Published in final edited form as:

Violence Vict. 2014 December 1; 29(6): 940–951. doi:10.1891/0886-6708.VV-D-12-00136.

The Occurrence of Female-to-Male Partner Violence Among Male Intimate Partner Violence Offenders Mandated to Treatment: A Brief Research Report

Cory A. Crane*,

University at Buffalo, SUNY

Samuel W. Hawes,

University of Pittsburgh Medical Center

Dolores Mandel, and

Yale University

Caroline J. Easton

Rochester Institute of Technology

Abstract

Little is known about the perceived perpetration of female-to-male intimate partner violence by victims of male offenders mandated to treatment. Sixty-eight male perpetrators of partner violence completed measures of dyadic violent and aggressive responding at intake and at a 12 week follow-up. Approximately 20% of male offenders reported partner violence perpetration and 30% reported victimization with bi-directional violence as the most common configuration of couple violence. Maladaptive responses to conflict were prevalent across partners. Significant and highly correlated reductions in aversive behaviors were detected across the assessment period for both males and their female partners. Results are interpreted within the context of motivational models of female-to-male partner violence and current treatment approaches.

Keywords

Male to female intimate partner violence; female to male intimate partner violence; response to conflict; domestic violence intervention

The Centers for Disease Control and Prevention recognize physical violence, which includes minor and severe acts of force that are implemented with the intention of causing harm, as a form of intimate partner violence (IPV) perpetrated by males against females (MFPV) and by females against males (FMPV) within the context of sexually or romantically involved relationships (Saltzman, Fanslow, McMahon, & Shelley, 2002). Research has consistently shown that females perpetrate minor acts of physical aggression at equal or greater frequency than males while males perpetrate severe and injurious violence more frequently than females (Archer, 2000; Swan, Gambone, Caldwell, Sullivan, & Snow, 2008). It has

*Corresponding Author. Cory A. Crane, Ph.D., Tel.: +1 716-887-2218, Fax: +1 716-887-2510, ccrane@ria.buffalo.edu.

further been established that a large percentage of partner violence is bi-directional in nature, with both partners perpetrating acts of physical violence (E.g. Archer, 2000; Schafer, Caetano, & Clark, 1998; Straus, 2008). IPV victimization has been associated with significant physical, psychological, and interpersonal consequences among both male and female victims (Coker, Davis, & Arias, 2002). Still, little is known about the occurrence of or changes in FMPV, a risk factor for MFPV victimization, among partners of violent males engaged in treatment for domestic violence. The present investigation examines reports of MFPV and FMPV within the partnerships of treatment mandated male domestic violence offenders prior to and at the conclusion of treatment.

A review conducted by Swan and colleagues (2008) reported that FMPV is often motivated by defense, fear, control, or retribution related cognitions. The review further reported that, regardless of motivation, women suffer greater negative effects, such as increased relationship distress and reduced relationship satisfaction, from victimization than do their male partners. It is possible that heightened female distress may result from being victimized by more severe physical violence than males. Nevertheless, the co-occurring nature of IPV puts female victims at greater risk as provocation in general, and FMPV in particular, has been shown to increase the likelihood of MFPV (Archer, 2000; Eckhardt, 2007; Swan et al., 2008). Exploration of the association between MFPV and FMPV has further revealed that violent women are at greater risk for more frequent and severe victimization than non-violent women (Whitaker, Haileyesus, Swahn, & Saltzman, 2007).

Indeed, FMPV is common within samples of treatment seeking male offenders. Wupperman and colleagues (2009) recently collected reports of FMPV from 75 alcohol dependent male partner violence offenders who had been mandated to treatment through criminal diversion. The researchers found that males reported significantly fewer acts of FMPV compared to their female partners. Twenty-three percent of male participants reported minor victimization and 19% reported severe victimization. Greater than 50% of female partners reported perpetrating minor and severe physical aggression towards a male partner during the reference period. Thus, participant reports placed the rate of FMPV in the forensic sample of male IPV offenders at roughly 20- 50%. Roberts-Williams and colleagues (2008) examined 31 published studies to conclude that rates of FMPV ranged from 13-68% of female partners. Whitaker and colleagues (2007) reported that reciprocal partner violence was associated with greater injury to both partners, suggesting that high rates of FMPV among male offenders may reflect the perpetration of severe violence that is more likely to precipitate legal involvement.

