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Childhood Abuse Types and Adult Relational Violence Mediated by Adult Attachment Behaviors and Romantic Relational Aggression in Couples

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Childhood Abuse Types and Adult Relational Violence
Mediated by Adult Attachment Behaviors and
Romantic Relational Aggression in Couples

Tabitha Nicole Webster

A dissertation submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

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The current study investigated how three distinct types of childhood abuse—witnessing of parental domestic violence, experiencing physical abuse and total in-home violence, and experiencing sexual abuse—predicted partner reports of relational violence through the mediating factors self-perceptions of attachment and partner reports of relational aggression. The study used paired dyadic data from 1,658 couples who had completed the RELATIONship Evaluation (RELATE). The Family Violence, the Brief Accessibility and Responsiveness, Couples Relational Aggression and Victimization, and the Conflict Tactics scales were the measures used. Data was analyzed by using structural equation modeling to estimate an actor-partner interdependence model exploring these relationships. Results showed only female childhood sexual abuse had direct associations with male relational violence; however, several mediating paths were identified.

Keywords: childhood abuse, relational violence, attachment behaviors, relational aggression
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Introduction

Childhood maltreatment (CM) is common and leads to many adverse outcomes. The Center for Disease Control (2016) defines childhood maltreatment as an inclusive term that encompasses “all types of abuse and neglect of a child under the age of 18 by a parent, caregiver, or another person in a custodial role (para. 1).” The types include sexual abuse, physical abuse, emotional abuse (e.g., verbal, physiological, witnessing violence), and neglect. Often, within the literature, various forms of CM are treated as a single entity in predicting outcomes, or one specific type of abuse is isolated in examining a particular outcome. There are only a few studies that compare different types of abuses with each other in their effects on a single outcome: often these are found under the Adverse Childhood Experiences (ACEs) study (Brown et al., 2009; Feletti et al., 1998). This paradigm is rarely explored in academic institutions. It is critical that researchers and clinicians better understand both the similarities and differences about how the types of abuse present. The current study looks to clarify further how the relationships among three specific types of maltreatment—childhood sexual abuse (CSA), childhood physical abuse (CPA) and witnessing domestic violence—predict relational violence in couples. Additionally, I examined how adult attachment behaviors and adult relational aggression may mediate that relationship.

To better understand the effects of CM on relational violence in couples, it is essential to define each of the variables of this study. In 1999 the World Health Organization tried to unify these variations stating:

Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not
developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. (p. 75).

Physical abuse (CPA), on the other hand, has a more agreed upon definition of caregiver inflicted, non-accidental injury of a child (Crosson-Tower, 2005). CPA includes injuries ranging from mild bruising to broken bones and skull fractures, that can result in fatalities (Kolko, 2002). In the literature, witnessing domestic violence is often described as ‘exposure to violence,’ ‘living with violence,’ ‘being exposed to violence’ or ‘being affected by violence’ (Humphreys, 2010; Powell & Murray 2008). This definition can include CPA and community violence (Eitle & Turner, 2002; Finkelhor, Turner, Ormrod, & Hamby, 2009; Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009; Covey, Menard, & Franzese, 2013).

Moreover, the term “witnessing domestic violence” provides a broader description of the traumatizing effects of the physical and verbal elements of viewing adults fight (Kantor & Little, 2003). Witnessing domestic violence is defined legally by each state, and the definitions widely vary and in some cases do not exist (Children Bureau, 2012). The current study defines witnessing domestic violence as witnessing or perceiving violence in the home. The present study uses the self-reported identification of each type of CM from both partners to explore their association with the outcomes of relational and physical violence in the couple relationship.

Relational violence (RV) is defined as physical, sexual, or psychological harm by a current or former partner or spouse. RV is one of the most pervasive and complex public health
problems in the United States (Centers for Disease Control and Prevention, 2009). The current study focuses on physical violence in the relationship. Researchers have identified four types of RV in couples: intimate terrorism, violent resistance, mutual violent control, and situational couple violence (Johnson, 2006; Johnson & Ferraro, 2000). If RV is one-sided, in which the perpetrator is using violence to control and dominate their partner, and the partner does not respond in kind, this is termed intimate terrorism. The other three types of RV involve a combination where both partners engage in violence (Johnson, 2006; Johnson & Ferraro, 2000). This more common form of RV within a couple relationship is reciprocal and involves patterns of unhealthy interaction which contribute to violence (Stith, McCollum, Amanor-Boadu, & Smith, 2012). With relational violence, individuals tend to underreport violence in the relationship (Sugarman & Hotaling, 1997; Cui, Lorenz, Conger, Melby, & Bryant, 2005). The current study uses the partners’ report of the level of physical violence in the relationship, which is often a more accurate depiction of the ongoing relational dynamics.

