggests that conjoint treatment has been effective for treating couples with low levels and limited incidents of physical violence by male partners, or couples that had individually completed gender-specific group treatments first (Brannen & Rubin, 1996; Geller, 1998; Geller & Wasserstrom, 1984; Hamby, 1998; Heyman & Neidig, 1997; Johannson & Tutty, 1998; Neidig et al., 1984). Other research has shown that men who use only minor physical aggression against their wives have a significant likelihood of stopping future violence with minimal intervention (Feld & Straus, 1992; Quigley & Leonard, 1996). In addition, conjoint treatment has been shown to be effective in identifying the reciprocal and recursive nature of the interpersonal dynamics between couples, which has been found to be a critical factor in

preventing future violence (Murphy & O'Leary, 1989; Neidig et al., 1984). These dynamics typically do not get addressed in current accepted treatment modalities of individual or gender-specific groups (Geffner & Rosenbaum, 1990).

The existing literature also suggests that conjoint therapy may NOT be effective for treating some types of intimate violence (Gondolf, 1997; Holtzworth-Munroe et al., 1994). For example, the typology research on male batterers indicates that some types of extreme male batterers show clear signs of unresolved psychopathology often accompanied by unresolved substance abuse issues (Berns et al., 1999; Chase et al., 2001; Dutton, 1998; Gondolf, 1997; Holtzworth-Munroe et al., 1994; Holtzworth-Munroe et al., 2000; Neidig et al., 1984; Waltz et al., 2000). This type of batterer typically uses a wide range of physical, psychological, social, and economic violence against their female partners. Recent typology research on women who are violent with their male partners indicates that women's violence may follow similar trends (Babcock et al., 2003; Swan et al., 2002). Attempting to treat these individuals conjointly will most likely not be effective, and may cause additional harm to these individuals and families.

Current accepted clinical practices and policies for the assessment and treatment of intimate violence do not yet make distinctions between types of violence (Bograd et al., 1999; Greene et al., 2002; Johnson et al., 2001). In essence, we are using a "one type fits all" model to address a complex phenomenon that is clearly not uni-dimensional. This is not consistent with findings that suggest that therapeutic treatment effectiveness is optimized by tailoring treatment approaches to match the needs of the client and the particular phenomenon being treated (American Psychological Association, 1995; Hubble, Duncan, & Miller, 1999). The integration of typologies of intimate violence into current clinical assessment and treatment protocols may allow clinicians to more accurately identify appropriate treatment modalities for different types of violence, which may improve treatment effectiveness (Bograd et al., 2002; Gondolf, 1997; Johnson et al., 2001).

These are critical issues to consider given that existing statistics on intimate violence indicate that from 12% to 51% of couples in the United States have experienced at least one incident of physical assault over the course of their relationship (Lawson,

2003; Straus, 2000), and that roughly 50% to 65% of family therapy client populations have reported at least one incident of physical violence in their relationship history (Lawson, 2003; O'Leary, Vivian, & Malone, 1992). In addition, once physical violence begins, it is likely to continue and escalate without some type of intervention (O'Leary, K. D., Barling, J., Arias, I., Rosenbaum, A., Malone, J., & Tyree, A., 1989). Couples counseling may be the first line of defense in the assessment and treatment of intimate violence (Bograd et al., 1999; Greene et al., 2002). Therefore, it is imperative that clinicians be prepared to make appropriate assessment and treatment decisions that incorporate the most current information on typologies and assessment criteria for intimate violence.

The goals of this paper are: (1) to integrate current information on typologies of intimate violence into the current conjoint assessment protocols; and (2) to develop an integrated tiered assessment approach that be used by clinicians to assess for intimate violence in conjoint sessions, and to determine whether conjoint treatment is indicated.

*Typologies of Intimate Violence: The Search for a Comprehensive Typology*

Typologies based on the characteristics of intimate violence (see Table 1.1) have identified several important interactional factors associated with types of violence, including differences in escalation, reciprocity, intimacy, satisfaction, and power structure. Typologies based on characteristics of perpetrators (see Table 1.2) have also identified several important psychobiological factors associated with types of perpetrators, including differences in attachment styles, social skills, cognitive processing, attitudes toward violence, generality of violence, psychopathology, and history of abuse. To date, however, no typology of intimate violence has been developed that integrates the characteristics of perpetrators with the characteristics of violence. In a review of the intimate violence research from the nineties, Johnson et al. (2001) proposed that "... major advances in our understanding of the origins of partner violence will come from bringing together and extending the work on types of violence and types of perpetrators" (p. 169).

*Johnson's Typology of Intimate Violence*

Michael Johnson's (1995; 2002) typology shows promise of being one of the most comprehensive typologies of intimate violence (Greene & Bogo, 2002; Johnson et al., 2001). Johnson proposed that there are four types of intimate violence: *Situational Couple Violence* (intermittent minor to severe physical violence that is not embedded in a pattern of coercive control); *Intimate Terrorism* (prolonged pattern of minor to severe physical violence by one partner over the other, and embedded in a pattern of coercive control); *Violent Resistance* (minor to severe physical violence by the oppressed partner in retaliation to the oppressive partner's intimate terrorism); and *Mutual violent Control* (a prolonged pattern of minor to severe physical violence by both partners that is embedded in a pattern of coercive control). The underlying hypotheses behind Johnson's typology are that physical violence embedded in a pattern of coercive control is distinctly different, and more harmful, than physical violence not embedded in a pattern of coercive control.

Johnson's typology offers several advantages over other typologies. From a systems perspective, Johnson's *Situational Couple Violence* and *Mutual Violent Control* types of violence capture the reciprocal and recursive interactional dynamics of relationships known to exist in conflicted relationships (Becvar & Becvar, 2000; Carter & McGoldrick, 1999; Lederer & Jackson, 1968; Watzlawick, Weakland, & Fisch, 1974). From a feminist perspective, Johnson's *Intimate Terrorism* and *Violent Resistance* types of violence capture the underlying gendered and socialized constructs of power and control also known to exist in conflicted relationships (Bograd et al., 1999; Lawson, 2003; Osmond & Thorne, 1993; Salari & Baldwin, 2002; Walker, 1995). No other existing typologies simultaneously capture these often competing perspectives.

Johnson's typology is unique in its underlying assertion that it is not the severity of physical acts that defines the type of violence, but rather it is the presence of these acts embedded in a pattern of coercive control. This hypothesis is supported in the literature in three ways. First, perceived power in relationships has been shown to be positively associated with the type and number of influence strategies used (i.e. physical, emotional, economic, etc), regardless of gender (Gordon, 2000; Greene et al., 2002; Rosen & Bird,

1996; Sagrastano, 1992). There is also evidence that suggests that the long-term effects of non-physical violence may be more harmful than the long-term effects of physical violence (Gleason, 1993; Vitanza, Vogel, & Marshall, 1995). And finally, for extreme cases of abuse, underlying power and control dynamics have been shown to play an integral part in creating and maintaining the cycle of violence that can lead to the battered woman syndrome (Dutton, 1995). A typology that makes distinctions between types of violence based on power and control dynamics (rather than physical violence alone) will more accurately identify harmful types of violence that would be dangerous to treat conjointly.

And lastly, Johnson's typology provides a theoretical framework from which to evaluate the different characteristics and motivation of both women and men's violence. For example, Violent Resistance is one type of violence in which women are physically violent in retaliation to their male partner's Intimate Terrorism. The motivation and characteristics of this type of violence are very different than Situational Couple Violence, where the women may employ minor to severe acts of physical violence to control a particular situation, or Mutual Violent Control, where the woman may employ a wide range of physical and non-physical violence in order to control the relationship or her partner. Future research into Johnson's typology may show that some women are also Intimate Terrorists, and that their male partners' violence is in retaliation to this. As Greene et al. (2002) pointed out, "Current assessment and treatment practices that focus almost exclusively on patriarchal male violence against women may not reflect an understanding of the lived experiences of many couples and ultimately may deny them the type of help they seek" (p. 456). In addition, because Johnson's typology makes distinctions based on power and control dynamics rather than gender, it can also be used to evaluate same sex couples for intimate violence.

One limitation to Johnson's typology is that no empirical research has been conducted to evaluate the characteristics of perpetrators within each type of violence. Another limitation to Johnson's typology is that it does not include couples that experience a pattern of coercive control not accompanied by physical violence. The existing literature indicates that non-physical violence often precedes and predicts

physical violence (Feld et al., 1992; Gordon, 2000; Jory, 2004; O'Leary, 1993; Stets, 1990; Straus & Sweet, 1992; Vivian & Malone, 1997), and that non-physical violence has been shown to cause mental health dysfunction and subjective distress, even when no physical violence is present (Straus et al., 1992; Tolman, 1989). Identifying the presence of a pattern of coercive control even when no signs of physical violence are present may not only identify couples at risk for psychological harm, but it may also identify couples at risk for future physical violence. There is a need to expand Johnson's typology to include characteristics of perpetrators, and to include men and women who experience coercive control without physical violence.

*Expanding Johnson's Typology*

An evaluation of the existing typologies identified two common themes among the typologies. One common theme is the presence of a type of violence that has low levels of control, low levels of severe physical violence, tends to be reciprocal and gender symmetric in nature, and in which the perpetrators show low to no rates of unresolved psychopathology and substance abuse. These types of violence include Johnson's (1995; 2002) *Situational Couple Violence*, Neidig et al.'s (1984) *Expressive* violence, Chase et al.'s (2001) *Reactive* violence, Whitchurch's (2000) *Agreeable-Intimate* violence, Gottman's (1999) *Type II* husbands, Holtzworth-Munroe et al.'s (1994) *Family-Only* violent men, and Babcock et al.'s (2003) *Partner-Only* Violent women. These types of violence appear to have a relatively low potential for long-term physical or psychological harm, and show promise of being amenable to conjoint treatment.

Another common theme within the typologies is the presence of a type of violence enacted by one or both partner that involves high levels of control, high levels of severe physical violence, high levels of unresolved psychopathology and substance abuse by the perpetrator, is typically motivated by a need to control or punish, and is followed by little to no remorse by the perpetrator. These types of violence include Johnson's (1995; 2002) *Intimate Terrorism* and *Mutual Violent Control*, Neidig et al.'s (1984) *Instrumental* violence, Chase et al.'s (2001) *Proactive* violence, Whitchurch's (2000) *Conflictive-Intimate* violence, Gottman's (1999) *Type I* husbands, Holtzworth-Munroe et al.'s (1994) *Generally Violent-Antisocial* and *Borderline-Dysphoric* men, and Babcock et

al.'s (2003) *Generally Violent* women. These types of violence show a high potential for long-term physical and psychological harm, as well as a high potential for retaliation, and would most likely not be amenable to conjoint treatment.

Based on these findings and on the limitations described above, we propose two modifications to Johnson's typology. The first modification is the inclusion of individuals who experience coercive control not accompanied by physical violence. Johnson's typology makes distinctions between types of violence based on physical violence evaluated within a context of the presence or absence of a pattern of coercive control. The modifications allows for the inclusion of couples who experience *Intimate Violence*, which is defined as any act of physical or non-physical aggression used against an intimate (emotional/sexual) partner without consent. For *Situational Couple Violence*, this modification has little impact because, by definition, these couples do not experience a wide range of non-physical violence. This modification does, however, impact the other three types of violence, and allows for the identification of couples that experience a wide range of harmful non-physical aggression that is not accompanied by physical violence.

The second modification involves the addition of an *Intimate Violent Control* category that encompasses Johnson's three types of intimate violence embedded in a pattern of coercive control (i.e. *Intimate Terrorism*, *Violent Resistance*, and *Mutual Violent Control*). This modification was made for two reasons. First, while Johnson's theoretical distinctions between these groups makes intuitive sense, there is currently no empirical data that supports these distinctions, or that provides information on the characteristics of individuals within each of these groups. There is, however, empirical evidence that violence embedded in a pattern of coercive control has significantly greater physical and psychological consequences than violence not embedded in a pattern of coercive control (Johnson et al., 2000; Leone et al., 2001). There is also evidence from the typology literature that suggests that this type of violence may be associated with high levels of unresolved psychopathology and substance abuse issues, however it is unclear if this pertains to all three categories, or just to *Intimate Terrorism*. Therefore, in order to err on the conservative side, these three types of violence have been combined.

*Integrating Typologies of Intimate Violence into Assessment and Treatment*

The remainder of this article outlines a proposed integrated tiered assessment approach that incorporates Johnson's expanded typology into current conjoint assessment protocols. From this information, a conceptual conjoint assessment tool was developed (Figure 3.1) that can be used by clinicians to assess couples for intimate violence, and to determine whether conjoint treatment is indicated. It should be emphasized that the integrated tiered assessment approach and assessment tool developed in this paper are conceptual in nature, and require further testing and evaluation before being implemented into clinical practice.

*Ruling Out Types of Violence Not Recommended for Conjoint Treatment*

The fundamental hypothesis that the proposed integrated tiered assessment approach is based on is that intimate violence that is embedded in a pattern of coercive control (i.e. *Intimate Violent Control*) is significantly more harmful, and may be associated with significantly higher levels of negative psychobiological factors than intimate violence that is not embedded in a pattern of coercive control. From a clinical assessment and treatment perspective, the clinician's primary responsibility is to ensure the safety of all clients (Bograd et al., 1999; Stith et al., 2002). Therefore, it also assumed that these types of violence should not be treated conjointly. Further it is recommended clinicians assume that *Intimate Terrorism* is present during the initial assessment and treatment process until ruled out, as this type of violence has the highest potential for harm during conjoint assessment and treatment.

*Identifying a pattern of coercive control.* At the crux of these hypotheses is the ability to identify a pattern of coercive control. Johnson (2002) has developed a theoretical construct for his coercive control criteria that includes the following four components: (a) inhibiting the will (e.g. psychological abuse, legitimization of control) and ability (e.g. economic control and social isolation) to resist; (b) threats and intimidation (violence enacted to show there is an ability and will to impose punishment); (c) surveillance (e.g. stalking and monitoring partner's behavior); and (d) contingent punishment (violence enacted as punishment for a failure to comply with the explicit or implicit demands). Johnson's theoretical construct of coercive control is based on the

Duluth Abuse Project's (2003) *Power and Control Wheel*, a widely accepted model that is used to describe the complex phenomenon of power and control in intimate violence. Johnson's construct of coercive control encompasses many of the established constructs typically used to measure non-physical violence (Dutton, 1995; Marshall, 1992; Straus, 2000; Tolman, 1989). Recent empirical studies of Johnson's coercive control construct indicate that the use of three or more coercive control behaviors may indicate of a pattern of coercive control that distinguishes between *Situational Couple Violence* and *Intimate Terrorism* types of violence (Johnson & Leone, 2000).

Jory's (2004) *Intimate Justice Scale* (IJS) is a promising assessment tool that measures ethical dynamics of relationships that are very similar to Johnson's coercive control criteria, and that has been shown to be highly correlated with Straus' (1979) *Conflict Tactics Scale*. Jory suggests that the IJS be administered as a written questionnaire to all couples presenting for couples counseling. The IJS includes the following assessment questions, evaluated on a scale from one (I do not agree at all) to five (I strongly agree): (a) My partner never admits when he/she is wrong; (b) My partner is unwilling to adapt to my needs and expectations; (c) My partner is more insensitive than caring; (d) I am often forced to sacrifice my own needs to meet my partner's needs; (e) My partner refuses to talk about problems that make him/her look bad; (f) My partner withholds affection unless it would benefit him/her; (g) It is hard to disagree with my partner because he/she gets angry; (h) My partner resents being questions about the way he/she treats me; (i) My partner builds himself/herself up by putting me down; (j) My partner retaliates when I disagree with him/her; (k) My partner is always trying to change me; (l) My partner believes he/she has the right to force me to do things; (m) My partner is too possessive or jealous; (n) My partner tries to isolate me from family and friends; and (o) Sometimes my partner physically hurts me. Total scores are obtained by summing the responses for all 15 items, with a possible range of 15 (no reported violations) to 75 (pervasive violations and a high likelihood of abuse). Scores ranging from 15 to 29 indicate little risk of physical violence, scores ranging from 30 and 45 indicate a likelihood of minor physical violence, and scores greater than 45 may be a predictor of severe physical violence. Jory suggests that additional assessment is warranted for clients

who score greater than 30, or for clients who respond with scores of 2 or greater on any of the items on the scale.

*Identifying a pattern of severe physical violence.* Because non-physical violence has been shown to be highly associated with physical violence, and often precedes and predicts it, it is reasonable to assume that a pattern of severe physical assault would also be accompanied by a pattern of coercive control. Straus' (2000) *Modified Conflict Tactics Scale* (CTS-2) is one of the most widely used assessment tools that measures frequency, severity, and range of physical assault behaviors by both partners. Bograd et al. (1999) suggests that conjoint treatment is not recommended if there is a history of two or more acts of severe physical violence within a 12-month period. Other authors (Greene et al., 2002; Jory, 2004; Stith et al., 2002) suggest that intimate violence should be evaluated based on the motivation for its use and on the impacts of the violence. In particular, intimate violence that is used to establish control, intimidate, punish, demoralize, exploit, or instill fear, or intimate violence that severely limits or affects employment, social networks, and physical or mental health, should not be treated conjointly.

*Identifying lethality and imminent harm risk factors.* Bograd et al. (1999) suggest that the presence of even one of the following lethality risk factors rules out conjoint treatment, even when no physical violence is present: unresolved substance abuse; a history of intimate violence; a history of violent crimes or violations outside the home (convictions and/or accusations of assault on spouses or non-family members); availability and use of weapons (including martial arts) on the partner or other family members; threats to retaliate, hurt, or kill the partner or self; obsession with the partner (intense jealousy, repeated accusations of infidelity, ongoing monitoring, stalking, social isolation); and bizarre forms of behavior (sadistic, depersonalized abuse with elements of torture such as rape, burning, starvation, sleep deprivation). It is suggested that the clinician evaluate the presence of these factors within the context of their link to imminent harm.

The typology research indicates that extreme types of male perpetrators often show signs of unresolved psychopathology, including antisocial personality disorder (APD), bi-polar disorder (BPD), narcissistic personality disorder (NCP), impulse-control

disorder (IPD), and depression (Berns et al., 1999; Chase et al., 2001; Dutton, 1998; Gondolf, 1997; Holtzworth-Munroe et al., 1994; Holtzworth-Munroe et al., 2000; Neidig et al., 1984; Waltz et al., 2000). The existing intimate violence literature also indicates that women who experience extreme types of intimate violence often show clear signs of depression and post-traumatic stress disorder (Anderson, 2002; Campbell & Sullivan, 1995; Cascardi, O'Leary, Lawrence, & Schlee, 1995; Cascardi, O'Leary, & Schlee, 1999; Johnson et al., 2000; Leone, Johnson, Cohan, & Lloyd, 2001; Stets & Straus, 1990), and perceived fear of their partner, or a belief that serious harm is imminent (Bograd et al., 1999; Cascardi et al., 1995; DeMaris & Swinford, 1996; Greene et al., 2002).