Longitudinal analyses have provided initial support for the association between MFPV and FMPV over time. Field and Caetano (2003) examined nationally representative, multistage surveys and reported that across ethnic samples, MFPV and FMPV frequently co-occurred and were longitudinal predictors of subsequent partner violence. Another investigation demonstrated that the presence of defensive FMPV predicted later separation or divorce (Jacobson, Gottman, Gortner, Berns, Shortt, 1996). Additionally, one study concluded that MFPV predicted both MFPV and bi-directional IPV at a 5 year follow-up (Field & Caetano, 2005). As indicated by the research described above, MFPV seems to share associations with both concurrent and subsequent FMPV. Thus, treatment approaches designed to reduce

MFPV over a short intervention period may benefit from a greater understanding of female to male aggression within the dyad. There have been no evaluations of rapid, congruent change in MFPV and FMPV over a brief (e.g., treatment) period.

The current study represents an effort to replicate and expand upon previous results that indicate high rates of FMPV among male IPV offenders by evaluating concurrent changes in MFPV and FMPV over a 12-week treatment period. We examined male reports, as a more conservative indicator of FMPV than female reports, at intake and again after 12 weeks. We used two separate, validated self-report measures to detect rates of aggression and reductions in both MFPV as well as FMPV. Given the association between MFPV and FMPV observed across previous investigations, we hypothesized that male participants would report 1) comparable rates of MFPV and FMPV at both the baseline and follow-up assessment periods and 2) associated changes in MFPV and FMPV over time.

Method

Participants

All male offenders with domestic violence and substance use charges were referred from the New Haven domestic violence court for criminal diversion to a domestic violence clinic associated with Yale University between January, 2007 and January 2008. The 77 eligible male participants recruited from this sample of offenders had been charged with a domestic violence offense toward an intimate partner over the previous year, were diagnosed with a substance use disorder, were over the age of 18, and failed to endorse items related to suicide, homicide, and psychotic symptoms. Nine participants failed to complete initial assessment measures, resulting in a final sample of 68. Participants were between 22 and 57 years of age ($M = 39.13$, $SD = 8.71$) and self-identified as Caucasian (45.7%), African American (35.7%), Hispanic (12.9%), and other (1.4%). Fifty-four participants (77.1%) reported having completed high school and 50 (71.4%) were employed full time, 8 (11.4%) were employed part-time, and 10 (14.3%) reported that they were unemployed or underemployed. On average, participants self-reported 1.68 ($SD = 6.06$) convictions prior to their involvement in the study. Participants had frequent contact with their partners, seeing them an average of 49.17 days ($SD = 38.44$ days) for 3.41 hours ($SD = 2.95$) per day over the assessment period.

Procedure

Prospective participants reported to the clinic at a prescheduled time and underwent an intake interview as part of an existing treatment evaluation process. All eligible clients were contacted within seven days of the intake interview, given information about the study, and asked if they would like to participate. Those who agreed were instructed to return to the clinic for the completion of baseline measures. Upon returning for the second appointment, each participant provided informed consent before completing a series of self-report assessment measures, including a demographic form and two IPV measures. At the end of the baseline evaluation session, participants were thanked for their time, and scheduled for their first of twelve weekly treatment sessions. Participants received reminder telephone

calls prior to each session. Both IPV scales were re-administered twelve weeks after the initial intake session.

Measures

Several measures are available to assess the quantity, frequency, and severity of IPV perpetration and victimization. We administered two self-report scales to broadly assess the occurrence of victimization and maladaptive conflict resolution strategies within the current sample of convicted IPV offenders.