Though there is an abundance of literature exploring relational violence, only recently has relational aggression received attention in couples research. The most recent literature suggests that romantic relational aggression (RA) may be seen not only as a stepping stone to violence (Oka, Sandberg, Bradford, & Brown, 2014) but also seen as its own relationally dysfunctional process. RA is defined as non-physical, aggressive actions taken by partners toward each other (Coyne et al., 2011; Carroll et al., 2010; Goldstein, Chesir-Teran, & McFaul, 2008). RA can be further described as “behaviors that harm others through damage (or the threat of damage) to relationships or feelings of acceptance, friendship, or group inclusion” (Crick & Grottpeter, 1995, p. 711). RA is reported to occur commonly in romantic relationships, and at
similar rates across gender (Carroll et al., 2010; Linder, Crick, & Collins, 2002). Therefore, RA as nonphysical form of damage may mediate the effects of how physical RV plays out in couples’ dynamics.

Examples of RA include social sabotage (passive aggression, spreading of rumors, gossip, triangulation of a third party, disclosure of personal information to others, intentionally embarrassing a partner in front of others) and love withdrawal (intentionally ignoring a partner, stone-walling, silence treatment, and withholding physical and emotional affection or intimacy) (Carroll et al., 2010; Byrne & Carr, 2000; Busby & Holman, 2009; Gottman, 1994, 1999). RA is different from psychological aggression where the goal is to create or threaten emotional harm and is often direct and overt (e.g., verbal threats, ridiculing, attempting to control partner, isolating from family and friends) (Lawrence et al., 2009; Murphy & Cascarci, 1999). RA is used to harm the relationship and is subtler and indirect (Carroll et al., 2010). As well, various forms of childhood abuse and adult relational aggression have not been considered together. The purpose of this study is to help fill these gaps by considering both relational aggression and attachment as potential mediators between types of childhood maltreatment and adult couple violence.

**Theoretical Foundations**

One theoretical perspective that offers understanding regarding the potential links between childhood maltreatment types, romantic relational aggression, and relational violence in couple relationships is attachment theory (Hazan & Shaver, 1987; Main, Kaplan, Cassidy, 1985; Mikulincer & Shaver, 2007). Adult attachment research has expanded upon the original work of Bowlby and Ainsworth. These authors describe attachment as the emotional bond between
parents and children allowing for a safe base to explore the world and seek refuge in times of distress and discomfort (Bowlby, 1969, 1980; Ainsworth et al., 1967, 1969, & 1978). Mikulincer and Shaver (2007) describe attachment as an “inborn regulatory system” central to “social behavior” and the development of “emotional stability, mental health, and satisfying, close relationships (p. 28).”

The importance of adult attachment has also been summarized, by Bowlby and King (2004), in this way: “A fundamental principle of Attachment Theory is that people of all ages show a preference for one primary attachment figure above all others; this will usually shift from a primary attachment figure… to a romantic partner over time” (p. 17). Hazan and Shaver (1987) were the first to overtly describe the emotional bond that develops between adult partners as functioning through the same motivational system—the attachment behavioral system. They state that the relationship between infants and caregivers and the relationship between adult romantic partners share the same features. Simply stated, the literature has shown attachment is a primary motivator and is central to romantic relationships and human connection (Feeney & Noller, 1990; Mikulincer & Shaver, 2007). Researchers have built on this foundation over time to define, describe, and measure adult attachment styles (Hazan & Shaver, 1990; Mikulincer & Shaver, 2007; Feeney, 2008).

Additionally, Bowlby (1969, 1980) and Ainsworth (1967) describe how certain behaviors link to different attachment styles: secure, avoidant and anxious. Bowlby (1980) states that “accessible and responsive…” behaviors from an attachment figure are essential to foster a secure base (p. 39). A growing number of researchers are now choosing to focus on these behaviors as a means to understand how secure couple relationships are formed (Sandberg,
Novak, Davis, & Busby, 2016). When measuring attachment style, the focus is on the individual’s feelings and beliefs about his/her romantic relationship, whereas in the measurement of attachment behaviors, the focus is on distinct actions carried out in a relationship that promote attachment security (Sandberg, Bradford, & Brown, in press). Among attachment behaviors, accessibility, responsiveness, and engagement seem to be of particular importance (Sandberg et al., 2012). Accessibility can be described as being available in the time of a partner’s need. Responsiveness can be seen as an openness to and reacting in a responsive way to a partner's needs. Engagement is connecting inept and meaningful ways to a partner.

The current study supposes that childhood maltreatment affects the attachment system of the victim, which often has long lasting effects into adulthood. The experiences leading to insecure attachment can lead to attachment related problems in adult romantic relationships (Godbout, Dutton, Lussier, & Sabourin, 2009; Schreiber, & Lyddon, 1998). Poor attachment behaviors may increase the pleas for connection with their partner in dysfunctional ways, like the use of aggression, and possible escalation of relational violence, to negotiate the bids for closeness and connection (Oka, et al., 2014). These unhealthy bids can simply be a form of proximity seeking as described in the attachment literature (Mikulincer & Shaver, 2007).