Bograd et al. (1999) also suggest that conjoint treatment should not be undertaken if one or both of the partners are court-mandated or involved with a child custody case, due to the possible ulterior motivation for treatment, or the potential for manipulation of one partner. While these concerns are valid, it is proposed that this should not be an absolute exclusionary criterion, but rather one that is weighed and evaluated during the assessment process. Greene et al. (2002) have pointed to a trend occurring in which municipalities, in conjunction with the courts and mental health systems, have started giving abusive partners the option of attending conjoint treatment, if the victim agrees, in lieu of a jail sentence. If this trend continues, clinicians may be seeing more court mandated cases of intimate violence. If children are present, these cases will necessarily involve child protective services. Given the high proportion of *Situational Couple Violence* to other types of intimate violence, it is likely that many of these cases may involve this type of violence, and could in fact be amenable to conjoint treatment. Therefore, it is recommended that clinicians evaluate each court-mandated case for the presence and type of violence, and for the potential for biased motivation and partner manipulation.

In summary, there are six key criteria for ruling out the potential for conjoint treatment during the assessment process: (a) the presence of a pattern of coercive control (three or more coercive control behaviors); (b) a total score of 30 or greater on the IJS, or scores on individual questions higher than a 2; (c) evidence of a pattern of severe physical assault (greater than two per year) towards the partner or family; (d) the

presence of physical or non-physical violence motivated by a need to control, intimidate, punish, demoralize, or exploit; (e) the presence of physical or non-physical violence that has severely limited or affected employment, social networks, physical, or mental health of either partner; and (f) the presence of one or more risk factors, including unresolved psychopathology and perceived fear of partner linked to imminent harm.

*Is Conjoint Treatment Indicated?*

Ruling out the types of violence not conducive to conjoint treatment does not necessarily imply that a couple is ready for conjoint treatment. For conjoint treatment to be successful, both partners must willingly agree to participate without coercion or fear (Greene et al., 2002; Stith et al., 2002). In addition, the violent partner(s) must show evidence of being aware of and accountable for their violence, with a commitment by the violent partner(s) to stop all forms of violence as experienced by their partner (Goldner, Penn, Sheinberg, & Walker, 1990; Gottman, 1999; Lipchik & Kubicki, 1996; Walker, 1995). The violent partner(s) must be able to tolerate hearing their partner's description of their violence, and they must be capable of managing their anger without the use of violence (Goldner et al., 1990; Walker, 1995). It may be that in some situations, one partner may be more dominant or have more power than the other (i.e. physical, economic, etc), while the other partner may be more dominant in other aspects of the relationship (i.e. mental, psychological). For conjoint treatment to be successful, both partners must recognize the differential effects that are present in the relationship, and be willing to learn new gender/role socialization behaviors (Almeida & Durkin, 1999; Bograd, 1999; Walker, 1995). Lipchik et al. (1996) suggest that both partners, regardless of whether or not they are being violent, must take responsibility for contributing to the quality of the relationship. In lastly, Gottman (1999) suggests that conjoint treatment is not recommended if an ongoing affair is occurring, and there is a high potential for intimate violence.

If conjoint treatment is undertaken, most authors agree that the primary focus of treatment should be on eliminating all forms of intimate violence, not on saving the relationship (Bograd et al., 1999; Stith et al., 2002). Stith et al. (2002) found that successful conjoint treatment programs included a skill-building component to teach

couples how to recognize when anger is escalating, de-escalation tools, and tools to build trust, respect, and caring into the relationship. Several authors also suggested individual sessions intermixed with conjoint sessions to periodically evaluate the viability of continuing with conjoint treatment, and to enhance treatment effectiveness (Bograd et al., 1999; Geller, 1998, Stith et al., 2002).

*Assessing for Intimate Violence: Creating the Context*

There are mixed views in the literature about when, where, and how much to assess for intimate violence with couples, and whether or not to see a couple conjointly until an assessment of intimate violence has been conducted. For example, Geller (1998) suggests that if a woman calls to schedule an appointment for conjoint treatment, brief but direct questions should be asked pertaining to the presence and severity of any physical violence in the relationship. Geller suggests that if severe physical violence is present, if it was not the woman's choice to enter into conjoint treatment, or if the woman's safety is at risk, that the clinician tell the client that conjoint treatment is not recommended, and instead suggest individual treatment, or refer the client to other available treatment modalities. While this approach is appropriate for *Intimate Violent Control* situations in which the woman is clearly being victimized or is victimizing her partner, it excludes couples that may be experiencing *Situational Couple Violence*. In addition, many couples experiencing intimate violence do not disclose this information during initial assessment interviews (Bograd et al., 1999; Greene et al., 2002).

Therefore, it is proposed that the assessment process for all couples should begin with an initial conjoint session that includes a conventional relationship assessment designed to safely explore the history and dynamics of the relationship (Almeida et al., 1999; Goldner et al., 1990; Lipchik et al., 1996; Stith et al., 2002). This session is then followed by individual sessions with both partners to more fully explore for the presence of intimate violence within the relationship. Further conjoint sessions are not recommended until the clinician has made an assessment of the type of violence present, and whether conjoint treatment is the preferred treatment alternative.

*Written intake assessments.* Empirical evidence suggests that written assessments may detect intimate violence more often than verbal assessments (O'Leary et al., 1992).

Bograd et al. (1999) propose using a multi-modal approach that includes the use of both. Most clinicians require some level of written intake information at the first session, and a few general questions that can alert the clinician to potential intimate violence without risking client safety can easily be added to these forms. Clients should be encouraged to fill out intake forms independently and confidentially.

The intake should include brief open-ended questions about the nature of the presenting problem, who is involved, how long it has been a problem, and any attempted solutions to that problem. General questions assessing for a history of coercive control can be included, such as "Have you ever been, or are you currently, in a relationship where you were hurt, threatened, insulted, or felt afraid physically or emotionally?" and "What is the approximate number of single incidents in any of your relationships (including your childhood) where you were physically (emotionally) mistreated in any way?" and "In any of your relationships (including childhood), do/did you ever find yourself being cautious and hesitant to express your point of view?" A general question at the end of the intake form such as "Is there anything else that you would like the clinician to know?" can also elicit special safety requests or additional information about the situation that could be critical to deciding the best treatment approach. Clinicians may also want to include validated measures of intimate violence such as Straus' (2000) *Conflict Tactics Scale*, or Jory's (2004) *Intimate Justice Scale*.

Because intimate violence has been shown to be associated with risk factors such as unemployment and education level differences (Anderson, 2002; Babcock, Waltz, Jacobson, & Gottman, 1993; Lorant & Eaton, 2003; Sagrastano, 1992) the intake form should also inquire about this information for both partners. Cultural, religious, spiritual, and gender orientation should be included in the assessment, as these can significantly influence beliefs about rules, roles, and distribution of power in the relationship (Almeida et al., 1999; Bograd, 1999). Questions asking about generally physical health, current medications being taken, and any life stressors (e.g. recent changes, losses, moves, financial, etc) should also be identified (Carter et al., 1999). The clinician should review the written intake forms carefully before meeting with the client. If no evidence of

intimate violence has been identified on the intake forms, the clinician should proceed to meet with the couple conjointly for an initial assessment.

*Initial conjoint session.* The initial conjoint session should begin with a discussion about client confidentiality and safety. Bograd et al. (1999) suggest that a "no secrets" policy by the clinician may not provide adequate safety conditions for the disclosure of intimate violence in conjoint treatment. Therefore, we have developed a *Relational Confidentiality Agreement* (Figure 3.2) that includes language that supports the withholding of individual client information if this information could threaten the safety of any family member. This agreement is critical, not only for providing safety to the clients, but also for developing trust and maneuverability with the client couple. It is recommended that this agreement be included in all conjoint work.

Along with the discussion about the confidentiality agreement, the clinician should discuss the standard protocol for meeting with each client individually following the initial conjoint session. The clinician should explain that the purpose of individual sessions is to conduct a thorough health assessment, and to allow for each partner to explain their side of the presenting problem without being interrupted (Bograd et al., 1999). It is important for the clinician to present this information at the beginning of the session rather than at the end, in order to minimize any perceived threat to the clients based on information disclosed during the session.

Bograd et al. (1999) suggest that the clinician should NOT inquire directly about intimate violence during the initial conjoint session, but rather should ask general questions regarding the presenting problem, attempted solutions, and general relationship dynamics, such as evidence of affection and reciprocity; marital satisfaction and functioning, mutual capacity for empathy and insight, shared commitment to the relationship, and periods of acceptable balance of control (Gottman, 1999; Lipchik, 1991; Lipchik, Sides, & Kubicki, 1997; Vivian & Heyman, 1996). Almeida et al., (1999) suggest that information about the clients' cultural and religious beliefs about gender rules and roles should also be explored during this session as a means of gaining a better understanding of the clients' beliefs and how these might be influencing the rules, roles, and power distribution in the relationship. Information on family relational patterns and

histories, as well as current life stressors (e.g. life cycle transitions, death, loss, moves) can also be explored. During this initial conjoint session, the clinician should pay close attention to indicators such as level of affect, communication interchanges (i.e. who talks first, who talks most, who interrupts more often, use of disrespectful or condescending language), and relational interchanges (tone of voice, body language, the presence of animosity, anger, tension, or fear), and the ability of each partner to tolerate hearing the other's explanations of the identified problem.

Towards the end of the initial conjoint session, the clinician should make a determination about the sequencing of the individual sessions based on the dynamics observed during the session. If there is reason to believe that *Intimate Terrorism* may be present in the relationship (i.e. it cannot be ruled out), the clinician should attempt to meet with the potential oppressed partner first (i.e. the partner in the relationship with the least amount of physical, mental, psychological, or economic power base), in order to assess the severity of the violence and particular safety concerns. The clinician can approach the couple tentatively by saying "Okay, we need to wrap this session up. I would like to go ahead and schedule our individual health assessment sessions that we talked about earlier, and I would like to see (oppressed partner) first." This should be followed by questions such as "How does that sound to you?" and "Are you comfortable with that?" directed towards the potential dominant partner, while noting both of their reactions to this information. If any reservation is noted (including silence or no reaction by either partner), or the dominant partner insists upon going first, this should be carefully explored before moving on to the individual sessions. If necessary, it is recommended that additional conjoint sessions be conducted in order to establish safe and accepted conditions for the individual sessions. The clinician might say "It seems like you have some concerns about meeting individually. Perhaps we can all meet together again next session to discuss these more fully before meeting individually. How does that sound to you?"

Some clinicians may disagree with this last point. They may believe that allowing the dominant partner to influence the sequence and timing of individual sessions gives this individual too much power in the treatment room, and subsequently contributes

towards supporting the underlying imbalance of power in the relationship. In addition, some clinicians may believe that postponing the assessment for intimate violence could increase the risk of serious harm to the oppressed partner. While these concerns are valid, it is believed that the benefit of taking this initial position far outweighs the cost for two reasons. First, in situations of *Intimate Terrorism* where the dominant partner typically has control over both the decision making process and the economic resources, taking this position increases the likelihood that the couple will return. If the dominant partner feels threatened in any way by the assessment process, they are likely to terminate treatment, and an opportunity to intervene in a critical situation will have been lost. Secondly, taking this position potentially decreases the likelihood of escalation, threats, and retaliation following the session. In essence, it is believed that taking the time to establish a sense of trust and safety in the treatment room prior to individually assessing for intimate violence increases the maneuverability of the clinician for future interventions.

In summary, the initial conjoint session should include an assessment of a wide range of clinical health information, collected in a natural way that elicits the development of a therapeutic bond, and provides for optimal client safety within the treatment room. During this time, the clinician should be paying close attention to beliefs and behaviors that may indicate an imbalance or pattern of control by one or both partners.

*Individual sessions.* If no intimate violence was disclosed during the initial conjoint session, the clinician should begin the individual session with the potential oppressed partner by conducting a general health assessment that includes a detailed assessment of mental, physical, emotional, and sexual health, including eating and sleeping patterns, and any unresolved substance abuse or psychiatric impairments. Because *Intimate Terrorism* has been shown to be associated with severe physical, psychological, social, and economic harm such as PTSD, depression, injuries requiring medical care, substance abuse, lost days of work, losses in support networks, the clinician should incorporate questions that tentatively assess for these conditions within the general health assessment. If no evidence of intimate violence is found, the clinician

should continue to explore the interactional patterns in the relationship (beliefs, roles, power distribution), and the client's individual and family history (culture, religion, immigration patterns, relational patterns, substance abuse issues, horizontal and vertical stressors, life cycle transitions, major changes, etc.).

If any of the three types of violence within the *Intimate Violent Control* category are present in the relationship, the general health assessment will most likely identify symptoms associated with these types of violence. If there is no evidence throughout the health assessment of intimate violence (including hesitancy or fear around disclosing information), then most likely intimate violence is not occurring in the relationship. However, the clinician should still directly inquire about intimate violence to be certain. If *Situational Couple Violence* is occurring in the relationship, it may not have been identified during the health assessment interview, as this type of violence typically has much less severe physical, emotional, social, and economic impacts, and may go undetected unless direct questions are asked about the severity, frequency, and range of physical and non-physical aggression present in the relationship. If no intimate violence is identified, the clinician should wrap up the session by exploring the client's goals, hopes, and expectations for both the relationship and for treatment, along with their readiness and motivation for change relating to the presenting problem (Hubble et al., 1999; Miller & Rollnick, 1991). The clinician should then proceed to meet with the other partner, and conduct a similar health assessment.

*When evidence of intimate violence is identified during the assessment process.* If evidence of intimate violence is identified during the assessment process (including hesitancy or fear around disclosing information), the clinician must evaluate the information quickly, and decide how best to proceed given the particular circumstances of each case. Bograd et al. (1999) provide an excellent summary of the protocol for handling spontaneous disclosures of intimate violence throughout the assessment process, and the authors refer the reader to this article for a more thorough review. One proposed modification to Bograd et al.'s protocol is that, when intimate violence is disclosed, the clinician should first conduct a safety assessment and develop protective conditions for further disclosure prior to continuing with an assessment of the characteristics of the

violence. This is a critical step that is often overlooked in the literature, but that is essential due to the high potential of retaliation for severe types of intimate violence.

If evidence of intimate violence is identified, the perceived risk for imminent harm for both clients and any other family members should be assessed first, and acted upon according to ethical guidelines for mandatory reporting, if appropriate. If evidence of intimate violence is identified during the conjoint session, the clinician should direct all questions towards the potential dominant partner using language that invites responsibility (Jenkins, 1990), while also indirectly alerting the oppressed partner to the potential dangers of the violence. Secondly, protective conditions for further disclosure should be discussed. Geller (1998) suggests asking "What if" questions, such as "What if he/she gets angry about something you say?" or "What if something happens during treatment that makes him/her angry?" and "What is the worst thing that could happen after you leave here?"

In summary, the clinician should fully explore all safety concerns before continuing with an assessment into the characteristics of the intimate violence. If either client declines or shows hesitancy in continuing with the assessment, the clinician should tell the client that conjoint treatment will not meet their needs, and the remainder of the session should be focused on alternative treatment options, and if possible, on developing a safety plan for future incidents of violence. If both clients willingly choose to continue with the assessment, and clear safety and protective disclosure criteria have been established, the clinician should proceed towards making an assessment of the type of violence presence in the relationship, and in determining whether conjoint treatment is indicated using the assessment criteria identified earlier in this article.

### *Conclusions*

The proposed integrated tiered assessment approach contains the most current information on typologies of intimate violence, as well as the most current information on conjoint assessment and treatment. The integration of typologies of intimate violence into current assessment and treatment protocols has several implications. First, this integrated approach may help to bridge the current divide that exists between researchers, theorists that share the common goal of stopping family violence, but who disagree about the

appropriate treatment methods to reach this end. Evidence suggests that some types of intimate violence may be effectively and safely treated using conjoint methods, while others may not. This proposed integrated assessment approach provides clinicians with practical guidelines to more accurately make this determination, which should help to reduce the potential for situations in which clinicians are attempting to treat couples that should not be treated with conjoint methods.

The proposed integrated tiered assessment approach may also improve treatment effectiveness and retention rates. For couples experiencing *Situational Couple Violence*, conjoint treatment that addresses the underlying recursive and reciprocal dynamics of the relationship may be beneficial in stopping future violence (Murphy et al., 1989; Neidig et al., 1984), and may provide a better fit than gender-specific group treatments (Geffner et al., 1990). Using conjoint methods to treat *Intimate Terrorism*, however, would most likely not be effective, and could cause considerable harm to the client-couple. For these couples, individual and gender-specific group treatment would most like provide a better fit. For couples in which one or both of the partners have severe clinical or personality disorders, neither conjoint treatment nor gender-specific group treatment may be effective for stopping the violence, and individual sessions combined with medical treatment may be required. Providing a treatment approach that most closely meets the needs of the client should increase retention and completion rates, which may in turn increase the effectiveness of the treatment (American Psychological Association, 1995; Hubble et al., 1999).

The proposed integrated tiered assessment approach also highlights the need to establish a context from which to assess for intimate violence. Assessing too quickly for intimate violence may cause premature termination of treatment, and possible retaliation after the session. Taking time to establish a therapeutic bond with both clients, and to develop protective conditions for future disclosure of violence increases the maneuverability of the clinician, as well as increases the potential for change (Miller & Rollnick, 1991; Hubble et al., 1999). Our development of the *Relational Confidentiality Agreement* is a unique contribution of this approach that is essential to this process (Bograd et al., 1999).

And lastly, the proposed assessment tool is a unique contribution to the existing literature on assessment and treatment of intimate violence. It combines the most current knowledge pertaining to the conjoint assessment and treatment of intimate violence, as well as the most current knowledge on typologies of violence. For many clinicians, assessing for intimate violence can be an intimidating and overwhelming process. The proposed assessment tool provides a concise summary of the important steps for that process, along with references for further resources.

*Limitations and Directions for Future Research*

The proposed integrated tiered assessment approach has not been empirically tested. Future empirical research is needed to evaluate the ability of this approach to assist clinicians in making determinations about type of violence, and the viability of conjoint treatment. Empirical validation of Johnson's coercive control construct as an indicator of type of violence is also needed. In addition, empirical research that evaluates the characteristics and motivations behind each of the modified types of violence proposed in this approach, including the six criteria suggested for ruling out extreme types of violence, is also needed. In summary, the proposed integrated assessment approach may significantly improve the current assessment and treatment protocols for intimate violence. Further research that tests this approach and its underlying hypotheses is needed.