We utilized the widely-used and well validated Revised Conflict Tactics Scale (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) to assess relationship aggression and victimization. The CTS2 is a 78-item inventory that is divided equally between victimization and perpetration items. Male participants were instructed to rate the frequency with which they had experienced various behavioral responses to conflict from and perpetrated against an intimate partner over the previous month. Participants responded to each item using a Likert-scale in which they indicated if either partner had implemented each behavior: 0 = never or not in the month, 1 = once, 2 = twice, 3 = 3-5 times (coded as 4 times), 4 = 4-10 times (coded as 8 times), 5 = 11-20 times (coded as 15 times), and 6 = more than 20 (coded as 25 times) in the past month. The measure produces five subscale scores, including physical violence (12 items), injury (6 items), psychological aggression (8 items), sexual coercion (7 items), and prosocial negotiation (6 items). In the current study, we examined male reports of the dyad's violent and aggressive behavior using scores for MFPV (perpetration items) and FMPV (victimization items). The subscales demonstrated good internal consistency at both baseline ($\alpha = .53-.83$) and follow-up ($\alpha = .88-.92$).

We administered a second self-report measure that has demonstrated good psychometric properties, the Response to Conflict Scale (RTC; Birchler & Fals-Stewart, 1994). The 24-item measure is a rapid assessment instrument with 12 items designed to assess male and 12 items to assess female behavior on 2 subscales of maladaptive responses to conflict: active aggression (7 items such as "hitting," "swearing," and "criticizing") and passive aggression (5 items such as "ignoring," "leaving the scene," and "crying"). Responses were made on a 5-point Likert-scale ranging from occurring "never" to occurring "always" when problems arose in a romantic relationship over the previous week. The total score was derived by summing the two subscales. Internal consistency was high for the active ($\alpha = .92, .90$), passive ($\alpha = .73, .92$), and total scales ($\alpha = .91, .93$) at both intake and follow-up.

Results

FMPV

MFPV occurred frequently in the current sample. Males reported that 19 (28.4%) female partners had perpetrated minor acts of violence, 6 (9.0%) used severe violence, and 42 (70.9%) had engaged in active responding to conflict. Minor acts of FMPV reported by male participants on the CTS2 occurred infrequently at both intake ($M = 1.07, SD = 2.56$) and follow-up ($M = 0.12, SD = 0.41$). Severe FMPV, compared to minor, was less common at time 1 ($t(66) = 3.17, p = .02$) and equally unlikely at time 2 ($t(41) = 1.00, p = .32$). Males

reported experiencing active maladaptive conflict resolution strategies implemented by female partners at both intake ($M = 5.03$, $SD = 5.99$) and follow-up ($M = 1.43$, $SD = 2.45$). Reductions in FMPV were observed across assessment periods in minor aggression, $t(41) = 2.55$, $p = .02$, severe aggression, $t(41) = 2.08$, $p = .04$, psychological responding, $t(41) = 2.87$, $p < .01$, and active responding, $t(37) = 3.88$, $p < .01$ (See Table 1).

MFPV

According to CTS2 reports, 14 (20.9%) males reported perpetrating minor acts of violence, 6 (9.0%) reported perpetrating severe physical violence, and 42 (70.1%) had engaged in active responding to conflicts at intake. One (1.4%) participant reported engaging in minor violence, none (0.0%) reported severe violence, and 48 (76.4%) had engaged in active responding to conflict at time 2. Males perpetrated an average of 0.81 ($SD = 3.17$) acts of minor and 0.15 ($SD = 0.53$) acts of severe physical violence at intake and 0.02 ($SD = 0.15$) acts of minor and 0.00 ($SD = 0.00$) acts of severe IPV at follow-up. Males indicated maladaptive active responding to conflict at intake ($M = 3.44$, $SD = 3.83$) and follow-up ($M = 1.45$, $SD = 2.32$).

Males reported significant reductions in psychological aggression, $t(41) = 2.34$, $p = .02$, and marginally significant reductions in physical aggression over time, $t(41) = 1.89$, $p = .07$. Males also reported implementing fewer maladaptive active, $t(39) = 3.05$, $p < .01$, and passive, $t(39) = 3.44$, $p < .01$, responses over the assessment period.