Thus, attachment theory serves as the theoretical foundation for the current study because it provides a framework which can help explain how and why people connect and disconnect in both childhood and adulthood. Therefore, it is a natural fit for a project that considers both the effects of childhood adversities that cause disruption (Tremblay & Sullivan, 2010; Murphy et al., 2014) and relational aggression and violence in couple relationships (Oka et al., 2014).
Empirical Foundations

There is currently only one study that has investigated adult attachment behaviors and both romantic relational aggression and relational violence in the same study (Oka et al., 2014). The current study will build upon the theoretical and empirical foundation established by Oka’s team. In that study, the authors reported that female reports of insecure attachment behavior predicted higher levels of both male and female aggression and male violence. Likewise, male reports of insecure attachment behaviors predicted higher levels of both male and female aggression and male relational violence. However, the current study will add components relating to family of origin (FOO) adversities to investigate how childhood abuse experiences may affect the relationship among attachment behaviors, romantic relational aggression, and violence in couple relationships.

Whereas, Oka et al. (2014) used a single mediation actor-partner interdependence model, the current study analyzes this dynamic using a serial multiple mediator actor-partner interdependence model. Oka et al. (2014) found both direct and indirect effects of relational aggression as important mediator between attachment behaviors and physical violence. “Insecure attachment behaviors and relational aggression were positively associated with their partner’s physical aggression (Oka et al., 2014, pg.12).” Likewise, “the indirect actor effect of insecure attachment behaviors on their physical aggression was significant (Oka et al., 2014, pg.13). As explained by Hayes (2013), “In a serial multiple mediator model, the assumption of no causal association between two or more mediators is not only relaxed, it is rejected outright a priori.” Therefore, the purpose of the current study is to extend the work of Oka and colleagues to
investigate the direct and indirect effects of different types of CM on adult relational violence within couple relationships.

**Literature Review**

This review of literature will begin by exploring the prevalence rate of overall childhood maltreatment (CM) and the rates of each type of abuse modeled in the analysis, including the societal and economic cost of CM. Next, I explore the definition of romantic relational aggression and theory which attempts to explain this phenomenon. I also review the documented effects of RA on relationships and the research which supports the potential mediating role RA, as related to physical Relational Violence (Oka et al., 2014). I then explore the prevalence rates of RV and the documented effects of both RA and RV. And finally, I summarize and synthesize the research on the research connecting CM, RA and RV.

The current study theorizes adult attachment behaviors and RA both mediate the path toward RV, as was supported in Oka et al. (2014). Therefore, I first both review and discuss the relationship of adult attachment and CM providing an overview of the existing studies of interest. Connecting these pieces, I will explore the literature on AA and its connection to RA and RV, highlighting again this importance as suggested by Oka et al. (2014). As this study explores dyadic couples data I will highlight the research regarding gender differences the relationship of AA and RA and RV. Finally, I will discuss how measuring attachment behaviors, as a way to assess attachment in couples, is supported by a new and rapidly growing body of literature.

**Childhood Maltreatment**

There are many noted effects of childhood maltreatment ranging from psychosocial, physical, interpersonal, and neurobiological. CM is often explored as one variable, yet there is
some literature that examines the different and specific effects of each type of abuse. The research shows startling yet inconsistent rates of its prevalence.

**Prevalence.** In 2012, the Children’s Bureau screened 3.2 million cases of CM. Of those cases, nearly 20% were found to be indicated or substantiated as maltreatment. In 2014, Child Protective Services reported 702,000 unique child victims of CM. Nearly 40% of children with substantiated or indicated cases of maltreatment did not receive any services. These numbers reflect only reported cases of CM, strongly suggesting that underreporting of maltreatment is a concern (Finkelhor & Dziuba-Leatherman, 1994). In 2003, Scher, Forde, McQuiad, and Stein estimated the prevalence of CM in a community sample to be about 30% for females and over 40% for males, with approximately 13% reporting multiple types of maltreatment. In 2009, the CDC analyzed information from 26,229 adults in five states using the 2009 ACE (adverse childhood experiences—these include different types of CM) module of the Behavioral Risk Factor Surveillance System (BRFSS) found nearly 60% of participants had one at least one ACE, with nearly 9% reporting 5 or more ACEs.

Where the research indicates wide ranges of inconsistency in rates for CM, the same holds true for specific types of abuse as well. There has been wide variation reported in prevalence studies, with sexual abuse ranging from 3% to 36% (Finkelhor, 1994). Gorey and Leslie (1997) used a combination of 25 samples to estimate sexual abuse prevalence for females at 22.3% and males at 8.5%. The 2009 CDC study found 6.7% of men and 17.2% of women had experienced at least one incident of sexual abuse.

Similarly, the CDC ACEs study (2009) reported rates of 14.1% of men and 15.4% of women reported at least one incident of physical abuse. In 2013, US Health and Human Services
reported that physical abuse counted for 18% of founded allegations of abuse. Of the founded physical abuse allegations for children under the age of three, 41% died from the abuse. Again, underreporting of CPA is a major concern. MacMillian et al. (1997), trying to account for underreporting, estimated the CPA rate at 21.1% for females and 31.2% for males.