Figure 3.2

*Relational Confidentiality Agreement*

This clinic operates within a "systemic" point of view. We are interested in many aspects of your life – you, your point of view, and your environment. Therefore, we may ask to meet with you and others in your life in a variety of combinations (e.g. if meeting with a couple, we will likely at times request individual meetings with each partner). This raises a question about whether information discussed in an individual meeting will be shared with others involved in your therapy. Please be aware that information discussed in an individual meeting, if important to the relational therapy, may be discussed in the relational meetings.

When a therapist believes that information discussed individually is very important for the relational therapy, he/she will: (1) inform you that he/she believes it is important; (2) discuss with you your ideas about the information and its importance; and, when appropriate (3) encourage you to discuss this information openly in the relational sessions. The therapist will not knowingly surprise the person who shared this information in the individual meeting by intentionally disclosing this information without prior notice. Our goal is to avoid a situation where sensitive information is discussed without advance notice. On occasion, though rarely, a therapist may end services and refer you to another provider if he/she believes the information is essential to discuss, though one party does not agree to do so.

Information shared in an individual session that, if discussed in a relational session could threaten the safety of either individual, will be handled with care. We maintain that protection and safety are above the right to have access to information that is discussed in individual meetings.

I have discussed this "Relational Confidentiality Agreement" with my therapist and agree to its conditions. If yes, please initial.

_____ (initial) _____ (initial) _____ (initial) _____ initial

Source: Center for Family Therapy, Eugene, OR.

References

[1]Almeida, R. V., & Durkin, T. (1999). The cultural context model: Therapy for couples with domestic violence. *Journal of Marital and Family Therapy, 25(3),* 313–324.

American Psychological Association. (1995). Task force reports on empirically validated treatments. *Task Force on Psycological Intervention, Division of Clinical Psychology, APA.* [Online], available: http:/www.apa.org/divisions/div12/rev_est/marital.shtml

Anderson, K. (2002). Perpetrator or victim: Relationships between intimate partner violence and well-being. *Journal of Marriage and Family, 64(4),* 851 - 863.

Babcock, J. C., Miller, S. A., & Siard, C. (2003). Toward a typology of abusive women: Differences between partner-only and generally violent women in the use of violence. *Psychology of Women Quarterly, 27(2),* 153 - 161.

Babcock, J. C., Waltz, J., Jacobson, N. S., & Gottman, J. M. (1993). Power and violence: The relation between communication patterns, power discrepancies, and domestic violence. *Journal of Consulting and Clinical Psychology, 61(1),* 40 - 49.

Becvar, D.S., & Becvar, R.J. (2000). *Family therapy: A systemic integration,* 4th ed. MA: Allyn and Bacon.

Becvar, R. J., Becvar, D. S., & Bender, A. E. (1982). Let us first do no harm. *Journal of Marital and Family Therapy, 8(4),* 385 - 391.

Berns, S. B., Jacobson, N. S., & Gottman, J. M. (1999). Demand/withdraw interaction patterns between different types of batterers and their spouses. *Journal of Marital and Family Therapy, 25(3),* 337 - 348.

[2]Bograd, M. (1999). Strengthening domestic violence theories: Intersections of race, class, sexual orientation, and gender. *Journal of Marital and Family Therapy, 25(3),* 275 - 289.

[3]Bograd, M., & Mederos, F. (1999). Battering and couples therapy: Universal screening and selection of treatment modality. *Journal of Marital and Family Therapy, 25(3),* 291 - 312.

Brannen, S., & Rubin, A. (1996). Comparing the effectiveness of gender-specific and couples groups in a court-mandated spouse abuse treatment program. *Research on Social Work Practice, 6(4),* 405 - 424.

Campbell, R. S., & Sullivan, C. M. (1995). Women who use domestic violence shelters. *Psychology of Women Quarterly, 19(2),* 237 – 255.

Carden, A. (1994). Wife abuse and the wife abuser: Review and recommendations. *The Counseling Psychologist, 22,* 539 - 582.

[4]Carter, B., & McGoldrick, M. (1999). *The expanded family life cycle: Individual, family, and social perspectives,* 3rd Ed. Boston, MA: Allyn and Bacon.

Cascardi, M., O'Leary, K. D., Lawrence, E. E., & Schlee, K. A. (1995). Characteristics of women physically abused by their spouses and who seek treatment regarding marital conflict. *Journal of Consulting and Clinical Psychology, 63(4),* 616 - 623.

Cascardi, M., O'Leary, K.D., Schlee, K. A. (1999). Co-occurrence and correlates of posttraumatic stress disorder and major depression in physically abused women. *Journal of Family Violence, 14(3),* 227 – 249.

Chase, K. A., O'Leary, K. D., & Heyman, R. E. (2001). Categorizing partner-violent men within the reactive-proactive typology model. *Journal of Consulting and Clinical Psychology, 69(3),* 567 – 572.

DeMaris, A., & Swinford, S. (1996) Female victims of spousal violence: Factors influencing their level of fearfulness. *Family Relations, 45,* 98 - 106.

Duluth Abuse Project (2003). *Duluth Domestic Abuse Intervention Project,* 206 West Fourth Street, Duluth, Minnesota 55806, http://domesticviolence.org/wheel.html.

Dutton, D. G. (1995). *The domestic assault of women: Psychological and criminal justice perspectives.* Vancouver BC: UBC Press.

Dutton, D. G. (1998). *The abusive personality.* New York: Guilford.

Feld, S. L., and Straus, M. A. (1992). Escalation and desistance from wife assault in marriage. In M. A. Straus and R. J. Gelles (Eds.), *Physical violence in American families* (pp. 489 - 506). New Brunswick, NJ: Transaction.

Geffner, R., & Rosenbaum, A. (1990). Characteristics and treatment of batterers. *Behavioral Sciences and the Law, 8,* 131 - 140.

Geller, J. A. (1998). Conjoint therapy for the treatment of partner abuse: Indications and contraindications. In Roberts, A. R. (Ed.). *Battered women and their families: intervention strategies and treatment programs, 2nd Edition.* (pp. 76 - 98). New York: Springer Publishing Company.

Geller, J. A., & Wasserstrom, J. (1984). Conjoint therapy for the treatment of domestic violence. In Roberts, A. R. (Ed.), *Battered women and their families: intervention strategies and treatment programs,* (pp. 33 - 48). New York: Springer Publishing Company.

[5]Glass, S.P., & Wright, T.L. (1997). Reconstructing marriages after the trauma of infidelity. In W.K. Halford & H.J. Markman (Eds.), *Clinical handbook of marriage and couples interventions* (pp. 471–578). NY: Wiley.

Gleason, W. (1993). Mental disorders in battered women: An empirical study. *Violence and Victims, 8,* 53 – 68.

[6]Goldner, V., Penn, P., Sheinberg, M., & Walker, G. (1990). Love and violence: Gender paradoxes in volatile attachments. *Family Process, 29(4),* 343 - 364.

Gondolf, E. W. (1997). Batterer programs: What we know and need to know. *Journal of Interpersonal Violence, 12,* 83 - 98.

Gordon, M. (2000). Definitional issues in violence against women. *Violence Against Women, 6(7),* 747 – 783.

[7]Gottman, J. (1999). *The Marriage Clinic: A Scientifically Based Marital Therapy.* NY: Norton.

Greene, K., & Bogo, M. (2002). The different faces of intimate violence: Implications for assessment and treatment. *Journal of Marital and Family Therapy, 28(4),* 455 – 466.

Hamby, S. L. (1998). Partner violence: Prevention and Intervention. In Jasinski, J. L. and Williams, L. M. (Eds.), *Partner violence: A comprehensive review of 20 years of research.* (pp. 210 - 258). Thousand Oaks, CA: Sage Publications.

Heyman, R. E., & Neidig, P.H. (1997). Physical aggression couples treatment. In K. W. Halfor and J. J. Markman (Eds.), *Clinical handbook of Marriage and couples interventions* (pp. 589 - 617). NY: Wiley.

Holtzworth-Munroe, A., Meehan, J. C., Herron, K., Rehman, U., & Stuart, G. L. (2000). Testing the Holtzworth-Munroe and Stuart (1994) batterer typology. *Journal of Consulting and Clinical Psychology, 68(6),* 1000 – 1019.

Holtzworth-Munroe, A., & Stuart, G. L. (1994). Typologies of male batterers: Three subtypes and the differences among them. *Psychological Bulletin, 116(3),* 476 - 497.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999). *The heart and soul of change: What works in therapy.* Washington, DC: American Psychological Association.

[8]Jenkins, A. (1990). *Invitations to responsibility: The therapeutic engagement of men who are violent and abusive.* Australia: Dulwich Centre Publications.

Johannson, M. A., & Tutty, L. M. (1998). An evaluation of after-treatment couples' groups for wife abuse. *Family Relations, 47(1),* 27-36.

Johnson, M. P. (1995). Patriarchal terrorism and common couple violence: Two forms of violence against women. *Journal of Marriage and the Family, 57,* 283 – 294.

[9]Johnson, M. P. (2002, In progress). *Violence and control in intimate relationships: Intimate terrorism and other types of domestic violence.*

Johnson, M. P., & Ferraro, K. J. (2001). Research on domestic violence in the 1990's: Making distinctions. In Milardo, R. M. (Ed.), *Understanding families into the new millennium: A decade in review* (pp. 38 – 51). MN: National Council on Family Relations.

Johnson, M. P., & Leone, J. M. (2000, July). *The differential effects of intimate terrorism and situational couple violence: Findings from the National Violence Against Women survey.* Presented at the Tenth International Conference on Personal Relationships, Brisbane, Australia.

[10]Jory, B. (2004). The intimate justice scale: An instrument to screen for psychological abuse and physical violence in clinical practice. *Journal of Marital and Family Therapy, 9(1),* 29 - 43.

Lawson, D. M. (2003). Incidence, explanations, and treatment of partner violence. *Journal of Counseling and Development, 81(1),* 19 – 33.

Lederer, W. J., & Jackson, D. D. (1968). *The mirages of marriage.* New York: Norton.

*Leone, J. M., Johnson, M. P., Cohan, & C. L., Lloyd, S., (2001, June).* Consequences of different types of domestic violence for low-income, ethnic women: A control-based typology of male-partner violence. Presented at the International Network on Personal Relationships, Prescott, Arizona.

[11]Lipchik, E. (1991). Spouse abuse: Challenging the party line. *Family Therapy Networker*, 5, 59 - 63.

[12]Lipchik, E., & Kubicki, A. (1996). Solution-focused domestic violence views: Bridges toward a new reality in couples therapy. In D. Miller Scott, M. Hubbell, & B. Duncan (Eds.), *Handbook of solution focused brief therapy* (pp. 65 - 98). San Francisco: Jossey Bass.

[13]Lipchik, E., Sides, E., & Kubicki, A. (1997). Multifaceted approaches in spouse abuse treatment. In R. Geffner, S. Sorenson, & P. Lundberg-Love (Eds.), *Violence and sexual abuse at home: Current issues in spousal battering and child maltreatment* (pp. 131 - 148). New York: Haworth.

Lorant, V., & Eaton, W. (2003). Review: There is marked socioeconomic inequality in persistent depression. *Evidence-Based Mental Health, 6(3)*, 75 – 76.

Marshall, L. L. (1992). Development of the Severity of Violence Against Women Scales. *Journal of Family Violence, 7,* 103 - 121.

Medical Outcomes Trust (1993). *SF-36 Health Survey, U.S. Acute Version, 1.0.*

MA: P.O. Box 1917, Boston, MA 02205.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. NY: Guilford Press.

Murphy, C. M., & O'Leary, K. D. (1989). Psychological aggression predicts physical aggression in early marriage. *Journal of Consulting and Clinical Psychology, 57(5)*, 579 - 582.

Neidig, P. H., & Friedman, D. H. (1984). *Spouse abuse: A treatment program for couples.* Champaign, IL: Research Press.

O'Leary, K. D. (1993). Through a psychological lens: Personality traits, personality disorders, and levels of violence. In R. J. Gelles and D. R. Loseke (Eds.), *Current controversies on family violence* (pp. 7 - 30). Newbury Park, CA: Sage.

O'Leary, K. D., Barling, J., Arias, I., Rosenbaum, A., Malone, J., & Tyree, A. (1989). Prevalence and stability of physical aggression between spouses: A longitudinal analysis. *Journal of Consulting and Clinical Psychology, 57(2),* 263 - 268.

O'Leary, K. D., Vivian, D., & Malone, J. (1992). Assessment of physical aggression against women in marriage: The need for multimodal assessment. *Behavioral Assessment, 14(1),* 5 - 14.

Olson, L. N. (2002). Exploring common couple violence in heterosexual romantic relationships. *Western Journal of Communication, 66(1),* 104 – 128.

Osmond, M. W. & Thorne, B. (1993). Feminist theories: The social construction of gender in families and society. In Boss, P. G., Doherty, W. J., Larossa, R., Shumm, W. R., and Steinmetz, S. K. (Eds.), *Sourcebook of family theories and methods: A Contextual Approach* (pp. 591 - 622). New York, NY: Plenum Press.

Quigley, B. M., & Leonard, K. E. (1996). Desistance of husband aggression in the early years of marriage. *Violence and Victims, 11,* 355 - 370.

Rosen, K. H., & Bird, K. (1996). A case of woman abuse. *Violence Against Women,* 2(3), 302 – 321.

Sagrestano, L. M. (1992). Power strategies in interpersonal relationships: The effects of expertise and gender. *Psychology of Women Quarterly, 16,* 481 - 495.

Salari, S. M., & Baldwin, B. M. (2002). Verbal, physical, and injurious aggression among intimate couples over time. *Journal of Family Issues, 23(4),* 523 –550.

[14]Saunders, D. G. (1992). A typology of men who batter women: Three types derived from cluster analysis. *American Orthopsychiatry, 62(2),* 264 – 275.

[15]Shamai, M. (1996). Couple therapy with battered women and abusive men: Does it have a future? In L. Edleson & Z. Eisikovits (Eds.), *Future interventions with battered women and their families* (pp. 201 - 215). Thousand Oaks, CA: Sage.

Stets, J. E. (1990). Verbal and physical aggression in marriage. *Journal of Marriage and the Family, 52,* 501 - 514.

Stets, J. E., & Straus, M. A. (1992). Gender differences in reporting marital violence and its medical and psychological consequences. In M. A. Straus and R. J. Gelles

(Eds.), *Physical violence in American families* (pp. 151 - 165). New Brunswick, NJ: Transaction Books.

[16]Stith, S. M., Rosen, K. H., McCollum, E. E. (2002). Domestic violence. In Sprenkle, D. H. (Ed.), *Effectiveness research in marriage and family therapy* (pp. 223 – 254). Alexandria, VA: AAMFT.

Straus, M. A. (1979). Measuring intrafamily conflict and violence: The Conflict Tactics Scales (CTS). *Journal of Marriage and the Family, 41,* 75 - 88.

[17]Straus, M. A. (2000). *Handbook for the conflict tactics scales (CTS) including revised versions CTS2 and CTSPC.* NH: Family Research Laboratory, University of New Hampshire.

Straus, M. A., & Sweet, S. (1992). Verbal/symbolic aggression in couples: Incidence rates and relationships to personal characteristics. *Journal of Marriage and the Family, 54(2),* 346 – 357.

Swan, S., & Snow, D. L. (2002) A typology of women's use of violence in intimate relationships. *Violence Against Women, 8(3),* 286 - 319.

Tolman, R. M. (1989). The development of a measure of psychological maltreatment of women by their male partners. *Violence and Victims, 4,* 159 - 177.

Verburg, P. (1994). The other half of domestic violence. *Alberta Report, 21(11),* 28 - 31.

Vitanza, S., Vogel, L., & Marshall, L. (1995). Distress and symptoms of post-traumatic stress disorder in abused women. *Violence and Victims, 10,* 23 – 24.

[18]Vivian D., & Heyman, R. (1996). Is there a place for couples treatment of couple violence? In *Session: Psychotherapy in Practice,* 2, 25 - 48.

Vivian, D., & Malone, J. (1997). Relationship factors and depressive symptomatology associated with mild and severe husband-to-wife physical aggression. *Violence and Victims, 12,* 3 - 18.

[19]Walker, L. (1995). Current perspectives on men who batter women – Implications for intervention and treatment to stop violence against women: Comment on Gottman et al. (1995). *Journal of Family Psychology, 9(3),* 264 – 271.

Waltz, J., Babcock, J. C., Jacobson, N. S., & Gottman, J. M. (2000). Testing a typology of batterers. *Journal of Consulting and Clinical Psychology, 68(4),* 658 - 669.

Watzlawick, P., Weakland, J., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution.* NY: Norton and Company.

Whitchurch, G. G. (2000). Violent critical incidents in four types of violent interpersonal relationships. *Marriage and Family Review, 30(1/2),* 25 – 49.

# Chapter 4: Conclusions

Typologies of intimate violence are part of an emerging paradigm towards a multi-faceted, multi-theoretical approach to the evaluation, assessment, and treatment of intimate violence. For this new paradigm to be successfully implemented into research and practice, there are several gaps in the knowledge base that must be addressed. The goal of this dissertation was to extend the current knowledge base on intimate violence typologies by: (a) empirically testing Johnson's hypotheses pertaining to the use of coercive control as an indicator of type and effects of intimate violence for women and men; (b) developing a more comprehensive typology of intimate violence that integrates characteristics of perpetrators with interactional characteristics of violence; and (c) developing an assessment approach that incorporates the most current knowledge on typologies of violence with the most current knowledge on assessment practices.

Two separate studies were undertaken to extend the current knowledge base on intimate violence typologies. The first study was an empirical analysis of the *National Violence Against Women* (NVAW) survey (Tjaden et al., 1999) using Johnson's theoretical coercive control construct to (a) establish a relationship between coercive control and psychological harm (depression, post-traumatic stress disorder, and perceived fear of partner) for women and men; (b) identify groups of women and men who had experienced no coercive control, low levels of coercive control (four behaviors or less), and high levels coercive control (five or more behaviors); and (c) compare levels of psychological harm experienced across these groups. The second study consisted of an integration of the most current literature pertaining to typologies of intimate violence with the most current literature on conjoint treatment of intimate violence, followed by the development of a tiered clinical assessment approach and tool that can be used by clinicians to assess couples for type of intimate violence, and to determine whether conjoint treatment is indicated. Below is a brief summary of the findings from these studies, followed by a discussion on the implications for research and practice, and directions for future research.