Bi-directional IPV

The majority of participants refused any IPV perpetration or experience over the month prior to intake. Rates of self-reported bi-directional IPV were high among those who reported violence at time 1, meaning that males reported both MFPV and FMPV. Among participants who endorsed violence on individual subscales of the CTS2, 12 (54.54%) participants indicated co-occurring physical violence perpetrated by the female partner, 8 (66.67%) reported co-occurring injury, 40 (80%) endorsed co-occurring psychological aggression, and 4 (50%) reported co-occurring sexual abuse. For participants who endorsed items on the RTC scale, 50 (78.00%) reported co-occurring maladaptive active and 36 (76.60%) indicated co-occurring maladaptive passive responding.

At intake, there was a strong relationship between MFPV and FMPV on the CTS2 subscales of physical ($r = .43$, $p < .01$), injury ($r = .62$, $p < 0.01$), psychological ($r = .83$, $p < .01$), and sexual ($r = .98$, $p < .01$) aggression as well as on the RTC scales of maladaptive active ($r = .71$, $p < .01$) and passive ($r = .59$, $p < .01$) responding (see Table 2). As noted earlier, aggression rarely occurred at time 2; relationships between variables were not examined at the follow-up assessment.

Changes in Partner Violence

MFPV, as indicated by the active responding subscale of the RTC, decreased across the assessment period. Participants also reported reductions in FMPV active responding over time, and passive responding on behalf of both male, $t(39) = 3.44$, $p < .01$, and female, $t(37) = 4.29$, $p < .01$, partners. Female active and passive responding were entered as predictors of

change in a regression analysis predicting male active responding. Males with partners who initially responded to conflict in a maladaptive (Active $\beta = -.42, p = .01$; Passive $\beta = -.34, p = .04$) and later an adaptive (Active $\beta = .01, p = .93$; Passive $\beta = .42, p = .01$) manner evidenced the greatest reductions in violence. These results are presented in Table 3. Males also reported reductions in MFPV over time as evidenced by CTS2 scores but a high proportion of zero values at time 2 precluded analyses.

Discussion

The present study was designed to investigate the quantity, severity, and concurrent changes in MFPV and FMPV within a population of males mandated to treatment for domestic violence offending. Male offenders were surveyed and reported intake prevalence rates of MFPV and FMPV at approximately 20 and 30%, respectively. These rates were consistent with those observed in clinical samples and expectedly higher than those attributed to community samples (Easton, Swan, Sinha, 2000; Schafer, Caetano, & Clark, 1998; Wupperman et al., 2008). Maladaptive, active responding included hitting or yelling at a partner and was detected in the behavior of approximately 70% of both male and female partners. As expected, males who reported partner violence largely described being both perpetrators and victims. Rates of minor and severe physical aggression were comparable across genders with female partners perpetrating minor IPV more often than male participants. Males further reported reductions in adverse behaviors over time across both gender and measure. Results collectively provided support for hypothesis 1 in that rates of MFPV and FMPV were comparable and associated at both assessment points. This was expected as the collective empirical literature supports bidirectional violence as the most common configuration of aggression among violent couples, including those involved in the legal system (Langhinrichsen-Rohling, Selwyn, & Rohling, 2012).

As a group, male participants reported reductions in their use of physical and psychological aggression over time. This was consistent with decreases in FMPV across the same assessment period, providing support for our second hypothesis. Males also reported that both they and their partners significantly reduced maladaptive reactions to conflict over the study period. Greater decreases in male maladaptive responding were associated with female behavioral responses to conflict. Specifically, high rates of female active and passive maladaptive responding at intake and lower ratings of passive responding at follow-up were associated with greater decreases in maladaptive active responding among males. Thus, males with the greatest reductions in aggressive responding to conflict also had partners who initially used maladaptive strategies as well. Passive responding is theoretically similar to avoidant behavior in response to partner aggression. Female partners of males who significantly reduced aggressive, maladaptive responding were more likely to cry or flee from conflict at time 1 and were less likely to do so at time 2, relative to partners of males who failed to decrease their aggressive maladaptive responding. This may be due to a combination of fewer aversive interactions and increased confidence in their male partner's ability to peacefully resolve conflict. Further study would be needed to reach such a conclusion and it is recommended that future investigations evaluate the mechanisms of change among female partners of males in treatment for IPV.