Although, all types of CM are underreported, witnessing domestic violence may be the most widely overlooked. In part, witnessing domestic violence has only recently begun to be investigated as a separate type of CM. Additionally, state by state variations in definition and reporting mandates make CM difficult to track. Underreporting of domestic or intimate partner violence alone is extremely high. Documented accounts of DV by authorities often do not include witnessing domestic violence in their records, even if a child was present (Bartels, 2010; Edleson, 1999; Richards, 2011).

Although it is clear that underreporting of witnessing violence in childhood is a problem, it has been estimated that 15-275 million children witness domestic violence each year (Gil-Gonzalez et al., 2007; Pinheiro, 2006; McDonald, Jouriles, Ramisetty-Milkler, Caetano, & Green, 2006). Early research suggests that nearly half of children interviewed stated they had seen their mother physically assaulted, including an event that involved choking (McCloskey, Figuerdo, &Koss, 1995). Similarly, McGee (2000) found that 71% of his sample of children had witnessed physical assaults in their lives, and 10% had witnessed sexual assaults of their mothers. Other research estimates that 20 to 24% of children under 18 have witnessed an attack on a family member (McDonald, Jouriles, Ramisetty-Milkler, Caetano, & Green, 2006; O’Brien, John, Margolin, & Erel, 1994; Finkelhor, Turner, Ormrod, & Hamby, 2009). The CDC study (2009) found rates of 15.7% of men and 16.9% of women reported at least one incident of
witnessing domestic violence. What is clear is, CM and its specific subtypes happen at alarming rates. Many of the adults have CM as part of their histories. The literature has explored, in depth, the long-term effect of CM histories in adulthood.

**Societal effects.** As the current study looks to examine the adult outcome of relational violence of those with CM histories, it is important to understand what the research generally states about the adult outcomes of CM. These long-term effects of childhood maltreatment are pervasive and vast. Approximately 80% of young adults with childhood maltreatment histories met DSM criteria for at least one psychiatric disorder by age 21 (Silverman, Reinherz, & Giaconia, 1996). CM is also quite costly for both individuals and society. In 2010, the estimated lifetime cost per victim of nonfatal CM was $210,012 (Fang et al., 2012). In that same year, the total lifetime economic burden resulting in new cases of CM in the U.S. was approximately $124 billion, which is costlier than the other main public health concerns such as stroke and Type 2 diabetes (Fang, Brown, Florence, & Mercy, 2012).

**Psychosocial effects.** Some of the documented long-term psycho-social effects of CM include depression, anxiety, eating disorders, substance abuse, self-harm, suicide, post-traumatic stress disorder (PTSD), divorce, marital discord, sexual dysfunction, and interpersonal concerns (Hunter, 2006; Mullen, Martin, Anderson, Romans, & Herbison, 1996; Williamson, 2009). CSA survivors are at an increased risk for mood and substance use disorders (Nelson, Heath, & Madden, 2002), sexual dysfunction (Noll, Trickett, & Putnam, 2003), and interpersonal dysfunction in adulthood (Rumstein-McKean & Hunsley, 2001). A meta-analysis further validates the correlations between CSA and PTSD, depression, suicide, sexual promiscuity, the victim-perpetrator cycle, and academic performance (Paolucci, Genuis, & Violato, 2001).
Furthermore, a longitudinal study by Spataro, Mullen, Burgess, Wells, and Moss (2004) suggests a three times greater risk for anxiety and acute stress disorders and a five-time increased risk for having a personality disorder for those who experienced CSA.

CPA survivors have reported higher levels of PTSD, anxiety, depression, substance abuse and other psychiatric disorders, cognitive or intellectual deficits, social skill deficits, low self-esteem, internalized aggression, risk taking and criminal behavior, externalized aggression and anger, and interpersonal dysfunction (Hoskote et al. 2003; Kolko 2002; Manly, Kim, Rogosch & Cicchetti, 2001; Finzi et al. 2002; Crosson-Tower, 2005; Egeland, Yates, Appleyard, & van Dulmen, 2002; Norman et al., 2012). Additionally, Pompili et al. (2009) found CPA survivors are at a significant risk for suicidal behaviors. Furthermore, adult male alcoholics with CPA histories had higher rates of serious suicide attempts than their non-abused counterparts (Kroll, Stock, & James, 1985). Other researchers have reported similar findings within different clinical and community populations; namely, CPA increases the risk of serious suicide attempts (Dube et al., 2001; Afifi et al., 2008; Ystgaard, Hestetun, Loeb & Mehlum, 2004; Lipschitz, Winegar, Hartnick, Foote & Southwick, 1999; Roy, 2001; Yoder, 1999; Blaauw, Winkel, Arensman, Sheridan & Freeve, 2002; Verona & Sachs-Ericsson, 2005). Moreover, the research has found a strong relationship between CPA and increased victimization of abuse experiences as an adult (Bensley, Van Eenwyk & Wynkoop-Simmon, 2003; Renner & Slack 2006); in part, these experiences can increase the level of violence in the adult survivors’ own home (Sahin, Baloglu, & Unalmis, 2010.)