## *Summary of Findings*

### *Coercive Control as an Indicator of Type and Effects of Intimate Violence*

The underlying hypotheses of Johnson's typology are that physical violence embedded in a pattern of coercive control is distinctly different, and more harmful, than physical violence not embedded in a pattern of coercive control, regardless of severity of physical assault. Johnson has also hypothesized that *Situational Couple Violence* (physical violence with no to low levels of coercive control) is the most common type of partner violence, and that it rarely escalates into severe physical assault. Johnson has developed a theoretical coercive control construct to make distinctions between types of violence that is grounded in the feminist perspective that power and control dynamics (which have been shown to be associated with the cycle of violence and the battered woman syndrome) are at the core of intimate violence. Johnson's coercive control construct provides a meaningful and theoretically sound measure for making distinctions between types of intimate violence. However, few existing studies have empirically tested Johnson's coercive control construct, or his hypotheses. In addition, no existing studies could be found that tested Johnson's coercive control construct and hypotheses for men who experienced intimate violence by their partner.

Findings from the first study indicate that coercive control was a significant positive predictor of depression, PTSD, and perceived fear of partner, and accounted for as much or more of the explained variance as severity of physical assault. This finding was true for both women and men. These findings support existing findings that non-physical violence is often a predictor of psychological harm (Cascardi et al., 1999, Feld et al., 1992; Gordon, 200; Jory, 2004, O'Leary, 1993; Stets, 1990; Straus et al., 1992; Tolman, 1989; Vivian et al., 1997), and has consequences as or more harmful than physical violence (Gleason, 1993; Vitanza et al., 1995). The results from the first study also support Johnson's hypotheses in that women and men who experienced high levels of coercive control by their partner had significantly higher depression and PTSD scores, and were significantly more likely to be afraid of their partner than women and men who experienced low levels of coercive control.

There was also some evidence in the first study to support Johnson's hypothesis pertaining to severity of physical assault for low levels of coercive control. In particular, there were no significant increases in depression, PTSD, and perceived fear of partner between the minor and severe physical assault groups for women and men who experienced low levels of coercive control. At high levels of coercive control, however, significant increases in depression, PTSD, and perceived fear of partner were noted between minor and severe physical assault categories, indicating that severity of physical assault is an important indicator for high levels of coercive control. The results from the first study also indicated that women and men who experienced high levels of coercive control with no physical violence experienced psychological harm equivalent to individuals who experienced low coercive control with minor to severe physical assault.

The results of this study also support Johnson's hypotheses that *Situational Couple Violence* is the most common type of violence among couples, and that it rarely escalates into severe physical violence. Roughly two-thirds of the women and men in the study sample experienced low levels of coercive control typical of Johnson's *Situational Couple Violence* (Table 2.1), with the remainder of the respondents experiencing high levels of coercive control typical of the other three types of intimate violence. In addition, only one-third of the women and men within the *Situational Couple Violence* category experienced severe physical assault by their partner, whereas roughly one-half of the women and two-thirds of the men in the high coercive control categories experienced severe physical assault by their partner. While no distinctions can be made between the types of violence within the high control categories without having information about both partner's behaviors, these results do support Johnson's hypotheses that types of violence associated with high levels of coercive control are distinctly different, and are more likely to cause harm, than violence associated with low levels of coercive control.

With regards to gender and intimate violence, the percentages of women and men within each of the coercive control and severity of physical assault groups were very similar for all analyses. This finding is consistent with other national data set findings (Johnson, 1995; Straus, 2000). It should be emphasized again, however, that this does not necessarily imply gender symmetry (see Footnote[1] in Chapter 1 for a definition of gender

symmetry). The interactional characteristics and motivations of both partners' behaviors would be needed to adequately address this issue. One finding that cannot be overlooked is that men are experiencing psychological harm due to intimate violence by their female partners at roughly the same rates and levels as women. The argument that women's violence is not as serious of a social issue as men's violence because it has less potential to inflict harm does not hold true for non-physical violence, especially given that the long-term effects of non-physical violence have been shown to be more harmful than the long-term effects of physical violence. One of the most pronounced findings from this study was that, holding severity of physical assault constant, women and men who experienced high levels of coercive control were 14 and 20 times more likely to be afraid of their partner as women and men in the low coercive control group, respectively. While this result was based on a single-item construct and further studies are needed to validate this finding, it is reasonable to conclude that both women and men are being psychologically traumatized by their intimate partners' controlling and intimidating behavior.

*Integrating Typologies of Violence with Typologies of Perpetrators*

Existing typologies of intimate violence tend to distinguish between types of violence based on individual characteristics of the perpetrator, or on characteristics of the violence (typically physical violence characteristics). For example, violent men with unresolved psychopathology or substance abuse issues, limited attachment styles and social skills, and a history of violence and/or victimization can be found in several prominent typologies of batterers (Berns et al., 1999; Chase et al., 2001; Holtzworth-Munroe, 1994; Waltz et al., 2000). Similarly, couples that experience a wide range of severe and frequent physical assault behaviors are often distinguished from couples with little to no physical assault behaviors. Other characteristics of violence that have been used to make distinctions between types of violence include reciprocity (comparison of both partner's behaviors), demand/withdraw interactions, and marital satisfaction (Neidig et al., 1984; Olson, 2002; Whitchurch, 2002). No typologies could be found, however, that combined these factors. In addition, most typology research has been based almost exclusively on men's violence.

Johnson's typology of violence shows promise of being one of the most comprehensive typologies that currently exists because it captures the interactional components of relationship, and makes distinctions based on power and control dynamics. In addition, Johnson's typology provides a theoretical framework that explains the (sometimes differing) motivation behind women and men's violence. However, Johnson's typology does not account for individual characteristics of perpetrators, nor does it account for relationships that involve one or both partner's extreme attempts to control the other partner without the use of physical violence. Therefore, Johnson's typology of violence was integrated with the most current typologies of perpetrators and typologies of violence in order to develop a comprehensive typology of violence (See Tables 1.1 and 1.2). Several similarities and overlap were found during this process, and the following hypotheses were been developed for further testing:

*Intimate violence characterized by low levels of coercive control.* It is hypothesized that couples experiencing low levels of coercive control indicative of Johnson's *Situational Couple Violence* will predominantly use *Expressive* violence (Neidig et al., 1984) that is most likely *Reactive* in nature (Chase et al., 2001) rarely escalating into severe physical violence, and is accompanied by no to low levels of unresolved psychopathology and substance abuse issues and moderate to high levels of attachment and social skills for both partners. This type of violence may also be characterized by moderate to high levels of marital satisfaction and reciprocity of violence, and low levels of demand-withdraw interactions and support of violence attitudes. Based on these findings, it is further hypothesized that conjoint treatment for this type of violence may be an effective treatment modality based on its low potential for retaliation and psychological harm.

*Intimate violence characterized by high levels of coercive control.* It is hypothesized that couples experiencing high levels of coercive control indicative of Johnson's *Intimate Terrorism*, *Mutual Violent Control*, and *Violent Resistance* will predominantly use *Instrumental* violence (Neidig et al., 1984) that is *Proactive* in nature (Chase et al., 2001) with frequent escalations into severe physical assault, and is accompanied by moderate to high levels of psychopathology and substance abuse issues

and low levels of attachment and social skills for one or both partners. These types of violence may also be characterized by low levels of marital satisfaction and remorse, with high levels of demand-withdraw interactions and support of violence attitudes. It is hypothesized that conjoint treatment for these types of violence will not be an effective treatment modality due to the high potential for retaliation and psychological harm.

The integration of Johnson's typology of violence with other existing typologies of intimate violence is a first step toward providing a more comprehensive typology of intimate violence. The existing literature suggests that there are clearly similarities and overlap between many of the typologies. Further research is needed to explore the hypotheses stated above.

*Incorporating Typologies of Violence into Assessment and Treatment Protocols*

Current accepted clinical practices and policies for the assessment and treatment of partner violence do not yet make distinctions between types of violence (Johnson et al., 2001). The second study of this article incorporated the integrated typologies from above into the most current standards on the assessment and treatment of intimate violence. In addition, a *Relational Confidentiality Agreement* designed to protect clients from disclosure of potentially dangerous information during conjoint assessment was developed. And finally, a tiered assessment approach was developed that creates a context from which to assess for intimate violence while also maintaining client confidentiality and therapist maneuverability. And finally, based on the above information, a conceptual clinical assessment tool was developed that can be tested for its use in assisting clinicians with determining the presence and type of violence, and for determining whether conjoint treatment is indicated.

*Implications for Research and Practice*

The implications for the development and implementation of an integrated typology of intimate violence into research and practice are many. In essence, while our understanding of intimate violence has evolved considerably over the past two decades, we are still using a "one type fits all" model to address a complex phenomenon that is clearly not uni-dimensional. This existing approach to intimate violence has allowed for the creation of a wide and varied range of competing and often dichotomous theories,

measures, outcomes, and policies that have perplexed and divided and researchers, clinicians, and policy makers. Integrating typologies of violence with typologies of perpetrators, and exploring the characteristics and effects of the different types of violence adds needed complexity to the understanding, assessment, and treatment of intimate violence. Research on a comprehensive typology may provide opportunities to develop improved intimate violence measures and theories. The use of a comprehensive typology for assessment and treatment of intimate violence may improve treatment effectiveness, which may in turn improve recidivism and drop-out rates. Improved research and clinical measures, theory, and outcomes may in turn provide a basis for the development of improved policies and funding that can support further research into the understanding, assessment, and treatment of intimate violence.

*Improved Theories and Measures*

There are a wide range of theories and measures used to study intimate violence (Gordon, 2000; Lawson, 2003). Many of these theories (such as feminist versus systems versus psychobiological perspectives) compete and contradict each other, which can lead to dichotomization and polarization among theorists, researchers, and clinicians. A comprehensive typology, such as the one proposed in this dissertation, provides a common ground from which to explore the efficacy of each theory for different types of violence. In addition, a comprehensive typology that includes characteristics and effects based on type of violence may allow for the development of improved measures for different types of violence and their differential effects. Integrating typologies of violence with typologies of perpetrators, and exploring the characteristics and effects of this integrated typology adds needed complexity to the understanding, assessment, and treatment of intimate violence.

*Improved Clinical Assessment and Identification of Intimate Violence*

The existing literature suggests that intimate violence is often overlooked during conjoint sessions (Bograd et al., 1999). The existing protocols for assessing for intimate violence in conjoint sessions, and for determining whether or not a couple can be treated conjointly vary widely and have provoked controversy and debate among clinicians, theorists, and researchers. Without clear guidelines and concrete assessment criteria, this

process is left largely to the discretion of the clinician, which allows for the possibility of (a) clinicians inappropriately treating violent couples conjointly; or (b) clinicians turning away client-couples that could benefit from conjoint treatment, and who might not access or benefit from conventional treatment programs (e.g. batterer intervention programs and women's shelters). Both of these scenarios have the potential to cause harm to the client-couple, which places clinicians in a very difficult ethical position. The proposed tiered clinical assessment approach and tool may assist clinicians in making appropriate assessment and treatment decisions based on the most current research on conjoint assessment and intimate violence typologies.

*A Place for Conjoint Treatment*

A common theme found within all of the typologies of violence is the presence of a type of violence that appears to be relatively low in potential for long-term physical or psychological harm. This type of violence is typically characterized by low levels of coercive control, low levels of severe physical violence, and to low rates of unresolved psychopathology and substance abuse. Based on the existing literature, this type of violence show promise of being effectively treated using conjoint methods. Existing research on conjoint treatment effectiveness indicates that couples with these characteristics typically have a high success rate (based on recidivism rates) and low drop-out rates (Brannon et al., 1995; Gottman, 1999; Heyman et al., 1997; Neidig et al., 1984; Stith et al., 2002).

*Earlier Detection of Physical and Non-Physical Violence*

An assessment protocol that makes distinctions between types of violence based on power and control dynamics (rather than physical violence alone) may provide earlier detection of physical and non-physical violence. The existing literature suggests that non-physical violence typically precedes and predicts physical violence in relationships, and that physical violence almost always occurs in conjunction with non-physical violence (Feld et al., 1992; Gordon, 2000; Jory, 2004; Stets, 1990; Straus et al., 1992; Vivian et al., 1997). In addition, non-physical violence has been shown to cause mental health dysfunction and subjective distress, even when no physical violence is present (Gleason, 1993; Vitanza et al., 1995). An assessment protocol that makes distinctions between

types of violence based on non-physical violence may help clinicians identify couples at risk for physical violence, as well as to identify individuals experiencing psychological harm that are typically overlooked during assessment because they did not experience physical violence.

*Improved Treatment Effectiveness*

The effectiveness of the current treatment approaches varies considerably, with typically high recidivism and drop-out rates (Dutton, 1995; Hamby, 1998; Lawson, 2003). One possible explanation for this phenomenon may be that different types of treatment may be more effective for different types of violence. This explanation parallels current findings that therapeutic treatment effectiveness is optimized by tailoring treatment approaches to match the needs of the client and the particular phenomenon being treated (American Psychological Association, 1995; Hubble, Duncan, & Miller, 1999). The integration of typologies into standard clinical assessment and treatment protocols may allow clinicians to more effectively assess and treat different types of intimate violence, which may in turn improve treatment effectiveness, and lower recidivism and drop-out rates.

*A More Accurate View of Women and Men's Violence*

National surveys tend to show that women and men are equally physically violent with each other. Public agency studies (e.g. women's shelters) tend to show that a much higher percentage of men are physically and emotionally violent with their partners, and cause much greater harm, then women. The reasons for these differences, as Johnson (1995) has suggested, may be due to the fact that these studies are evaluating two (or more) different types of intimate violence. Assessment criteria that make distinctions based on non-physical and physical violence by both partners may provide researchers, clinicians, and theorists a more accurate view of what is really going on in conflicted relationships. For example, we may well determine that women match their partner's violent behaviors in *Situational Couple Violence* and *Mutual Violent Control* types of violence. Or we may find that the nature, characteristics, and motivations behind men's and women's violence within the different types is very different. Current assessment and treatment protocols are largely based on the assumptions that, if women are violent with

their partner, it is most likely motivated by self-defense, but if men are violent with their partner, it is most likely motivated by a need to control, dominate, or retaliate against their female partner. While there is no doubt that this type of scenario does exist, there is also evidence that suggests that in some cases the reverse may be true, or there may be cases in which these assumptions do not apply to either partner, or they apply to both partners simultaneously. As Greene et al., (2002) pointed out, "Current assessment and intervention practices that focus almost exclusively on patriarchal male violence against women may not reflect an understanding of the lived experiences of many couples and ultimately may deny them the type of help they seek" (p. 456). An assessment protocol that incorporates the most current knowledge on typologies of women and men's violence may help clinicians more accurately assess and treat intimate violence experienced by both women and men.

*Directions for Future Research*

Johnson's typology is one of the most inclusive typologies of intimate violence. However, it also is limiting in that it does not address the important psychobiological components of intimate violence known to exist. It also does not allow for the presence of coercive control not accompanied by physical violence. The results from the first study of this dissertation provide evidence that high levels of coercive control can be as psychologically harmful as minor and severe physical assault. As a result of these findings, Johnson's typology was modified and integrated with other typologies of intimate violence to develop two distinct types of intimate violence categories: intimate violence marked by low levels of coercive control, and intimate violence marked by high levels of coercive control. Based on these findings, it is hypothesized that couples who experience low levels of coercive control by one or both partners may be successfully treated using conjoint treatment methods, or possibly a combination of individual, couple, and group treatments. It is also hypothesized that couples who experience high levels of coercive control by one or both partners are not good candidates for conjoint treatment methods, and in fact these methods may cause additional harm. These hypotheses are speculative only, and based on the existing literature that indicates that some types of

low-conflict couples have been successfully treated using conjoint methods. Further research is needed in the following areas in order to test these hypotheses.

*Is Coercive Control the Best Indicator of Type and Effects of Intimate Violence?*

The results of this dissertation show a clear link between Johnson's theoretical coercive control construct and psychological harm. Johnson's theoretical coercive control construct encompasses most if not all of the established criteria used to measure non-physical violence, however it has not been empirically validated. In addition, is Johnson's coercive control construct truly the best criteria for determining type and effects of intimate violence? Jory (2004) has developed a 15-item measure of ethical relational dynamics that is closely correlated with Straus' (1979) Conflict Tactics Scale (CTS). However, Jory's scale is not as inclusive as Johnson's construct with regards to the range of non-physical violence behaviors typically used to measure non-physical violence. Perhaps Straus' (2000) revised CTS2 would be the best indicator, given that the revised version contains several measures of non-physical aggression as well as physical abuse. But there is also some controversy about the efficacy of asking couples directly about physical violence. Further research is needed to establish a valid and reliable intimate violence (e.g. physical and non-physical) measure that can be used to safely and accurately distinguish between types of intimate violence.

*A Need to Establish the Characteristics, Motivation, and Effects of Different Types of Intimate Violence for Women and Men*

Along with the need to define how we will distinguish between types of intimate violence, there is also a need to define the characteristics, motivation, and physical and non-physical effects of different types of intimate violence. If a couple is experiencing non-physical and physical aggression by one or both partners, at what point does this aggression become as issue that makes conjoint treatment no longer a viable option? In other words, how do we establish a pattern of physical and/or non-physical behaviors that are 'too harmful' to treat conjointly? These are all difficult questions that must be dealt with before accurate assessment and treatment protocols can be established. Further research is needed to identify the characteristics (i.e. type, range, frequency, etc.), motivation, and effects (i.e. physical and psychological) between types of intimate

violence that can cause severe psychological or physical harm (such as *Intimate Terrorism*, *Mutual Violent Control*, and *Violent Resistance*) versus types of intimate violence that cause minor psychological or physical harm (e.g. *Situational Couple Violence*).

*A Need to Assess and Evaluate Women's and Men's Intimate Violence*

Much of the existing domestic violence data contains either women's accounts of their male partner's behaviors, or both partner's accounts of the male partner's behaviors. Very often information pertaining to the woman's violence (both physical and non-physical) against her male (or female) partner is not gathered. This information is critical to understanding and differentiating between types of intimate violence. It is possible that this information is not gathered based on the assumption that asking a battered woman about her own violent behaviors may in some way place blame on her for her partner's violence, or that men are typically violent more often than women, and that their violence tends to be more harmful than women's violence. The preliminary results of this study and other studies of women's violence indicate that these assumptions may only hold true in some cases. Some women, in some situations, are clearly being violent against their male (and female) partners. Whether this violence is in self-defense, or whether it is in service of *Intimate Terrorism* or *Mutual Violent Control* against their partners is largely unknown. We must begin to assess and evaluate the nature and characteristics of women's ***and*** men's physical and non-physical violence within conflicted relationships. It is also imperative that we collect self-report and partner-reports of this violence, in order to minimize reporting biases by women ***and*** men. If some men lie about and minimize their violence, why do we assume that it would be any different for some women? In order for intimate violence to be effectively identified and treated, we must take an unbiased assessment and treatment approach that accounts for, but does not discriminate, based on gender. As bell hooks (2000) so eloquently stated,

> *"So far feminist movement has primarily focused on male violence, and as a consequence lends credibility to sexist stereotypes that suggest men are violent, women are not; men are abusers, women are victims. This type of*

*thinking allows us to ignore the extent to which women (with men) in this society accept and perpetuate the idea that it is acceptable for a dominant party or group to maintain power over the dominated by using coercive force. It allows us to overlook or ignore the extent to which women exert coercive authority over others or act violently. The fact that women may not commit violent acts as often as men does not negate the reality of female violence. We must see both men and women in this society as groups who support the use of violence if we are to eliminate it*" (p. 63).