The literature indicates that intervention programs are relatively ineffective at reducing criminal recidivism beyond initial legal intervention and continued monitoring (Babcock, Green, & Robie, 2004). Although the current investigation was not a treatment evaluation study, all offenders were court-mandated to receive a 12-week course of CBT based domestic violence treatment between the study intake session and the 12-week follow-up. Males in the current investigation reported perceiving significant reductions in violence perpetration, victimization, and maladaptive strategies to deal with conflict from baseline to follow-up. Together, the observed reductions in aggression and maladaptive responding across genders indicate that males perceived improvements in behaviors specifically targeted by treatment programs. Not only may male attendees have benefited from treatment as primary consumers of coping and problem solving skills but their partners may have benefitted as well.

The current sample was distinct from most IPV treatment samples described in the literature in that all participants had been identified as problematic substance users. Previous treatment samples have demonstrated considerable overlap between problematic substance use and IPV, with the prevalence of IPV among males seeking treatment for alcohol abuse and dependence exceeding 50% and with substance use problems observed disproportionately among men seeking treatment for IPV perpetration (e.g., Klostermann, 2006; Stuart, 2005; Stuart et al., 2003). Evidence suggests that problematic substance use among males, particularly heavy episodic drinking, is a contributing cause of both MFPV and FMPV (e.g., Eckhardt, 2007; Leonard, 2005; Schafer, Caetano, Cunradi, 2004). Thus, the current sample had a higher prevalence of substance use problems than common IPV treatment seeking samples, which may have exacerbated frequency, severity, and difficulty in the modification of both MFPV and FMPV.

Limitations

Several limitations should be kept in mind when interpreting the current results. First, it was not possible to determine the direction of the relationship between reductions in MFPV and FMPV under the current design. The current findings are consistent with both the course of treatment and existing etiological models that describe motivation for FMPV (e.g. Swan & Snow, 2006). The majority of aggression and maladaptive responding was bi-directional in the current investigation and previous studies have found that when FMPV occurs, it often does so concurrently with MFPV (Hamberger & Guse, 2002; Straus, 2008; Whitaker et al., 2007). The current interventions were designed to provide male offenders with adaptive conflict resolution strategies to reduce their own reliance upon violent and aggressive behaviors. Research shows that FMPV is commonly motivated by a desire to defend oneself or others, act despite emotion dysregulation, reduce or avoid fear, gain or exert control, or enact retribution (Stuart, Moore, Ramsey, & Kahler, 2004; Swan et al., 2008; Swan & Snow, 2006). Reductions in MFPV and improving conflict responses may well have negated many of these motivational influences. It is unlikely that spontaneous reductions in FMPV would have attenuated MFPV.

Second, we attempted to collect collateral reports of violence and maladaptive responding from female partners and received cooperation from fewer than 10% of those contacted.

Sensitivity to legal and emotional limitations prohibited efforts to pursue collateral reports further. Nevertheless, research suggests that males report lower rates of both IPV perpetration and victimization than female partners, making their conservative estimates more rigorous than those gathered by females (Schafer, Caetano, & Clark, 1998; Wupperman, et al., 2009). Furthermore, the perception of FMPV by male offenders is of particular interest in treatment settings and may serve to inform models of cognitive and behavioral change beyond common outcomes such as program completion and recidivism (e.g., Murphy & Eckhardt, 2005). Indeed, motivational enhancement techniques that solicit and validate the offender's victimization experiences, an intervention procedure that requires additional empirical validation, have proven beneficial in reducing recidivism and improving treatment compliance among IPV offenders (Crane & Eckhardt, in press; Murphy & Eckhardt, 2005). Despite these benefits, the use of self-report data among a sample of court mandated offenders introduces the risk of both intentional deception and unintentional false responding due to perceived social expectations, legal pressures, and retrospective errors. It should also be noted that, while MFPV and FMPV largely co-occurred in the current sample, we lacked adequate data (i.e. validity of offender reports, female partner input, historical and motivational factors), to surmise the true nature and type of violence within these relationships. MFPV and FMPV may or may not have occurred within the context of reciprocal interactions and perpetration may or may not have been mutual in terms of severity. Future investigations should replicate the current study and make use of collateral reports from partners as well as legal data.