Witnessing domestic violence likewise has a variety of negative outcomes associated with it, including: substance abuse, psychological dysfunction and poor adjustment, bullying in
schools, post-traumatic stress, depression, anxiety, anti-social behaviors, running away,
prostitution, teenage pregnancy, sexual assaults, low self-esteem, problems in school, lower
verbal abilities, delinquency, criminal behaviors, and animal cruelty (Arbetter, 1995; Baldry,
2003; Edwards, 1992; Kilpatrick & Williams, 1998; McCloskey & Lichter, 2003; Carlson, 1984;
Diamond & Muller, 2004; Hughes, 1988; Maker, Kemmelmeier, & Peterson, 1998; Silvern et al.,
1995; Huth-Bocks, Levendosky, & Semel, 2001; Levendosky & Graham-Bermann, 1998;
Osofsky, 2005; Currie, 2006; Evans, 2008; Agnew, 2002; Kernic et al., 2003). Many of these
issues persist through adulthood (Geffner, Igelman, & Zellner, 2003). Research has also
identified that increased frequency and intensity of witnessing domestic violence is associated
with poorer relational and mental health outcomes (even when fewer than 10 lifetime witnesses
of domestic violence incidences have occurred) including enduring depression symptoms
(Fergusson & Horwood, 1998; Russell, Springer, & Greenfield, 2010). Dube et al., (2001) found
that children who witnessed domestic violence were up to five times more likely to commit
suicide as adults. The literature also suggests that those who witness domestic violence in
childhood have a higher risk for entering abusive relationships themselves in adulthood
(Arbetter, 1995; Miller, Handal, Gilner, & Cross, 1991; Purvin, 2003; Marker et al., 1998.)

Although exact prevalence rates for CM are unknown, it occurs at alarming rates.
Definitions continue to be unclear and underreporting is all too common. CM is clearly related to
broad and varied negative outcomes that are often pervasive in adulthood, affecting biology,
physical and physiological health, and relationships (see appendix A).
**Romantic Relational Aggression and Relational Violence**

Like CM, romantic relational aggression and violence in adulthood is all too common and often underreported. Similarly, research has indicated that there are a variety of negative outcomes when individuals use relational aggression and violence in adulthood. There are several theoretical conceptualizations as to the cause and contributing factors for relational aggression and violence. Feminist theorists suggest that the need for power and dominance is central to relational violence (Straus, 1976; Yllö, 2005). Examining societal and cultural factors provides for another explanation. Examples of this theory include socialization to violence, societal acceptance/tolerance of violence, and poverty (Copenhaver, Lash, & Eisler, 2000). Social learning theory suggests those that witness violence or any repeated behavior are more likely to repeat that behavior. The literature also describes an intergenerational effect of relational violence (Ehrensaft et al., 2003). More recently, researchers have explored a relational/dyadic perspective to relational violence, focusing on the couples’ role, typologies and interactional effects (Bartholomew & Allison, 2006; Johnson, 2008).

It is also important to understand how romantic relational aggression affects relationships. Research suggests that relational aggression is learned in early peer relationships during adolescence and early adulthood and then used with romantic partners in adulthood (Murray-Close, Ostrov, Nelson, Crick, & Coccaro, 2010). Females seem to use and are bothered more by relational aggression than their male counterparts. Females perceive relational aggression to have a greater impact on their relationships and report thinking about and discussing it more than males (Salmivalli & Kaukiainen, 2004). Relational aggression seems to
damage the overall development, formation, and maintenance of relationships (Prinstein, Boegers, & Vernberg, 2001).

Romantic relational aggression is typically conceptualized as a path toward the use of violence or as a unique end point. Currently, there is only minimal support for either conceptualization. A few studies support the idea that relational aggression is part of the path toward the use of violence in adult relationships (Bagner, Storch, & Preston, 2007; White, Smith, Koss, & Figueredo, 2000; Rothbaum, Weisz, Pott, Miyake, & Morelli, 2000). Whereas, Oka et al. (2014) and Wright and Benson (2010) found that relational aggression is associated with relational violence, suggesting that relational aggression can be a unique construct.