*A Need to Test the Proposed Clinical Assessment Approach and Tool*

The proposed intimate violence assessment approach and tool is a compilation of the most current knowledge on intimate violence typologies and conjoint assessment. In the absence of clearly defined and tested protocols and measures for intimate violence typologies, the proposed approach may provide clinicians and researchers with a useful starting point. In addition, the proposed approach and tool provide clinicians with a framework to safely assess for intimate violence by one or both partners. In summary, the proposed integrated assessment approach may significantly improve the current assessment and treatment protocols for intimate violence. Further research is needed to evaluate the ability of this approach to assist clinicians in making determinations about type of violence and the viability of conjoint treatment. In addition, In addition, further research is needed to identify the characteristics of individuals and couples that can be effectively treated using conjoint methods.

In summary, while we have come a long ways in the past two decades towards understanding the cause, characteristics, and effects of intimate violence, we clearly have a long journey ahead. It is my hope that the work put forth in this dissertation will add another step towards reaching that goal.

# BIBLIOGRAPHY

Allen, K. R. (2001). A conscious and inclusive family studies. In Milardo, R. M. (Ed.), *Understanding families into the new millennium: A decade in review* (pp. 38 – 51). MN: National Council on Family Relations.

Almeida, R. V., & Durkin, T. (1999). The cultural context model: Therapy for couples with domestic violence. *Journal of Marital and Family Therapy, 25(3),* 313–324.

American Psychological Association. (1995). Task force reports on empirically validated treatments. *Task Force on Psycological Intervention, Division of Clinical Psychology, APA.* [Online], available: http:/www.apa.org/divisions/div12/rev_est/marital.shtml

Anderson, K. (2002). Perpetrator or victim: Relationships between intimate partner violence and well-being. *Journal of Marriage and Family, 64(4),* 851 - 863.

Babcock, J. C., Miller, S. A., & Siard, C. (2003). Toward a typology of abusive women: Differences between partner-only and generally violent women in the use of violence. *Psychology of Women Quarterly, 27(2),* 153 - 161.

Babcock, J. C., Waltz, J., Jacobson, N. S., & Gottman, J. M. (1993). Power and violence: The relation between communication patterns, power discrepancies, and domestic violence. *Journal of Consulting and Clinical Psychology, 61(1),* 40 - 49.

Becvar, D.S., & Becvar, R.J. (2000). *Family therapy: A systemic integration,* 4th ed. MA: Allyn and Bacon.

Becvar, R. J., Becvar, D. S., & Bender, A. E. (1982). Let us first do no harm. *Journal of Marital and Family Therapy, 8(4),* 385 - 391.

Berns, S. B., Jacobson, N. S., & Gottman, J. M. (1999). Demand/withdraw interaction patterns between different types of batterers and their spouses. *Journal of Marital and Family Therapy, 25(3),* 337 - 348.

Bograd, M. (1999). Strengthening domestic violence theories: Intersections of race, class, sexual orientation, and gender. *Journal of Marital and Family Therapy, 25(3),* 275 - 289.

Bograd, M., & Mederos, F. (1999). Battering and couples therapy: Universal screening and selection of treatment modality. *Journal of Marital and Family Therapy, 25(3),* 291 - 312.

Brannen, S., & Rubin, A. (1996). Comparing the effectiveness of gender-specific and couples groups in a court-mandated spouse abuse treatment program. *Research on Social Work Practice, 6(4),* 405 - 424.

Bubolz, M. M., & Sontag, S. M. (1993). Human ecology theory. In Boss, P. G., Doherty, W. J., Larossa, R., Shumm, W. R., and Steinmetz, S. K. (Eds.), *Sourcebook of family theories and methods: A Contextual Approach* (pp. 419 - 447). New York, NY: Plenum Press.

Campbell, R. S., & Sullivan, C. M. (1995). Women who use domestic violence shelters. *Psychology of Women Quarterly, 19(2),* 237 – 255.

Carden, A. (1994). Wife abuse and the wife abuser: Review and recommendations. *The Counseling Psychologist, 22,* 539 - 582.

Carter, B., & McGoldrick, M. (1999). *The expanded family life cycle: Individual, family, and social perspectives,* 3rd Ed. Boston, MA: Allyn and Bacon.

Cascardi, M., O'Leary, K. D., Lawrence, E. E., & Schlee, K. A. (1995). Characteristics of women physically abused by their spouses and who seek treatment regarding marital conflict. *Journal of Consulting and Clinical Psychology, 63(4),* 616 - 623.

Cascardi, M., O'Leary, K.D., Schlee, K. A. (1999). Co-occurrence and correlates of posttraumatic stress disorder and major depression in physically abused women. *Journal of Family Violence, 14(3),* 227 – 249.

Chase, K. A., O'Leary, K. D., & Heyman, R. E. (2001). Categorizing partner-violent men within the reactive-proactive typology model. *Journal of Consulting and Clinical Psychology, 69(3),* 567 – 572.

Chornesky, A. (2000) The dynamics of battering revisited. *Journal of Women and Social Work, 15(4),* 480 – 501.

Clark, A. H., & Foy, D. W. (2000). Trauma exposure and alcohol use in battered women. *Violence Against Women, 6(1),* 37 – 48.

Crosbie-Burnett, M., & Lewis, E. A. (1993). Theorectical contributions from social- and cognitive- behavioral psychology. In Boss, P. G., Doherty, W. J., Larossa, R., Shumm, W. R., and Steinmetz, S. K. (Eds.), *Sourcebook of family theories and methods: A contextual approach* (pp. 531 - 557). New York, NY: Plenum Press.

DeMaris, A., & Swinford, S. (1996) Female victims of spousal violence: Factors influencing their level of fearfulness. *Family Relations, 45,* 98 - 106.

DiClemente, C. C., & Prochaska, J. O. (1982). Self-change and therapy change of smoking behavior: A comparison of processes of change in cessation and maintenance. *Addictive Behaviors, 7,* 133 - 142.

Duluth Abuse Project (2003). *Duluth Domestic Abuse Intervention Project*, 206 West Fourth Street, Duluth, Minnesota 55806, http://domesticviolence.org/wheel.html.

Dutton, D. G. (1995). *The domestic assault of women: Psychological and criminal justice perspectives.* Vancouver BC: UBC Press.

Dutton, D. G. (1998). *The abusive personality*. New York: Guilford.

Feld, S. L., and Straus, M. A. (1992). Escalation and desistance from wife assault in marriage. In M. A. Straus and R. J. Gelles (Eds.), *Physical violence in American families* (pp. 489 - 506). New Brunswick, NJ: Transaction.

Feldman, C. M., & Ridley, C. A. (1995). The etiology and treatment of domestic violence between adult partners. *Clinical Psychology: Science and Practice, 2,* 317 - 348.

Geffner, R., & Rosenbaum, A. (1990). Characteristics and treatment of batterers. *Behavioral Sciences and the Law, 8,* 131 - 140.

Geller, J. A. (1998). Conjoint therapy for the treatment of partner abuse: Indications and contraindications. In Roberts, A. R. (Ed.), *Battered women and their families: intervention strategies and treatment programs, 2nd Edition,* (pp. 76 - 98). New York: Springer Publishing Company.

Geller, J. A., & Wasserstrom, J. (1984). Conjoint therapy for the treatment of domestic violence. In Roberts, A. R. (Ed.), *Battered women and their families: intervention strategies and treatment programs,* (pp. 33 - 48). New York: Springer Publishing Company.

Glass, S.P., & Wright, T.L. (1997). Reconstructing marriages after the trauma of infidelity. In W.K. Halford & H.J. Markman (Eds.), *Clinical handbook of marriage and couples interventions* (pp. 471–578). NY: Wiley.

Gleason, W. (1993). Mental disorders in battered women: An empirical study. *Violence and Victims, 8,* 53 – 68.

Goldhaber, D. E. (2000). *Theories of human development: Integrative perspectives.* Mountain View CA: Mayfield.

Goldner, V. (1999). Morality and multiplicity: Perspectives on the treatment of violence in intimate life. *Journal of Marital and Family Therapy, 25(3),* 325 – 336.

Goldner, V., Penn, P., Sheinberg, M., & Walker, G. (1990). Love and violence: Gender paradoxes in volatile attachments. *Family Process. 29(4),* 343 - 364.

Gondolf, E. W. (1997). Batterer programs: What we know and need to know. *Journal of Interpersonal Violence, 12,* 83 - 98.

Gordon, M. (2000). Definitional issues in violence against women. *Violence Against Women, 6(7),* 747 – 783.

Gottman, J. (1999). *The Marriage Clinic: A Scientifically Based Marital Therapy.* NY: Norton.

Greene, K., & Bogo, M. (2002). The different faces of intimate violence: Implications for assessment and treatment. *Journal of Marital and Family Therapy, 28(4),* 455 – 466.

Hamby, S. L. (1998). Partner violence: Prevention and Intervention. In Jasinski, J. L. and Williams, L. M. (Eds.), *Partner violence: A comprehensive review of 20 years of research.* (pp. 210 - 258). Thousand Oaks, CA: Sage Publications.

Heyman, R. E., & Neidig, P.H. (1997). Physical aggression couples treatment. In K. W. Halfor and J. J. Markman (Eds.), *Clinical handbook of Marriage and couples interventions* (pp. 589 - 617). NY: Wiley.

Holtzworth-Munroe, A., Meehan, J. C., Herron, K., Rehman, U., & Stuart, G. L. (2000). Testing the Holtzworth-Munroe and Stuart (1994) batterer typology. *Journal of Consulting and Clinical Psychology, 68(6),* 1000 – 1019.

Holtzworth-Munroe, A., & Stuart, G. L. (1994). Typologies of male batterers: Three subtypes and the differences among them. *Psychological Bulletin, 116(3),* 476 - 497.

hooks, b. (2000). *Feminism is for everybody: Passionate politics.* Cambridge, MA: South End Press.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999). *The heart and soul of change: What works in therapy.* Washington, DC: American Psychological Association.

Jenkins, A. (1990). *Invitations to responsibility: The therapeutic engagement of men who are violent and abusive.* Australia: Dulwich Centre Publications.

Johannson, M. A., & Tutty, L. M. (1998). An evaluation of after-treatment couples' groups for wife abuse. *Family Relations, 47(1),* 27-36.

Johnson, M. P. (1995). Patriarchal terrorism and common couple violence: Two forms of violence against women. *Journal of Marriage and the Family, 57,* 283 – 294.

Johnson, M. P. (2002, In progress). *Violence and control in intimate relationships: Intimate terrorism and other types of domestic violence.*

Johnson, M. P., & Ferraro, K. J. (2001). Research on domestic violence in the 1990's: Making distinctions. In Milardo, R. M. (Ed.), *Understanding families into the new millennium: A decade in review* (pp. 38 – 51). MN: National Council on Family Relations.

Johnson, M. P., & Leone, J. M. (2000, July). The differential effects of intimate terrorism and situational couple violence: Findings from the *National Violence Against Women survey.* Presented at the Tenth International Conference on Personal Relationships, Brisbane, Australia.

Jory, B. (2004). The intimate justice scale: An instrument to screen for psychological abuse and physical violence in clinical practice. *Journal of Marital and Family Therapy, 9(1),* 29 – 43.

Kalmuss, D. S., & Straus, M. A. (1992). Wife's marital dependence and wife abuse. In M. A. Straus and R. J. Gelles (Eds.), *Physical violence in American families* (pp. 369 - 382). New Brunswick, NJ: Transaction.

Langhinrichsen-Rohling, J., Huss, M. T., & Ramsey, S. (2000). The clinical utility of batterer typologies. *Journal of family violence, 15(1),* 37 – 53.

Lawson, D. M. (2003). Incidence, explanations, and treatment of partner violence. *Journal of Counseling and Development, 81(1),* 19 – 33.

Lederer, W. J., & Jackson, D. D. (1968). *The mirages of marriage.* New York: Norton.

Leone, J. M., Johnson, M. P., Cohan, & C. L., Lloyd, S., (2001, June). Consequences of different types of domestic violence for low-income, ethnic women: A control-based typology of male-partner violence. Presented at the International Network on Personal Relationships, Prescott, Arizona.

Lipchik, E. (1991). Spouse abuse: Challenging the party line. *Family Therapy Networker, 5,* 59 - 63.

Lipchik, E., & Kubicki, A. (1996). Solution-focused domestic violence views: Bridges toward a new reality in couples therapy. In D. Miller Scott, M. Hubbell, & B. Duncan (Eds.), *Handbook of solution focused brief therapy* (pp. 65 - 98). San Francisco: Jossey Bass.

Lipchik, E., Sides, E., & Kubicki, A. (1997). Multifaceted approaches in spouse abuse treatment. In R. Geffner, S. Sorenson, & P. Lundberg-Love (Eds.), *Violence and sexual abuse at home: Current issues in spousal battering and child maltreatment* (pp. 131 - 148). New York: Haworth.

Lloyd, S. A. (1996, November). The effects of violence on women's employment. Paper presented at the Association for Public Policy Analysis and Management (APPAM).

Lorant, V., & Eaton, W. (2003). Review: There is marked socioeconomic inequality in persistent depression. *Evidence-Based Mental Health, 6(3),* 75 – 76.

Madanes, C. (1990). *Sex, love, and violence: Strategies for transformation.* NY: Norton.

Marshall, L. L. (1992). Development of the Severity of Violence Against Women Scales. *Journal of Family Violence, 7,* 103 - 121.

McFarlane, J., & Willson, P. (2000). Intimate partner violence. *Journal of Interpersonal Violence, 15(2),* 158 - 169.

Medical Outcomes Trust (1993). *SF-36 Health Survey. U.S. Acute Version, 1.0.* MA: P.O. Box 1917, Boston, MA 02205.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior.* NY: Guilford Press.

Murphy, C. M., & O'Leary, K. D. (1989). Psychological aggression predicts physical aggression in early marriage. *Journal of Consulting and Clinical Psychology, 57(5),* 579 - 582.

Neidig, P. H., & Friedman, D. H. (1984). *Spouse abuse: A treatment program for couples.* Champaign, IL: Research Press.

NIJCDC (National Institute of Justice Centers for Disease Control and Prevention) (1998). *Prevalence, incidence, and consequences of violence against women: Findings from the national violence against women survey.* U.S. Department of Justice.

O'Leary, K. D. (1993). Through a psychological lens: Personality traits, personality disorders, and levels of violence. In R. J. Gelles and D. R. Loseke (Eds.), *Current controversies on family violence* (pp. 7 - 30). Newbury Park, CA: Sage.

O'Leary, K. D. (1996). Physical aggression in intimate relationships can be treated within a marital context under certain circumstances. *Journal of Interpersonal Violence, 11(3),* 450 - 452.

O'Leary, K. D., Barling, J., Arias, I., Rosenbaum, A., Malone, J., & Tyree, A. (1989). Prevalence and stability of physical aggression between spouses: A longitudinal analysis. *Journal of Consulting and Clinical Psychology, 57(2),* 263 - 268.

O'Leary, K. D., Vivian, D., & Malone, J. (1992). Assessment of physical aggression against women in marriage: The need for multimodal assessment. *Behavioral Assessment, 14(1),* 5 - 14.

Olson, L. N. (2002). Exploring common couple violence in heterosexual romantic relationships. *Western Journal of Communication, 66(1),* 104 – 128.

Osmond, M. W. & Thorne, B. (1993). Feminist theories: The social construction of gender in families and society. In Boss, P. G., Doherty, W. J., Larossa, R.,

Shumm, W. R., and Steinmetz, S. K. (Eds.), *Sourcebook of family theories and methods: A Contextual Approach* (pp. 591 - 622). New York, NY: Plenum Press.

Pan, H. S., Neidig, P. H., & O'Leary, K. D. (1994). Predicting mild and severe husband-to-wife physical aggression. *Journal of Consulting and Clinical Psychology, 62(5),* 975 - 981.

Quigley, B. M., & Leonard, K. E. (1996). Desistance of husband aggression in the early years of marriage. *Violence and Victims, 11,* 355 - 370.

Rosen, K. H., & Bird, K. (1996). A case of woman abuse. *Violence Against Women,* 2(3), 302 – 321.

Rosenbaum, A., & Maiuro, R. D. (1990). Perpetrators of spouse abuse. In R. T. Ammerman and M. Hersen (Eds.), *Treatment of family violence: A sourcebook* (pp. 280 - 309). New York: Plenum Press.

Sagrestano, L. M. (1992). Power strategies in interpersonal relationships: The effects of expertise and gender. *Psychology of Women Quarterly, 16,* 481 - 495.

Salari, S. M., & Baldwin, B. M. (2002). Verbal, physical, and injurious aggression among intimate couples over time. *Journal of Family Issues, 23(4),* 523 –550.

Saunders, D. G. (1992). A typology of men who batter women: Three types derived from cluster analysis. *American Orthopsychiatry, 62(2),* 264 – 275.

Saunders, D. G. (1996). Feminist-cognitive-behavioral and process-psychodynamic treatments for men who batter: Interactions of abuser traits and treatment models. *Violence and Victims, 11,* 393 - 412.

Schafer, J., & Caetano, R. (1998). Rates of intimate partner violence in the United States. *American Journal of Public Health, 88(11),* 1702 - 1705.

Sexton, T. L. (1994). Systemic thinking in a linear world: Issues in the application of interactional counseling. *Journal of Counseling and Development, 72(2),* 249 - 258.

Shackelford, T. K. (2001). Partner-killing by women in cohabitation relationships and marital relationships. *Homicide Studies, 5(3),* 253 - 266.

Shamai, M. (1996). Couple therapy with battered women and abusive men: Does it have a future? In L. Edleson & Z. Eisikovits (Eds.), *Future interventions with battered women and their families* (pp. 201 - 215). Thousand Oaks, CA: Sage.

Sprenkle, D. (1994). Wife abuse through the lens of systems theory. *Counseling Psychologist, 22*, 597 - 602.

Statistics Canada (1994). *Canadian Violence Against Women Survey*. Canada: Housing, Family and Social Statistics Division.

Stets, J. E. (1990). Verbal and physical aggression in marriage. *Journal of Marriage and the Family, 52*, 501 - 514.