Conclusion

Both MFPV and FMPV was prevalent within the current sample of male IPV offenders, thus confirming previous reports. Male and female aggression concurrently reduced over the assessment period, which coincided with domestic violence treatment among the male offenders. Thus, the current study has demonstrated associations between both the occurrence of and changes in MFPV and FMPV. Certainly, FMPV is a complex issue and likely contributed to by a combination of factors, including IPV victimization, substance use, childhood experiences, socioeconomic status, social and problem solving skills, and multiple other factors that require further study. The current results emphasize the potential benefit of more traditional, male-only treatment approaches to effect meaningful changes in aggressive and maladaptive behavior among both male and female intimate partners.

Acknowledgments

This research was supported in part by grants from the National Institute of Drug Abuse (RO1 DA018284-01 A1) and K12 DA00167-11. We would also like to thank the State of Connecticut Department of Mental Health and Addiction Services.

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Table 1

Distribution scores and paired sample t-test results of male and female aggression on CTS2 and RTC subscales.

	MFPV		FMPV		FMPV	
	Intake M (SD)	Follow-Up M (SD)	df	t	Intake M (SD)	Follow-Up M (SD)
CTS2						
Physical	0.96(3.30)	0.02(0.15)	41	1.89	1.19(2.71)	0.02(0.15)
Injury	0.33(0.96)	0.00(0.00)	41	2.06*	0.31(0.84)	0.00(0.00)
Psychological	5.67(9.54)	1.38(3.20)	41	2.34*	7.98(16.20)	1.48(3.22)
Sexual	0.58(3.20)	0.60(3.86)	41	0.30	0.63(3.23)	0.60(3.86)
Negotiation	21.51(24.76)	19.00(29.13)	41	0.65	19.30(23.42)	19.55(29.13)
RTC						
Active	3.44(3.83)	1.45(2.32)	39	3.05**	5.03(5.99)	1.43(2.45)
Passive	2.19(2.17)	0.75(1.55)	39	3.44**	2.95(3.34)	0.63(2.12)
Total	5.63(5.51)	2.20(3.50)	39	3.52**	8.02(8.50)	2.05(4.21)

Notes: MFPV = Male to female partner violence, FMPV = Female to male partner violence, CTS2 = Conflict Tactics Scale – Revised, RTC = Reaction to Conflict Scale.

* = $p < .05$

** = $p < .01$

Table 2

Bivariate relationships among male and female aggression and maladaptive responding at time 1.

	1	2	3	4	5	6	7	8	9	10	11	12
1. M. Physical	--	.15	.38**	-.05	.43***	.20	.43***	.28*	.37**	-.03	.33**	.21
2. M. Injury	--	--	.32**	-.06	.30*	.28*	.34**	.62***	.31**	-.03	.29*	.26*
3. M. Psychological			--	-.05	.54***	.34**	.37**	.38**	.83***	-.03	.49***	.34**
4. M. Sexual				--	.19	.19	-.08	-.06	-.05	.98***	.28*	.31*
5. M. RTC Active					--	.67***	.26*	.38**	.56***	.21	.71***	.50***
6. M. RTC Passive						--	.16	.27*	.40**	.21	.60***	.59***
7. F. Physical							--	.23	.36**	-.03	.28*	.36**
8. F. Injury								--	.42***	-.05	.30*	.25
9. F. Psychological									--	-.05	.61***	.40**
10. F. Sexual										--	.29*	.31*
11. F. RTC Active											--	.63***
12. F. RTC Passive												--

Note. M = Male, F = Female, RTC = Response to Conflict Scale.

*
=p .05**
=p .01***
=p .001

Table 3

Regression analysis predicting change in male active maladaptive responding on the RTC from reports of active and passive partner responding at time 1 and time 2.

Variable	Standardized Coefficient	<i>t</i>	<i>p</i>
Time 1			
Partner RTC Active	-0.42	-2.66	.01
Partner RTC Passive	-0.34	-2.10	.04
Time 2			
Partner RTC Active	0.01	0.08	.93
Partner RTC Passive	0.42	2.83	.01

Note. RTC = Response to Conflict Scale.