**Relational violence prevalence.** Relational violence is, unfortunately, commonplace in many adult relationships. Nationally, RV is estimated to affect up to 21% of couples in any given year (Jose & O’Leary, 2009; Schafer, Caetano, & Clark, 1998). In the United States, up to 25% of women will experience at least one incidence of RV in their lifetime (Breiding, Black, & Ryan, 2008; Tjaden & Thoennes, 2000). Research suggests that physical aggression is relatively stable over time, and RV in adolescent romantic relationships predicts RV in marriages (O’Leary & Slep, 2003; O’Leary et al., 1989). Others have found that one-third of young adults have engaged in RV against their romantic partners (Straus, 2004; Sugarman & Hotaling, 1989). Thus, all genders experience both perpetration and victimization in RV. However, women are more often physically injured by RV. Archer’s (2000) study suggests that women are more often the perpetrators of RV than men. In cases of non-reciprocal violence, women perpetrated more than 70% of the time, but in more than 50% of RV cases, violence was reciprocated within the partnership (Whitaker, Haileyesus, Swann, and Saltzman, 2007).
**Effects.** As previously mentioned, RV has many documented negative outcomes. RV is highly associated with mental and physical health problems, which in turn create a significant burden on the health care system (Rivara et al., 2007; Bonomi et al. 2006; Coker, Weston, Creson, Justice, & Blakeney, 2005). Golding (1999) reports up to 85% of RV survivors meet criteria for PTSD diagnosis. Personality disorders (dysphoric, borderline, anti-social) psychological traits and other internal factors (low self-esteem, anger, hostility, and poor problem-solving skills) are also associated with increased RV risk (Ehrensaft, Cohen, & Johnson, 2006; Sedlar & Hanson, 2001; Holtzworth-Munroe & Stuart, 1994). Research additionally shows a high correlation between substance use and RV (Coker, Smith, McKeown, & Melissa, 2000).

Similarly, RA is associated with psychosocial maladjustment, social anxiety, substance use, loneliness, depression, lower relationship quality, lower sense of belonging, lower levels of acceptance, and poor intimacy (Goldstein & Tisak, 2004; Landbeater, Bannister, Ellis, & Yeung, 2008; Welsh, Grello, & Harper, 2003; Bagner, Storch, & Preston, 2007). In both samples of children and adults, targets of RA have been shown to exhibit more adjustment difficulties, poorer relationship quality, depression symptoms, and substance use (Bagner, Storch, & Preston, 2007; Linder et al., 2002; Schad, Szwedo, Antonishak, Hare, & Allen, 2008). Whereas the perpetrators of RA demonstrate higher levels of depression, hostility, psychopathy, hostile attribution style, alcohol use, and anger (Coyne, Nelson, Graham-Kevan, Keister, & Grant, 2010; Murray-Close et al., 2010; Schad et al., 2008). RA has also been associated with psychopathic, anti-social, and borderline personality traits (Czar, Dahlen, Bullock & Nicholson, 2011; Schmeelk, Sylvers, & Lilienfeld, 2008; Marsee, Silverthron, & Frick, 2005; Storch, Masia-Warner, & Brassard, 2003; Werner & Crick, 1999).
Results from the Murray-Close (2012) study suggest an elevated fight or flight response to conflict when RA was present, especially in low-quality relationships. Furthermore, Martin, Miller, Kubricht, Yorgason and Carroll (2015) report that wives and husbands who used social sabotage in the relationship reported a decrease in overall health during the next five years. In summary, there are well-documented effects of both relational aggression and violence, which are often severe and long-term for their negative outcomes. In order to better serve this population, researchers and clinicians ought to better understand the precursors to the use of aggression and violence in adult relationships.

**Childhood maltreatment, relational violence, and aggression.** The literature clearly supports a relationship between CM and adult violence (Epps, Carlin, & Ward, 1999; Lansford et al., 2007; Maneta, Cohen, Schulz, & Waldinger, 2012; Scarpa, Haden, & Abercromby, 2010). One documented risk factor of RV in adulthood is previous violence exposure as a child (Black, Heyman, & Smith-Slep, 2001; Cougle, Resnick, & Kilpatrick, 2009; Desai, Arias, Thompson, & Basile, 2002; Noll, 2005; Whitfield, Anda, Dube, & Felitti, 2003; Dutton, 2009). The literature also supports the reverse relationship, that DV in a home increases the risk of CM, direct physical and sexual abuse, ranging from 45 to 70% of home reporting co-occurrence (Farmer & Owen, 1995; Kellog & Menard, 2003; McGee, 2000; Osofsky, 2003; Connolly et al., 2006; Cunningham & Baker, 2004; Edleson, 1999; Guille, 2004; Hester, Pearson, & Harwin, 2007). These findings highlight the critical importance of better understanding the relationships among CM and relational violence and any mediating factors.

Where there is some research exploring the role of RV in CM, the role of RA in CM is unclear. Chen, Coccaro, Lee, and Jacobson (2012) found a significant association between CM
and aggressive behavior in adulthood, even when controlling for hostile attribution biases and negative emotional responses. This effect was further amplified when examining emotional abuse. However, the researchers did not differentiate between direct vs. indirect types of aggression. On the other hand, other research shows a correlation between CM and RV but not an association with RA (Burnette & Dickson-Reppucci, 2009).