Stets, J. E., & Straus, M. A. (1992). Gender differences in reporting marital violence and its medical and psychological consequences. In M. A. Straus and R. J. Gelles (Eds.), *Physical violence in American families* (pp. 151 - 165). New Brunswick, NJ: Transaction Books.

Stith, S. M., Rosen, K. H., McCollum, E. E. (2002). Domestic violence. In Sprenkle, D. H. (Ed.), *Effectiveness research in marriage and family therapy* (pp. 223 – 254). Alexandria, VA: AAMFT.

Stith, S. M. & Straus, M. A. (1995). Introduction. In S. M. Stith & M. A. Straus (Eds.), *Understanding partner violence: Prevalence, causes, consequences, and solutions* (pp. 1 - 11). Minneapolis, MN: National Council on Family Relations.

Stosny, S. (1996). *Treating attachment abuse: A compassionate approach*. NY: Springer.

Straus, M. A. (1979). Measuring intrafamily conflict and violence: The Conflict Tactics Scales (CTS). *Journal of Marriage and the Family, 41*, 75 - 88.

Straus, M. A. (2000). *Handbook for the conflict tactics scales (CTS) including revised versions CTS2 and CTSPC*. NH: Family Research Laboratory, University of New Hampshire.

Straus, M. A., & Sweet, S. (1992). Verbal/symbolic aggression in couples: Incidence rates and relationships to personal characteristics. *Journal of Marriage and the Family, 54(2)*, 346 – 357.

Swan, S., & Snow, D. L. (2002) A typology of women's use of violence in intimate relationships. *Violence Against Women, 8(3)*, 286 - 319.

Taylor, M. J., & Barusch, A. S. (2004). Personal, family, and multiple barriers of long-term welfare recipients. Social Work, 49(2), 175 – 183.

Tjaden, P. (2000). Prevalence and consequences of male-to-female and female-to-male intimate partner violence as measured by the national violence against women survey. *Violence Against Women, 6(2),* 142 - 161.

Tjaden, P., & Thoennes, N. (1999). *Violence and threats of violence against women and men in the United States, 1994-1996.* Washington, D.C.: National Institute of Justice/Centers for Disease Control and Prevention.

Tolman, R. M. (1989). The development of a measure of psychological maltreatment of women by their male partners. *Violence and Victims, 4,* 159 - 177.

Tolman, R. M., & Bennett, L. W. (1990). A review of quantitative research on men who batter. *Journal of Interpersonal Violence, 5,* 87 - 119.

U.S. Department of Commerce (2000). *United States Census 2000.* Economics and Statistics Administration, U.S. Census Bureau. Washington D.C. Website: http://www.census.gov/index.html

van Wormer, K. (1998). Domestic violence and substance abuse: An integrated approach. In Roberts, A. R. (Ed.), *Battered women and their families: intervention strategies and treatment programs, 2nd Edition,* (pp. 345 - 364). New York: Springer Publishing Company.

Verburg, P. (1994). The other half of domestic violence. *Alberta Report, 21(11),* 28 - 31.

Vitanza, S., Vogel, L., & Marshall, L. (1995). Distress and symptoms of post-traumatic stress disorder in abused women. *Violence and Victims, 10,* 23 – 24.

Vivian D., & Heyman, R. (1996). Is there a place for couples treatment of couple violence? In *Session: Psychotherapy in Practice,* 2, 25 - 48.

Vivian, D., & Malone, J. (1997). Relationship factors and depressive symptomatology associated with mild and severe husband-to-wife physical aggression. *Violence and Victims, 12,* 3 - 18.

Walker, L. (1995). Current perspectives on men who batter women – Implications for intervention and treatment to stop violence against women: Comment on Gottman et al. (1995). *Journal of Family Psychology, 9(3),* 264 – 271.

Waltz, J., Babcock, J. C., Jacobson, N. S., & Gottman, J. M. (2000). Testing a typology of batterers. *Journal of Consulting and Clinical Psychology, 68(4),* 658 - 669.

Watzlawick, P., Weakland, J., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution.* NY: Norton and Company.

Weiss, D. S., & Marmar, C. R. (1997). The Impact of Event Scale revised. In J.P. Wilson and T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 399 - 411). NY: Guilford.

Whitchurch, G. G. (2000). Violent critical incidents in four types of violent interpersonal relationships. *Marriage and Family Review, 30(1/2),* 25 – 49.

Whitchurch, G. G., & Constantine, L. L. (1993). Systems theory. In Boss, P. G., Doherty, W. J., Larossa, R., Shumm, W. R., and Steinmetz, S. K. (Eds.), *Sourcebook of family theories and methods: A Contextual Approach* (pp. 325 - 352). New York, NY: Plenum Press.

# APPENDIX: MISCELLANEOUS TABLES NOT USED IN THE ARTICLES

Table A.1

*Background Variables: Descriptive Statistics* [a]

| Variables | *M* | *SD* | Range |
|---|---|---|---|
| Female Respondent Demographics | | | |
| Age | 43.46 | 13.94 | 18 – 88 |
| Education level[b] | 3.80 | 1.16 | 0 – 6 |
| Respondent income level[c] | $22,809 | $21,010 | 0 – $100 |
| General overall health[d] | 3.79 | 1.05 | 1 – 5 |
| Years lived together with partner | 18.77 | 14.58 | <1 – 74 |
| Male Respondent Demographics | | | |
| Age | 44.67 | 14.37 | 18 – 93 |
| Education level [b] | 3.96 | 1.25 | 0 – 6 |
| Respondent income level[c] | $40,355 | $25,069 | 0 – $100K |
| General overall health[d] | 3.78 | 1.04 | 1 – 5 |
| Years lived together with partner | 17.42 | 14.29 | < 1 - 69 |

*Note.* [a]Based on total sample size for women ($N$ = 4772) and men ($N$ = 5868). [b]Education level: 0 = *no school*, 1 = *1st through 8th grade*, 2 = *some high school*, 3 = *high school graduate*, 4 = *some college*, 5 = *four year college degree*, 6 = *post graduate work.* [c]Respondent income level recoded to midrange of each category: 0 = *none*, 1 = *$2,500*, 2 = *$7,500*, 3 = *$12,500*, 4 = *$17,500*, 5 = *$22,500*, 6 = *$30,000*, 7 = *$42,500*, 8 = *$65,000*, 9 = *$90,000*, and 10 = *$100,000.* [d]General overall health: 1 = *poor*, 2 = *fair*, 3 = *good*, 4 = *very good*, 5 = *excellent.*

Table A.2

*Demographic Variables: Descriptive Statistics*[a]

| Variables | | Female | | Male | |
|---|---|---|---|---|---|
| | | *N* | % | *N* | % |
| Marital[b] | Married or common-law | 4316 | 90.4% | 5284 | 90.0% |
| | Divorced or separated | 181 | 3.8% | 228 | 3.9% |
| | Single and never married | 254 | 5.3% | 339 | 5.8% |
| | Widowed | 20 | .4% | 16 | .3% |
| | Same-sex partner[c] | 26 | .5% | 29 | .5% |
| Ethnicity[d] | White | 4009 | 84.0% | 4887 | 83.3% |
| | Black/African American | 299 | 6.3% | 381 | 6.5% |
| | Asian/Pacific Islander | 79 | 1.7% | 98 | 1.7% |
| | Am. Indian/Alaskan Native | 49 | 1.0% | 65 | 1.1% |
| | Mixed or other | 244 | 5.1% | 264 | 4.5% |
| | Hispanic Origin[e] | 395 | 6.7% | 387 | 8.3% |
| Employment[f] | Employed full-time | 2256 | 47.3% | 4347 | 74.1% |
| | Employed part-time | 681 | 14.3% | 188 | 3.2% |
| | Unemployed/Looking | 122 | 2.6% | 139 | 2.4% |
| | Retired/Not looking | 523 | 11.0% | 817 | 13.9% |
| | Homemaker | 934 | 19.6% | 10 | .2% |
| | Student, military, or other | 244 | 5.1% | 350 | 6.0% |

*Note.* [a]Based on total sample size for women ($N = 4772$) and men ($N = 5868$). [b]Marital status at time of interview. Approximately .4% ($N = 17$) females and .2% ($N = 10$) males refused or did not respond to this question. [c]Living with same-sex partner determined independently of marital status. [d]Ethnic heritage. Approximately 2% ($N = 92$) females and 3% ($N = 173$) males refused or did not respond to this question. [e]Hispanic origin determined independent of race. [f]Employment status. Approximately .2% ($N = 12$) females and .3% ($N = 17$) males refused or did not respond to this question.

Table A.3

*Comparison of 2000 U.S. Census, NVAW Survey, and Study Sample Demographics*

| Variables | 2000 Census[a] $N = 281,421,904$ | NVAW Survey $N = 16,000$ | Study Sample[b] $N = 10,640$ |
|---|---|---|---|
| Gender | | | |
| Male | 49.1% | 50.0% | 55.2% |
| Female | 50.9% | 50.0% | 44.8% |
| Age | | | |
| Median age (18 and older) | 35.3 | 41.0 | 42.0 |
| Mean age (18 and older) | NA | 43.3 | 44.1 |
| Range | NA | 18 – 97 | 18 – 93 |
| Household Size | | | |
| Median household size | NA | 2.0 | 2.21 |
| Mean household size | 2.59 | 2.1 | 2.0 |
| Range | NA | 1 – 7 | 1 – 7 |
| Income[c] | | | |
| Median household income | $41,994 | $42,500 | $42,500 |
| Mean household income | NA | $46,891 | $48,403 |
| Median respondent income | NA | $22,500 | $30,000 |
| Mean respondent income | NA | $28,716 | $32,676 |
| Range | NA | 0 - $100,000 | 0 - $100,000 |
| Education Level[d] | | | |
| Less than 9th grade | 7.5% | 3.0% | 2.6% |
| Some high school | 12.1% | 7.4% | 6.6% |
| High school diploma | 28.6% | 32.5% | 32.3% |
| Some college | 27.3% | 27.9% | 26.9% |
| Four year college degree | 15.5% | 18.9% | 20.2% |
| Post-graduate work | 8.9% | 10.0% | 11.1% |
| Mean education level | NA | 3.82 | 3.89 |
| Range | NA | 0 – 6 | 0 – 6 |

Table A.3

*Continued*

| Variables | 2000 Census $N = 281,421,904$ | NVAW Survey $N = 16,000$ | Study Sample $N = 10,640$ |
|---|---|---|---|
| Employment Status | | | |
| Employed | 59.7% | 66.3% | 68.9% |
| Unemployed/Looking | 3.7% | 3.4% | 2.5% |
| Not in labor force | 36.1% | 29.4% | 27.3% |
| Military | .5% | .6% | .5% |
| Marital Status | | | |
| Married | 54.4% | 64.5% | 90.2% |
| Divorced or separated | 11.9% | 11.6% | 3.9% |
| Single, never married | 27.1% | 18.1% | 5.6% |
| Widowed | 6.6% | 5.2% | .3% |
| Refused or missing | NA | .5% | 0% |

*Note:* [a]2000 Census values based on a 1 in 6 sample weighted to represent the total population. [b]NVAW sample included only those respondents living with their current partner. [c]NVAW household income recoded to midrange (0 = *none*, 1 = *$2,500*, 2 = *$7,500*, 3 = *$12,500*, 4 = *$17,500*, 5 = *$22,500*, 6 = *$30,000*, 7 = *$42,500*, 8 = *$65,000*, 9 = *$90,000*, and 10 = *$100,000*). [d]Education level: 0 = *no school*, 1 = *1st through 8th grade*, 2 = *some high school*, 3 = *high school graduate*, 4 = *some college*, 5 = *four year college degree*, 6 = *post graduate work.*

Table A.4

*Coercive Control Variables: Descriptive Statistics*[a]

| Coercive Control Item[b] | Women | | | Men | | |
|---|---|---|---|---|---|---|
| | *N* | *M* | *SD* | *N* | *M* | *SD* |
| 1. Has hard time seeing your point of view | 4731 | .26 | .44 | 5794 | .22 | .41 |
| 2. Is jealous or possessive | 4749 | .12 | .32 | 5812 | .15 | .36 |
| 3. Tries to provoke arguments | 4750 | .06 | .24 | 5820 | .07 | .26 |
| 4. Tries to limit contact with family or friends | 4753 | .04 | .19 | 5828 | .04 | .20 |
| 5. Insists on knowing who you are with… | 4735 | .08 | .27 | 5805 | .11 | .31 |
| 6. Calls you names, puts you down… | 4756 | .04 | .19 | 5830 | .03 | .17 |
| 7. Makes you feel inadequate | 4727 | .06 | .24 | 5799 | .03 | .18 |
| 8. Shouts or swears at you | 4754 | .06 | .24 | 5827 | .11 | .32 |
| 9. Prevents you from access to family income | 4745 | .10 | .29 | 5810 | .02 | .13 |
| 10. Prevents you from working outside the home | 4757 | .02 | .15 | 5830 | .01 | .11 |
| 11. Insists on changing residences | 4754 | .01 | .11 | 5826 | .02 | .15 |
| 12. Follows you | 3282 | .00 | .05 | 4507 | .00 | .05 |
| 13. Spies on you | 3282 | .00 | .03 | 4507 | .00 | .04 |
| 14. Stands outside …home, school, or workplace | 3282 | .00 | .06 | 4507 | .00 | .04 |
| 15. Sends unsolicited written correspondence | 3282 | .00 | .00 | 4507 | .00 | .03 |
| 16. Leaves unwanted items for you to find | 3282 | .00 | .00 | 4507 | .00 | .02 |
| 17. Makes unsolicited phone calls to you | 3282 | .00 | .02 | 4507 | .00 | .04 |
| 18. Vandalizes your personal property | 3282 | .00 | .05 | 4507 | .00 | .05 |
| 19. Kills your pet | 3282 | .00 | .00 | 4507 | .00 | .00 |
| 20. Shows up at places… uninvited | 3282 | .00 | .02 | 4507 | .00 | .02 |
| 21. Tries to communicate… against your will | 3282 | .00 | .02 | 4507 | .00 | .00 |
| 23. Threatened to kill your pet | 3282 | .00 | .02 | 4507 | .00 | .02 |
| 24. Threatened to harm or kill you | 4626 | .01 | .09 | 5552 | .00 | .06 |
| 25. Threatened you with a gun | 3707 | .00 | .07 | 3632 | .00 | .02 |
| 26. Threatened you with a knife or other weapon | 3707 | .00 | .06 | 3632 | .00 | .07 |

*Note.* [a]Based on total sample size. [b]All variables coded as 0=*No*, 1 = *Yes*.

Table A.5

*Coercive Control Factor Analysis[a] for Women (N = 2696)[b]*

| | Factors and Loadings[c] | | | | | |
|---|---|---|---|---|---|---|
| Coercive Control Item[d] | 1 | 2 | 3 | 4 | 5 | 6 |
| Inhibiting Will and Ability to Resist | | | | | | |
| *Inhibiting Will to Resist: Psychological* | | | | | | |
| 1. Has hard time seeing your point of view | **.53** | -.01 | .02 | .32 | -.05 | -.06 |
| 3. Tries to provoke arguments | **.65** | .04 | .05 | .17 | .05 | -.06 |
| 6. Calls you names, puts you down… | **.67** | .07 | -.01 | .00 | .21 | .15 |
| 7. Makes you feel inadequate | **.66** | .06 | .06 | .11 | .08 | .12 |
| 8. Shouts or swears at you | **.70** | .07 | .10 | .07 | .00 | .00 |
| *Inhibiting Ability to Resist: Social, Economic* | | | | | | |
| 2. Is jealous or possessive | .22 | .07 | .05 | **.69** | .04 | .11 |
| 4. Tries to limit contact w/family or friends | .30 | -.06 | .14 | **.46** | .14 | .26 |
| 5. Insists on knowing who you are with… | .12 | .04 | .05 | **.74** | .04 | .09 |
| 11. Insists on changing residences | -.01 | .12 | -.18 | **.43** | .21 | -.30 |
| 10. Prevents you working outside home | -.06 | .04 | .01 | .15 | -.03 | **.81** |
| 9. Prevents access to family income | .33 | .01 | -.08 | .03 | .23 | **.49** |
| Surveillance | | | | | | |
| 12. Follows you | .11 | -.10 | .36 | .21 | **.54** | -.11 |
| 13. Spies on you | -.04 | .02 | -.08 | .08 | **.78** | .15 |
| 14. Stands outside …home, school, or work | .21 | .03 | .01 | .02 | **.75** | -.01 |

Table A.5

*Continued*

| Coercive Control Item [d] | Factors and Loadings[c] 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| Threats and Intimidation | | | | | | |
| 24. Threatened to harm or kill you | .14 | **.89** | .35 | .06 | .02 | .01 |
| 25. Threatened you with a gun | .07 | **.95** | -.04 | .08 | -.02 | .01 |
| 26. Threatened you with a knife or weapon | .12 | .45 | **.74** | .02 | .05 | .06 |
| 18. Vandalizes your personal property | .06 | .02 | **.90** | .03 | .00 | -.03 |
| Eigenvalues for Rotated Solution | 2.45 | 1.94 | 1.69 | 1.66 | 1.65 | 1.14 |
| Percent of Variance for Rotated Solution | 13.6 | 10.8 | 9.4 | 9.2 | 9.2 | 6.4 |

*Notes.* [a]Principal component extraction with Varimax rotation, factors selected based on Eigenvalues greater than 1.0. [b]Analysis sample size reduced due to listwise deletion. [c]Factor loadings over .40 appear in bold. [d]All variables coded as 0=*No*, 1 = *Yes*. Items not shown had no *Yes* responses, and therefore were not included in the analysis.