Where there is some literature on the association of CM and RV and RA, CSA is an example of where there has been little inquiry into the specific types of abuse and their effects on RV and RA. However, research available on CSA does support a greater risk of interpersonal dysfunction and violence in the home (Kellogg & Menard, 2003; McCloskey et al., 1995; Gilbert, El-Bassel, Schilling, & Friedman, 1997). The Fullerton-Sen et al. (2008) study found a higher level of RA used in relationships of female survivors of CM, specifically if the abuse was CSA.

Where there is little research on CSA and RV and RA, there have been studies exploring the relationship of CPA and RV and RA. The research has found a significant association between CPA and physical aggression, anger, and hostility in adulthood (Keene & Epps, 2016; Carter, Crabtree, Epps, & Roberts-Davis, 2014; Egeland et al., 2002; Springer, Sheridan, Kuo, & Carnes, 2007). Menard, Weiss, Franzese and Covey (2014) reported an association between of CPA and RA only in males. Some factors have been identified as influencing the effects of CPA on RA including emotional regulation and cognitive processing (Gratz, Paulson, Jakupcak, & Tull, 2009; Stevens et al., 2013; Teisl & Cicchetti, 2008; Chen, Coccaro, Lee, & Jacobson, 2012; Verona & Sachs-Ericsson, 2005). Similarly, CPA increases the likelihood that a child will use and view aggressive strategies as an efficient way to meet their relational needs (Herrenkohl, Egolf,
& Herrenkohl, 1997; Shields & Cicchetti, 2001; Weiss, Dodge, Bates, & Pettit, 1992). Swogger, You, Ashman-Brown, & Conner (2011) found CPA was not only correlated with lifetime frequency of aggression but was also correlated with a lifetime history of suicide attempts.

By far, witnessing domestic violence is the most explored specific type of CM as it relates to RV and RA, though most studies focus on violence. To date, this body of research produces inconsistent findings. Some studies have found no significant association (Alexander, Moore, & Alexander, 1991; Bevan & Higgins, 2002; Capaldi & Clark, 1998; Ernst et al., 2007; Simons, Johnson, Conger, & Elder, 1998). Whereas, other studies have found only indirect effects (Fergusson, Boden, & Horwood, 2006; Mihalic & Elliott, 1997). While others support a significant and direct effect of increased risk of RV in adulthood for both perpetration and victimization (Babcock, Green, Webb & Graham, 2004; Rivera & Fincham, 2015; Ehrensaft et al., 2003; Ernst et al., 2009; Iverson, Jimenez, Harrington, & Resick, 2011; Karakurt, Kelley, & Posada, 2013). It has also been shown that children exposed to RV are 15 times more likely to be physically abused (Osofsky, 1999). Studies have even examined the child welfare record, finding that 64 to 71% of cases were reports of dual violence (CPA and DV) in the families (Beeman, Hagenmeister, & Edleson, 2001; Shepard & Raschick’s, 1999). One purpose of the current study is to examine further if witnessing violence increases use of violence in adult relationships.

There are several theories that attempt to explain why witnessing violence increases the risk of the use of violence. Social learning theory proposes that youth who witness domestic violence learn that it is an acceptable means of conflict resolution and emotion regulation (Ehrensaft et al., 2003; Kalmuss, 1984; O’Leary, 1988). This hypothesis is supported by the research that suggests witnessing domestic violence increases the risk of RV as an adult (Caesar,
The intergeneration transmission theorists have found the same, exposure to violent parents leads to RV in adults (Elbow, 1982; Kantor & Jasinski, 1998; Straus, Gelles, & Steinmetz, 1980). Whereas the General Strain Theory from Agnew (1985, 1992, 2002) states that the use of violence is a reactionary strategy; it may often be used in an effort to avoid negative relational and emotional stimuli and to further deter personal victimization, indicating an ‘I hurt you before you hurt me’ attitude. This theory also has research support (Baron, 2009; Hay & Evans, 2006; Rebellon & Van Gundy, 2005).

There are additional mixed results for children who witnessed DV, as some studies have not differentiated between directly experiencing violence (as the victim) from exposure to violence (Acosta, Albus, Reynolds, Spriggs, & Weist, 2001; Gewirtz & Edleson, 2007). While others argue ‘witnessing’ goes beyond direct observation of the violence, it can include overhearing and seeing the aftermath (e.g., injuries, broken home goods) of the incidences (Cunningham & Baker, 2004; Mullender et al., 2002). Kaufman and Ziegler (1987), found only 30% of individuals who witnessed domestic violence become violent as adults, meaning not everyone who is exposed to violence perpetrates (Stith, Busch, Lundberg & Carlton, 2000). Therefore, any research that can shed light on the circular nature of CM and RA is of value.