Table A.6

*Coercive Control Factor Analysis[a] for Men (N =2911)[b]*

| Coercive Control Item[d] | Factors and Loadings[c] 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| Inhibiting Will and Ability to Resist | | | | | | |
| *Inhibiting Will to Resist: Psychological* | | | | | | |
| 1. Has hard time seeing your point of view | -.03 | **.59** | -.01 | .02 | -.01 | .09 |
| 3. Tries to provoke arguments | .03 | **.65** | .07 | .07 | .05 | .11 |
| 6. Calls you names, puts you down… | .02 | **.53** | .06 | .20 | .20 | .01 |
| 7. Makes you feel inadequate | -.01 | **.43** | .00 | .09 | .15 | .28 |
| 8. Shouts or swears at you | .01 | **.64** | .03 | .05 | .01 | .06 |
| *Inhibiting Ability to Resist: Social* | | | | | | |
| 2. Is jealous or possessive | .04 | **.64** | .01 | -.02 | -.01 | -.03 |
| 4. Tries to limit contact w/family or friends | .08 | **.57** | .03 | -.08 | .14 | .11 |
| 5. Insists on knowing who you are with… | .09 | **.60** | .06 | -.01 | -.11 | .01 |
| Surveillance, Threats, Intimidation | | | | | | |
| 13. Spies on you | **.89** | .11 | .03 | .14 | .02 | .10 |
| 14. Stands outside …home, school, or work | **.93** | .02 | .08 | -.03 | .01 | .13 |
| 15. Sends unsolicited written correspondence | **.71** | .09 | -.13 | .15 | .04 | -.29 |
| 18. Vandalizes your personal property | **.63** | .10 | .14 | .40 | .38 | .08 |

Table A.6

*Continued*

| Coercive Control Item[d] | Factors and Loadings[c] 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| Surveillance, Threats, Intimidation (cont'd) | | | | | | |
| 20. Shows up at places...uninvited | .02 | .06 | **.64** | -.15 | -.14 | -.30 |
| 24. Threatened to harm or kill you | .07 | .11 | **.88** | .26 | .23 | .18 |
| 26. Threatened you with a knife or weapon | .08 | .11 | **.88** | .26 | .23 | .18 |
| 12. Follows you | .36 | .18 | -.06 | **.74** | .03 | -.10 |
| 25. Threatened you with a gun | -.09 | -.02 | .34 | **.78** | -.07 | .16 |
| 10. Prevents you working outside home | .15 | .14 | -.07 | -.09 | **.42** | .35 |
| 16. Leaves unwanted items for you to find | -.04 | .05 | .19 | -.01 | **.91** | -.08 |
| 17. Makes unsolicited phone calls to you | .29 | .11 | .12 | .59 | **.62** | -.11 |
| 9. Prevents access to family income | -.01 | .15 | -.07 | .20 | .00 | **.63** |
| 11. Insists on changing residences | .04 | .25 | .07 | -.10 | -.04 | .39 |
| 23. Threatened to kill your pet | .49 | -.03 | .33 | -.20 | -.02 | **.59** |
| Eigenvalues for Rotated Solution | 3.94 | 2.95 | 2.30 | 2.03 | 1.76 | 1.48 |
| Percent of Variance for Rotated Solution | 16.4 | 12.3 | 9.6 | 8.5 | 7.3 | 6.2 |

*Notes.* [a]Principal component extraction with Varimax rotation, factors selected based on Eigenvalues greater than 1.0. [b]Analysis sample size reduced due to listwise deletion. [c]Factor loadings over .40 appear in bold. [d]All variables coded as 0=*No*, 1 = *Yes*. Items not shown had no *Yes* responses, and therefore were not included in the analysis.

Table A.7

*Coercive Control Factor Analysis[a] for Women (N = 2696)[b] and Men (N =2911)[b]*

| | Factors and Loadings[c] | | | | | |
|---|---|---|---|---|---|---|
| | Women | | | Men | | |
| Coercive Control Item[d] | 1 | 2 | 3 | 1 | 2 | 3 |
| Inhibiting Will and Ability to Resist | | | | | | |
| *Inhibiting Will to Resist: Psychological* | | | | | | |
| 1. Has hard time seeing your point of view | **.58** | .03 | -.02 | .00 | **.59** | -.01 |
| 3. Tries to provoke arguments | **.62** | .09 | .04 | .04 | **.65** | .09 |
| 6. Calls you names, puts you down… | **.60** | .06 | .15 | .06 | **.53** | .22 |
| 7. Makes you feel inadequate | **.64** | .10 | .07 | .03 | **.50** | .12 |
| 8. Shouts or swears at you | **.62** | .15 | .01 | .03 | **.63** | .04 |
| *Inhibiting Ability to Resist: Social, Economic* | | | | | | |
| 2. Is jealous or possessive | **.54** | .10 | .13 | .02 | **.61** | -.03 |
| 4. Tries to limit contact w/family or friends | **.51** | .04 | .24 | .08 | **.58** | .02 |
| 5. Insists on knowing who you are with… | **.47** | .07 | .14 | .07 | **.58** | -.03 |
| 9. Prevents access to family income | **.40** | -.05 | .21 | .08 | .30 | .08 |
| 10. Prevents you working outside home | .19 | .00 | .02 | .20 | .25 | .08 |
| 11. Insists on changing residences | .15 | -.03 | .18 | .06 | .33 | -.01 |
| Surveillance, Intimidation, Threats | | | | | | |
| 12. Follows you | .13 | .15 | **.63** | **.45** | .16 | .30 |
| 13. Spies on you | .04 | -.05 | **.73** | **.90** | .12 | .02 |
| 14. Stands outside …home, school, or work | .17 | .03 | **.70** | **.92** | .04 | -.03 |

Table A.7

*Continued*

| Coercive Control Item[d] | Factors and Loadings[c] | | | | | |
|---|---|---|---|---|---|---|
| | Women | | | Men | | |
| | 1 | 2 | 3 | 1 | 2 | 3 |
| Surveillance, Intimidation, Threats | | | | | | |
| 15. Sends unsolicited written correspondence | | - | | **.70** | .01 | -.08 |
| 23. Threatened to kill your pet | | - | | **.50** | .10 | .11 |
| 18. Vandalizes your personal property | -.01 | **.59** | .21 | **.71** | .13 | .41 |
| 24. Threatened to harm or kill you | .15 | **.91** | -.05 | .12 | .15 | **.87** |
| 25. Threatened you with a gun | .15 | **.71** | -.19 | .02 | .01 | **.64** |
| 26. Threatened you with a knife or weapon | .08 | **.81** | .14 | .12 | .15 | **.87** |
| 16. Leaves unwanted items for you to find | | - | | .03 | .08 | **.52** |
| 17. Makes unsolicited phone calls to you | | - | | .40 | .12 | **.62** |
| 20. Shows up at places...uninvited | | - | | -.05 | -.04 | .32 |
| Eigenvalues for Rotated Solution | 2.96 | 2.43 | 1.74 | 4.21 | 3.14 | 3.05 |
| Percent of Variance for Rotated Solution | 16.5 | 13.5 | 9.6 | 17.5 | 13.1 | 12.7 |

*Notes.* [a]Principal component extraction with Varimax rotation, factors selected based on Eigenvalues greater than 1.0. [b]Analysis sample size reduced due to listwise deletion. [c]Factor loadings over .40 appear in bold. [d]All variables coded as 0=*No*, 1 = *Yes*. Items not shown had no *Yes* responses, and therefore were not included in the analysis.

Table A.8

*Physical Assault and Sexual Coercion Variables: Descriptive Statistics*[a]

| | Women | | | Men | | |
|---|---|---|---|---|---|---|
| Physical Assault Item[b, c] | *N* | *M* | *SD* | *N* | *M* | *SD* |
| Minor Physical Assault | | | | | | |
| 1. Thrown something at you that could hurt you | 1190 | .06 | .23 | 1184 | .07 | .26 |
| 2. Pushed, grabbed, or shoved you | 1188 | .17 | .38 | 1185 | .09 | .29 |
| 3. Pulled your hair | 1187 | .06 | .24 | 1186 | .03 | .18 |
| 4. Slapped or hit you | 1189 | .15 | .36 | 1184 | .10 | .30 |
| Severe Physical Assault | | | | | | |
| 5. Kicked or bit you | 1188 | .04 | .20 | 1188 | .04 | .20 |
| 6. Choked or attempted to drown you | 1190 | .04 | .20 | 1188 | .01 | .08 |
| 7. Hit you with some object | 1188 | .04 | .19 | 1186 | .05 | .21 |
| 8. Beat you up | 1189 | .05 | .21 | 1188 | .02 | .14 |
| 9. Used a gun on you | 1189 | .01 | .10 | 1187 | .01 | .09 |
| 10. Used a knife or other weapon on you | 1189 | .02 | .12 | 1187 | .01 | .11 |
| Severe Sexual Coercion | | | | | | |
| 11. Made you have sex...[c] | 1187 | .05 | .22 | 0 | .00 | .00 |
| 12. Made you have oral sex...[c] | 1188 | .02 | .15 | 1184 | .00 | .06 |
| 13. Made you have anal sex...[c] | 1189 | .01 | .10 | 1185 | .00 | .04 |
| 14. Put fingers/objects in your vagina or anus...[c] | 1188 | .02 | .15 | 1186 | .00 | .06 |

*Note*. [a]Sample size includes only respondents who experienced intimate violence in their current relationship. [b]All variables coded as 0=*No*, 1 = *Yes* in response to "Has your partner ever... " [c]Based on Straus' (2000) criteria. [d]"...against your will by using force or threat of harm?"

Table A.9

*Depression Inventory: Descriptive Statistics*[a]

| | Women | | | Men | | |
|---|---|---|---|---|---|---|
| Depression Item[b] | *N* | *M* | *SD* | *N* | *M* | *SD* |
| 1. Felt full of pep | 1171 | 2.07 | .90 | 1168 | 1.91 | .90 |
| 2. Been very nervous | 1187 | 1.97 | .96 | 1186 | 1.72 | .88 |
| 3. Felt so down in the dumps that nothing could cheer you up | 1186 | 1.59 | .86 | 1183 | 1.45 | .77 |
| 4. Had a lot of energy | 1189 | 1.94 | .86 | 1183 | 1.73 | .80 |
| 5. Felt downhearted and blue | 1183 | 2.02 | .92 | 1182 | 1.78 | .88 |
| 6. Felt worn out | 1183 | 2.75 | .93 | 1183 | 2.48 | .95 |
| 7. Been a happy person | 1188 | 1.38 | .64 | 1185 | 1.37 | .59 |
| 8. Felt tired | 1181 | 2.98 | .76 | 1186 | 2.79 | .84 |

*Note.* [a]Sample size includes only respondents who experienced intimate violence in their current relationship. [b]Depression: 8-item likert scale (1 = *never*, 2 = *rarely*, 3 = *some of the time*, 4 = *most of the time*) adapted from the *SF-36 Health Survey, Acute Version 1.0* (Medical Outcomes Trust, 1993) in response to "How often in the past week do you/have you..." Items 1, 4, and 7 were recoded so that higher scores represents higher depression.

Table A.10

*Post-Traumatic Stress Disorder Inventory: Descriptive Statistics*[a]

| | Women | | | Men | | |
|---|---|---|---|---|---|---|
| Post-Traumatic Stress Disorder Item[b] | *N* | *M* | *SD* | *N* | *M* | *SD* |
| Intrusion Subscale | | | | | | |
| 1. Reminders brought back feelings about it | 252 | 1.64 | .97 | 138 | 1.40 | .79 |
| 2. I had trouble staying asleep | 250 | 1.37 | .84 | 139 | 1.27 | .75 |
| 3. Other things kept making me think about | 353 | 1.49 | .91 | 137 | 1.34 | .78 |
| 4. I thought about it when I didn't mean to | 252 | 1.44 | .85 | 139 | 1.37 | .80 |
| 5. Pictures about it popped into my mind | 252 | 1.55 | .90 | 137 | 1.35 | .76 |
| 6. I had waves of strong feelings about it | 251 | 1.64 | 1.04 | 138 | 1.53 | .94 |
| 7. I had dreams about it | 252 | 1.23 | .67 | 139 | 1.10 | .46 |
| Hyper-arousal Subscale | | | | | | |
| 8. I felt irritable and angry | 253 | 1.77 | 1.09 | 140 | 1.54 | .91 |
| 9. I was jumpy and easily startled | 252 | 1.45 | .89 | 138 | 1.25 | .69 |
| 10. I found myself acting or feeling like I was back at that time | 251 | 1.29 | .71 | 137 | 1.25 | .69 |
| 11. I had trouble falling asleep | 195 | 1.38 | .88 | 138 | 1.36 | .81 |
| 12. I had trouble concentrating | 252 | 1.42 | .86 | 139 | 1.31 | .75 |
| 13. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea… | 251 | 1.27 | .76 | 138 | 1.12 | .48 |
| 14. I felt watchful and on guard | 251 | 1.49 | .90 | 138 | 1.48 | .96 |

Table A.10

*Continued*

| Post-Traumatic Stress Disorder Item[b] | Women | | | Men | | |
|---|---|---|---|---|---|---|
| | *N* | *M* | *SD* | *N* | *M* | *SD* |
| Avoidance Subscale | | | | | | |
| 15. I avoided letting myself get upset when I thought about it or was reminded | 248 | 1.66 | 1.01 | 137 | 1.58 | 1.02 |
| 16. I felt it hadn't happened or wasn't real | 247 | 1.30 | .74 | 136 | 1.20 | .58 |
| 17. I stayed away from reminders about it | 250 | 1.54 | .97 | 139 | 1.47 | .99 |
| 18. I tried not to think about it | 251 | 1.68 | 1.12 | 138 | 1.43 | .90 |
| 19. I was aware that I had a lot of feelings about it, but I didn't deal with them | 251 | 1.59 | .99 | 138 | 1.47 | .87 |
| 20. My feelings about it were kind of numb | 250 | 1.61 | 1.01 | 136 | 1.35 | .78 |
| 21. I tried to remove it from my memory | 252 | 1.73 | 1.12 | 138 | 1.53 | 1.00 |

*Note*. [a]Sample size includes only respondents who experienced intimate violence in their current relationship. [b]Post-traumatic stress disorder: 21-item likert scale (1 = *not at all*, 2 = *a little bit*, 3 = *moderately*, 4 = *quite a bit*), adapted from the *Impact of Event Scale* (Weiss & Marmar, 1997), in response to "Thinking about the violence you have experienced by your current husband/wife/partner, please tell me how much these difficulties bothered you in the past seven days." Only asked to respondents who reported experiencing physical/sexual assault.

Table A.11

*Cluster Analyses Groupings for Women (N = 4772)* [a]

| | Total Sample | | First Half | | Second Half | |
|---|---|---|---|---|---|---|
| Cluster Groupings | Range | *N* | Range | *N* | Range | *N* |
| Two Cluster Groups | | | | | | |
| Low coercive control | 1 – 4 | 1023 | 1 – 4 | 523 | 1 – 4 | 500 |
| High coercive control | 5 – 14 | 118 | 5 - 11 | 52 | 5 – 14 | 66 |
| | *M* | *SD* | *M* | *SD* | *M* | *SD* |
| Cluster number of cases | 1.10 | .30 | 1.09 | .85 | 1.88 | .32 |
| Cluster center distance | .84 | .63 | .29 | .62 | .83 | .64 |
| Three Cluster Groups | | | | | | |
| Low coercive control | 1 – 3 | 951 | 1 – 3 | 485 | 1 – 3 | 466 |
| Med coercive control | 4 – 7 | 163 | 4 – 7 | 76 | 4 – 7 | 87 |
| High coercive control | 8 – 14 | 27 | 8 – 11 | 14 | 8– 14 | 13 |
| | *M* | *SD* | *M* | *SD* | *M* | *SD* |
| Cluster number of cases | 1.19 | .45 | 1.29 | .65 | 1.87 | .66 |
| Cluster center distance | .65 | .42 | .69 | .38 | .40 | .45 |
| Four Cluster Groups [b] | | | | | | |
| Low coercive control | 1 – 3 | 951 | NA | NA | NA | NA |
| Med-Low control | 4 – 7 | 163 | NA | NA | NA | NA |
| Med-High control | 8 – 11 | 26 | NA | NA | NA | NA |
| High coercive control | 12 – 14 | 1 | NA | NA | NA | NA |
| | *M* | *SD* | *M* | *SD* | *M* | *SD* |
| Cluster number of cases | 1.21 | .55 | NA | NA | NA | NA |
| Cluster center distance | .65 | .40 | NA | NA | NA | NA |

*Notes.* [a]Total sample size. Missing values: *No Intimate Violence* (*N* = 2246) *Violence by Others* (*N* = 1326), and *Don't Know/Refused/Missing* (*N* = 10). [c]Split-half analyses were not conducted due to the small number of individuals in the fourth cluster. *No Coercive Control* group (*N* = 49) not included in the cluster analysis.

Table A.12

*Cluster Analyses Groupings for Men (N =5868)* [a]

| | Total Sample | | First Half | | Second Half | |
|---|---|---|---|---|---|---|
| Cluster Groupings | Range | *N* | Range | *N* | Range | *N* |
| Two Cluster Groups | | | | | | |
| Low coercive control | 1 – 4 | 1052 | 1 – 4 | 514 | 1 – 4 | 538 |
| High coercive control | 5 – 16 | 108 | 5 – 14 | 56 | 4 – 14 | 52 |
| | *M* | *SD* | *M* | *SD* | *M* | *SD* |
| Cluster number of cases | 1.91 | .29 | 1.90 | .30 | 1.09 | .28 |
| Cluster center distance | .83 | .68 | .84 | .62 | .83 | .74 |
| Three Cluster Groups | | | | | | |
| Low coercive control | 1 – 3 | 981 | 1 – 4 | 481 | 1 – 3 | 500 |
| Med coercive control | 4 – 8 | 167 | 5 – 10 | 83 | 4 – 8 | 84 |
| High coercive control | 9 – 16 | 12 | 11 – 16 | 6 | 9 – 16 | 6 |
| Cluster number of cases | 1.87 | .37 | 2.09 | .30 | 1.16 | .39 |
| Cluster center distance | .69 | .47 | .82 | .56 | .66 | .48 |
| Four Cluster Groups [c] | | | | | | |
| Low coercive control | 1 – 2 | 875 | NA | NA | NA | NA |
| Med-Low control | 3 – 5 | 217 | NA | NA | NA | NA |
| Med-High control | 6 – 10 | 63 | NA | NA | NA | NA |
| High coercive control | 11 – 16 | 5 | NA | NA | NA | NA |
| | *M* | *SD* | *M* | *SD* | *M* | *SD* |
| Cluster number of cases | 1.88 | .49 | NA | NA | NA | NA |
| Cluster center distance | .50 | .32 | NA | NA | NA | NA |

*Notes.* [a]Total sample size. Missing values: *No Intimate Violence* (*N* = 2380), *Violence by Others* (*N* = 2297), and *Don't Know/Refused/Missing* (*N* = 3). [b]Split-half analyses were not conducted due to the small number of individuals in the fourth cluster. *No Coercive Control* group (*N* = 28) not included in the cluster analysis.

Table A.13

*Intimate Violence Variables: Descriptive Statistics*[a]

| Variables | Women | | Men | |
|---|---|---|---|---|
| | *N* | % | *N* | % |
| Type of Violence | | | | |
| No intimate violence | 2246 | 47.1% | 2380 | 40.5% |
| Coercive control only | 925 | 19.4% | 1037 | 17.7% |
| Physical/sexual assault only | 40 | .8% | 22 | .4% |
| Both coercive and physical | 205 | 4.3% | 114 | 1.9% |
| Violence by other | 1326 | 28.0% | 2297 | 39.2% |
| Level of Coercive Control[b] | | | | |
| No intimate violence | 2246 | 47.1% | 2380 | 40.5% |
| No coercive control | 40 | .8% | 22 | .4% |
| Low coercive control | 1015 | 21.3% | 1043 | 17.8% |
| High coercive control | 115 | 2.4% | 108 | 1.8% |
| Violence by Other | 1326 | 28.0% | 2297 | 39.2% |
| Severity of Physical/Sexual Assault | | | | |
| No intimate violence | 2246 | 47.1% | 2380 | 40.5% |
| No physical assault | 925 | 19.4% | 1037 | 17.7% |
| Minor physical assault | 157 | 3.3% | 77 | 1.3% |
| Severe physical assault (or both) | 88 | 1.8% | 59 | 1.0% |
| Violence by other | 1326 | 28.0% | 2297 | 39.2% |

*Note.* [a]Total sample size for women ($N = 4772$) and men ($N = 5868$) reduced due to missing values for women ($N = 30$) and men ($N = 18$). [b]Level of coercive control determined by cluster analysis of total number of coercive control behaviors summed from 26 (0 = *no*, 1 = *yes*) questions adapted from the *Canadian Violence Against Female Survey* (Statistics Canada, 1994).

Table A.14

*Women's (N = 4772) and Men's (N = 5868) Imminent Harm, Physical Assault, and Background Variables: Correlations*[a]

| Variables | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Gender[b] | W/M | W/M | W/M | W/M | W/M | W/M | W/M | W/M | W/M | W/M | W/M |
| 1. Depress[c] | _ / _ | | | | | | | | | | |
| 2. PTSD[d] | .29/.31 | _ / _ | | | | | | | | | |
| 3. Control[e] | .30/.24 | .44/.55 | _ / _ | | | | | | | | |
| 4. Severity[f] | .28/.21 | .29/.48 | .82/.82 | _ / _ | | | | | | | |
| 5. Frequency[g] | .14/.15 | .34/.29 | .39/.60 | .44/.74 | _ / _ | | | | | | |
| 6. Range[h] | .25/.19 | .40/.50 | .74/.76 | .91/.92 | .56/.80 | _ / _ | | | | | |
| 7. Years[i] | -.07/-.05 | -.16/ ns | -.08/-.14 | -.08/-.12 | ns /-.09 | -.08/-.12 | _ / _ | | | | |
| 8. Age | -.08/-.05 | ns /-.18 | -.08/-.15 | -.09/-.14 | ns /-.12 | -.10/-.14 | .83/.82 | _ / _ | | | |
| 9. Education[j] | -.13/-.11 | ns /-.24 | -.11/-.10 | -.10/-.08 | -.04/-.06 | -.10/-.06 | -.15/-.04 | -.09/ ns | _ / _ | | |
| 10. Income[k] | -.12/-.15 | ns / ns | -.05/-.08 | -.05/-.06 | ns /-.04 | -.06/-.05 | -.04/.05 | ns /.07 | .35/.42 | _ / _ | |
| 11. Health[l] | -.34/-.32 | -.17/ ns | -.14/-.04 | -.12/ ns | -.08 / ns | -.11 / ns | -.15/-.16 | -.16/-.19 | .27/.25 | .21/.23 | _ / _ |

*Note.* [a]Total sample size. Analysis size varied due to pairwise deletion. [b]W = *Women*, M = *Men*. [c]Depression: 8-item likert scale (1 = *never*, 2 = *rarely*, 3 = *some of the time*, 4 = *most of the time*) adapted from the *SF-36 Health Survey, Acute Version 1.0* (Medical Outcomes Trust, 1993). [d]Post-traumatic stress disorder: 21-item likert scale (1 = *not at all*, 2 = *a little bit*, 3 = *moderately*, 4 = *quite a bit*), adapted from the *Impact of Event Scale* (Weiss & Marmar, 1997). Only asked to respondents who reported experiencing physical/sexual assault. [e]Total number of coercive control behaviors: summed from 26 (0 = *no*, 1 = *yes*). [f]Severity of physical/sexual assault: 0 = *no intimate violence*, 1 = *no physical/sexual assault*, 2 = *minor*, 3 = *severe (or both)*. [g]Number of times physically/sexually assaulted by partner. [h]Number of different physical/sexual assault behaviors used. [i]Years lived together. [j]Education level: 0 = *no school*, 1 = *1st through 8th grade*, 2 = *some high school*, 3 = *high school graduate*, 4 = *some college*, 5 = *four year college degree*, 6 = *post graduate work*. [k]Respondent income level: 0 = *none*, 1 = *$2,500*, 2 = *$7,500*, 3 = *$12,500*, 4 = *$17,500*, 5 = *$22,500*, 6 = *$30,000*, 7 = *$42,500*, 8 = *$65,000*, 9 = *$90,000*, and 10 = *$100,000*. [l]General overall health: 1 = *poor*, 2 = *fair*, 3 = *good*, 4 = *very good*, 5 = *excellent*.

[ns]Non-significant result. All values displayed were significant at the .05 level.

Table A.15

*Hierarchical Linear Regression Analysis for Variables Predicting Depression*[a, b]

| | Model 1 | | Model 2 | | Model 3 | | Model 4 | |
|---|---|---|---|---|---|---|---|---|
| Variable | *B* | *SE B* | *B* | *SE B* | *B* | *SE B* | *B* | *SE B* |
| Gender[c] | W / M | W / M | W / M | W / M | W / M | W / M | W / M | W / M |
| Control[d] | .08/.06 | .01/.01 | .06/.06 | .01/.01 | - | - | - | - |
| Severity[e] | - | - | - | - | .18/.15 | .01/.01 | .15/.14 | .01/.01 |
| Years[f] | | | -.01/-.01 | .00/.00 | | | -.01/-.01 | .00/.00 |
| Educ[g] | | | ns / ns | ns / ns | | | ns / ns | ns / ns |
| Income[h] | | | ns / -.00 | ns / .00 | | | ns /.00 | ns / .00 |
| Health[i] | | | -.15/-.12 | .01/.01 | | | -.15/-.12 | .01/.01 |
| $R^2$ | .08 / .06 | | .18 / .14 | | .07 /.04 | | .17 / .12 | |
| $F_{change}$ | 238.41 / 178.34 | | 80.18 / 66.84 | | 189.92 / 125.48 | | 82.31 / 66.68 | |

*Note*. [a]Analysis size for severity ($N_W$ = 2590; $N_M$ = 2582) and control ($N_W$ = 2604; $N_M$ = 2863) models varied due to listwise deletion and missing values. [b]Depression: 8-item likert scale (1 = *never*, 2 = *rarely*, 3 = *some of the time*, 4 = *most of the time*). [c]Gender: W = *Women*, M = *Men*. [d]Total number of coercive control behaviors summed from 26 (0 = *no*, 1 = *yes*) questions. [e]Severity of physical/sexual assault: 0 = *no intimate violence*, 1 = *no physical/sexual assault*, 2 = *minor*, 3 = *severe (or both)*. [f]Years lived together. [g]Education level: 0 = *no school*, 1 = *1st through 8th grade*, 2 = *some high school*, 3 = *high school graduate*, 4 = *some college*, 5 = *four year college degree*, 6 = *post graduate work*. [h]Respondent income level: 0 = *none*, 1 = *$2,500*, 2 = *$7,500*, 3 = *$12,500*, 4 = *$17,500*, 5 = *$22,500*, 6 = *$30,000*, 7 = *$42,500*, 8 = *$65,000*, 9 = *$90,000*, and 10 = *$100,000*. [i]General overall health: 1 = *poor*, 2 = *fair*, 3 = *good*, 4 = *very good*, 5 = *excellent*. [ns]Non-significant result. All values displayed were significant at the .05 level.

Table A.16

*Hierarchical Linear Regression Analysis for Variables Predicting PTSD*[a, b]

| | Model 1 | | Model 2 | | Model 3 | | Model 4 | |
|---|---|---|---|---|---|---|---|---|
| Variable | *B* | *SE B* | *B* | *SE B* | *B* | *SE B* | *B* | *SE B* |
| Gender[c] | W / M | W / M | W / M | W / M | W / M | W / M | W / M | W / M |
| Control[d] | .31/.28 | .04/.04 | .30/.26 | .04/.04 | - | - | - | - |
| Severity[e] | - | - | - | - | 1.12/1.64 | .28/.27 | .99/1.57 | .29/.27 |
| Years[f] | | | ns / ns | ns / ns | | | ns / ns | ns / ns |
| Educ[g] | | | ns /-.24 | ns /.12 | | | ns /-.28 | ns /.12 |
| Income[h] | | | ns / ns | ns / ns | | | ns / ns | ns / ns |
| Health[i] | | | ns / ns | ns / ns | | | ns / ns | ns / ns |
| $R^2$ | .21 / .29 | | .24 / .32 | | .07 / .23 | | .10 / .30 | |
| $F_{change}$ | 58.06 / 51.60 | | ns / ns | | 15.95 / 36.03 | | ns / 2.77 | |

*Note.* [a]Analysis size for severity ($N_W$ = 207 $N_M$ = 121) and control ($N_W$ = 217; $N_M$ = 127) varied due to listwise deletion and missing values. [b]Post-traumatic stress disorder: 21-item likert scale (1 = *not at all*, 2 = *a little bit*, 3 = *moderately*, 4 = *quite a bit*). [c]Gender: W = *Women*, M = *Men*. [d]Total number of coercive control behaviors summed from 26 (0 = *no*, 1 = *yes*) questions. [e]Severity of physical/sexual assault: 0 = *minor*, 1 = *severe (or both)*. [f]Education level: 0 = *no school*, 1 = *1st through 8th grade*, 2 = *some high school*, 3 = *high school graduate*, 4 = *some college*, 5 = *four year college degree*, 6 = *post graduate work*. [g]Respondent income level: 0 = *none*, 1 = *$2,500*, 2 = *$7,500*, 3 = *$12,500*, 4 = *$17,500*, 5 = *$22,500*, 6 = *$30,000*, 7 = *$42,500*, 8 = *$65,000*, 9 = *$90,000*, and 10 = *$100,000*. [h]General overall health: 1 = *poor*, 2 = *fair*, 3 = *good*, 4 = *very good*, 5 = *excellent*.

[ns]Non-significant result. All values displayed were significant at the .05 level.

Table A.17

*Hierarchical Logistic Regression Analysis for Variables Predicting Fear of Partner*[a, b]

| | Model 1 | | Model 2 | | Model 3 | | Model 4 | |
|---|---|---|---|---|---|---|---|---|
| Variable | *SE B* | $e^B$ | *SE B* | $e^B$ | *SE B* | $e^B$ | *SE B* | $e^B$ |
| Gender[c] | W / M | W / M | W / M | W / M | W / M | W / M | W / M | W / M |
| Control[d] | .05/.06 | 1.86/1.69 | .05/.06 | 1.89/1.72 | - | - | - | - |
| Severity[e] | - | - | - | - | .14/.17 | 4.28/4.31 | .15/.18 | 4.42/4.39 |
| Years[f] | | | ns / ns | ns / ns | | | ns / ns | ns / ns |
| Educ[g] | | | ns / ns | ns / ns | | | ns / ns | ns / ns |
| Income[h] | | | ns / ns | ns / ns | | | .00 / ns | 1.00 / ns |
| Health[i] | | | ns / .20 | ns / .67 | | | ns / .19 | ns / .68 |
| $\chi^2$ | 107.93 / 62.14 | | 117.41 / 71.78 | | 177.26 / 95.03 | | 186.92 / 103.15 | |
| *df* | 1 | | 5 | | 1 | | 5 | |

*Note.* [a]Analysis size for severity ($N_W$ = 2587; $N_M$ = 2847) and control ($N_W$ = 2601; $N_M$ = 2858) varied due to listwise deletion and missing values. [b]Fear of Partner (0 = *no*, 1 = yes). [c]Gender: W = Women, M = Men. [d]Total number of coercive control behaviors summed from 26 (0 = *no*, 1 = *yes*) questions adapted from the *Canadian Violence Against Female Survey* (Statistics Canada, 1994). [e]Severity of physical/sexual assault: 0 = *no intimate violence*, 1 = *no physical/sexual assault*, 2 = *minor*, 3 = *severe (or both).* [f]Education level: 0 = *no school*, 1 = *1st through 8th grade*, 2 = *some high school*, 3 = *high school graduate*, 4 = *some college*, 5 = *four year college degree*, 6 = *post graduate work.* [g]Respondent income level: 0 = *none*, 1 = *$2,500*, 2 = *$7,500*, 3 = *$12,500*, 4 = *$17,500*, 5 = *$22,500*, 6 = *$30,000*, 7 = *$42,500*, 8 = *$65,000*, 9 = *$90,000*, and 10 = *$100,000.* [h]General overall health: 1 = *poor*, 2 = *fair*, 3 = *good*, 4 = *very good*, 5 = *excellent.* [ns]Non-significant result. All values displayed were significant at the .05 level.

Table A.18

*Comparison of Coercive Control Groups on Background Variables*

| Variable | Gender | *No violence*[a] *M (SD)* | *Low control*[b] *M (SD)* | *High control*[b] *M (SD)* |
|---|---|---|---|---|
| Age | Women | 45.53 (14.42)$_j$ | 43.88 (14.63)$_j$ | 40.68 (13.32)$_j$ |
| | Men | 47.74 (14.86)$_k$ | 44.06 (15.20)$_k$ | 39.04 (14.29)$_k$ |
| Years[c] | Women | 22.04 (15.12)$_g$ | 20.47 (14.69)$_g$ | 16.61 (12.80)$_g$ |
| | Men | 20.74 (15.05)$_h$ | 17.54 (14.80)$_i$ | 12.88 (12.60)$_{h,i}$ |
| Education[d] | Women | 3.88 (1.18)$_{l,m}$ | 3.61 (1.15)$_l$ | 3.51 (1.16)$_m$ |
| | Men | 4.05 (1.27)$_{n,o}$ | 3.78 (1.30)$_n$ | 3.71 (1.24)$_o$ |
| Income[e] | Women | 23.6 (22.2)$_{p,q}$ | 21.7 (19.5)$_p$ | 18.6 (17.8)$_q$ |
| | Men | 41.8 (25.1)$_r$ | 38.0 (25.8)$_r$ | 37.1 (26.6) |
| Health[f] | Women | 3.92 (1.02)$_s$ | 3.66 (1.04)$_s$ | 3.44 (1.12)$_s$ |
| | Men | 3.80 (1.04)$_t$ | 3.69 (1.06)$_t$ | 3.78 (.99) |

*Note*. [a]No intimate violence (i.e. no coercive control or physical/sexual assault). [b]Categories derived from cluster analysis of total number of coercive control behaviors. [c]Number of years lived together. [d]Education level: 0 = *no school*, 1 = *1st through 8th grade*, 2 = *some high school*, 3 = *high school graduate*, 4 = *some college*, 5 = *four year college degree*, 6 = *post graduate work*. [e]Respondent income level (in thousands): 0 = *none*, 1 = *$2,500*, 2 = *$7,500*, 3 = *$12,500*, 4 = *$17,500*, 5 = *$22,500*, 6 = *$30,000*, 7 = *$42,500*, 8 = *$65,000*, 9 = *$90,000*, and 10 = *$100,000*. [f]General overall health: 1 = *poor*, 2 = *fair*, 3 = *good*, 4 = *very good*, 5 = *excellent*. Means with a common subscript differed significantly ($p < .05$) based on a One-Way ANOVA with contrasts.

Table A.19

*Comparison of Coercive Control Groups on Outcome and Physical Assault Variables*

| Variable | Gender | *No violence*[a] *M (SD)* | *Low control*[b] *M (SD)* | *High control*[b] *M (SD)* |
|---|---|---|---|---|
| Depression[c] | Women | 1.80 (.46)$_i$ | 2.06 (.50)$_i$ | 2.37 (.58)$_i$ |
| | Men | 1.70 (.44)$_j$ | 1.88 (.49)$_j$ | 2.12 (.50)$_j$ |
| PTSD[d] | Women | - | 4.01 (1.65)$_k$ | 5.75 (2.26)$_k$ |
| | Men | - | 3.49 (.87)$_l$ | 5.29 (2.12)$_l$ |
| Severity[e] | Women | - | .28 (.45)$_m$ | .54 (.50)$_m$ |
| | Men | - | .33 (.47)$_n$ | .64 (.49)$_n$ |
| Frequency[f] | Women | - | .54 (3.43)$_o$ | 6.66 (16.86)$_o$ |
| | Men | - | .24 (1.32)$_p$ | 1.59 (3.41)$_p$ |
| Range[g] | Women | - | .34 (.97)$_q$ | 2.27 (2.56)$_q$ |
| | Men | - | .19 (.76)$_r$ | 1.72 (2.32)$_r$ |

*Note*. [a]No intimate violence (i.e. no coercive control or physical/sexual assault). [b]Categories derived from cluster analysis of total number of coercive control behaviors. [c]Depression: 8-item likert scale (1 = *never*, 2 = *rarely*, 3 = *some of the time*, 4 = *most of the time*).. [d]Post-traumatic stress disorder: 21-item likert scale (1 = *not at all*, 2 = *a little bit*, 3 = *moderately*, 4 = *quite a bit*). [e]Severity of physical/sexual assault: 0 = *minor*, 1 = *severe (or both)*. [f]Number of times physically/sexually assaulted by partner. [g]Number of different physical/sexual assault behaviors used. Means with a common subscript differed significantly ($p < .05$) based on a One-Way ANOVA with contrasts.

Table A.20

*Comparison of Coercive Control Groups on Perceived Fear of Partner*

| | | *No violence*[a] | | *Low control*[b] | | *High control*[b] | | Total | |
|---|---|---|---|---|---|---|---|---|---|
| Fear[c] | Gender | *N* | *%* | *N* | *%* | *N* | *%* | *N* | *%* |
| Yes | Women | 4 | .2 | 24 | .3 | 31 | 27.2 | 59 | .7 |
| | Men | 6 | .2 | 10 | .9 | 20 | 18.5 | 36 | .1 |
| No | Women | 2236 | 99.8 | 1027 | 97.7 | 83 | 72.8 | 3346 | 98.3 |
| | Men | 2359 | 99.8 | 1055 | 99.1 | 88 | 81.5 | 3502 | 98.9 |
| Total | Women | 2240 | 65.8 | 1051 | 30.9 | 114 | 3.3 | 3405 | 100 |
| | Men | 2365 | 66.8 | 1065 | 30.1 | 108 | 3.1 | 3538 | 100 |

*Note*. [a]No intimate violence (i.e. no coercive control or physical/sexual assault).

[b]Categories derived from cluster analysis of total number of coercive control behaviors.

[c]Perceived fear of partner: 0 = *no*, 1 = *yes*. Percentages within each group are based on the number of respondents who answered within that group.