It is clear that the inconsistency in conceptualization, definitions, and findings has limited the fields understanding of the relationship between RV and RA. The literature is also clear that there are significant correlations between negative outcomes for adults and an impact on their romantic partnerships.
Adult Attachment

Adult attachment may be a significant part of understanding how CM (and its specific types) are related to RA and RV in adult romantic relationships. A secure adult attachment style can serve as a secure base and helps to improve marital quality (Sandberg, Bradford & Brown, 2016). Whereas, couples with insecure attachment styles report decreased relationship quality (Hollist & Miller, 2005). Research on anxiously attached adults suggest maladaptive and dysfunctional schemas, including severe symptoms of depression, anxiety, hostility, hyperactive coping strategies, heightened attention to others negative emotions, increased perception of threats and distress to unavailable or unresponsive partners, excessive desire for proximity to others, fear of abandonment and rejection, (Mikulincer & Shaver, 2007; Maunder, Lancee, Nolan, Hunter, & Tannenbaum, 2006; Mikulincer, Gillath, & Shaver, 2002; Pielage, Gerlsma, & Schade. 2000; Mikulincer, Florian, & Weller, 1993).

Research on an avoidant adult attachment style also suggests other maladaptive and dysfunctional schema, including depression, reduction in seeking social support, deactivating emotion regulation strategies, chronic self-reliance, inattention to threatening information, suppression of distressing memories, and reduction in emotional capacity and acknowledgement (Fraley & Shaver, 1997; Shaver & Mikulincer, 2008, Simpson, Rholes, & Nelligan, 1992; Wei, Russell, Mallinckrodt, & Vogel, 2007). The literature also reports strong associations between health outcomes and adult attachment (Hammill, 2010; Mcevoy, 2005; Reis & Grenyer, 2004; Tremblay & Sullivan, 2010). As can be clearly seen in the literature, attachment is a powerful variable in understanding adult romantic relationships.
Whereas insecure attachment has many maladaptive and dysfunctional relational, physical and emotional outcomes (Mikulincer & Shaver, 2007), including RV (Dutton, Saunders, Starzomski, & Bartholomew, 1994; Dutton, 2011; Dutton & White, 2012), secure attachment leads to many positive outcomes. Researchers suggest that violence is a way to manage distance and closeness in the relationship (Allison, Bartholomew, Mayseless, & Dutton, 2008; Pistole, 1994), while others have found that violence often occurs when a partner fears abandonment (Dutton & Kerry, 1999; Holtzworth-Munroe & Anglin, 1991). These finding suggest the importance in understanding how insecure attachment leads to the use of violence in the adult relationships.

Similarly, researchers have found couples with insecure adult attachment report higher levels of RA (Fournier, Brassard, & Shaver, 2011; Linder, Crick, & Collins, 2002; Oka, Sandberg, Bradford, & Brown, 2014; Weiss, 2006; Wilson, 2010). Oka, Brown, and Miller (2016) found higher levels of insecure attachment predict the partners’ reports of low relationship power. Additionally, self-reports of low power correlated increased risk of the partner using relational aggression. Goldstein et al. (2008) found that couples that used insecure attachment language in describing their relationships have higher levels of RA.

**Childhood maltreatment and adult attachment.** There is a large body of research exploring the relationship of CM and attachment styles in adulthood. CM has been shown to lead to higher risks of interpersonal and relational dysfunction, highlighted by insecure adult attachment, which predict higher rates of involvement in violent and abusive relationships (Briere & Runtz, 1988; Morimoto & Sharma, 2004; Carbone, 2010; Dodge-Reyome, 2011; Gauthier, Stollak, Messe, & Aronoff, 1996; Nicholas & Bieber, 1996; Wekerle & Wolfe, 1998;
Gilbert et al., 1997; Messman-Moore & Coates, 2007; Whitfield et al., 2003; Dutton et al., 1994). Fullerton-Sen et al. have theorized the use of relational aggression in the context of learning theory: through the interactions with unresponsive and inaccessible caregivers, individuals learn that love and affection can be used as a tool to negotiate closeness in a relationship. Love and affection can be given or withdrawn when they are confronted with perceived relational threats.

When a parental or attachment figure is unresponsive, inaccessible, unsupportive, rejecting, harsh, insensitive, intrusive, controlling or inconsistent—all characteristics of CM—children develop negative mental representations of themselves, others, and relationships, and they develop maladaptive coping and emotional regulation strategies (Bowlby, 1969, 1973, 1980; Thompson, 1991; Ainsworth et al., 1978; Carlson & Sroufe, 1995; DeWolff & van IJzendoorn, 1997). These early dynamics associated with CM are all related to insecure adult attachment styles, which is endorsed by higher rates in the CM population, and often marked with relational dysfunction, emotional maltreatment and psychological disorders (Carlson & Sroufe, 1995; Davis, Petretic-Jackson, & Ting, 2001; DiLillo, Lewis, & Di Lareto-Colgan, 2007; Riggs, 2010; Brennan, Clark, & Shaver, 1998; Lyons-Ruth & Block, 1996; Mickelson, Kessler, & Shaver, 1997; Riggs & Jacobvitz, 2002; Cloitre, Stovall-McClough, Zorbas, & Charuvastra, 2008; Hankin, 2005; Muller, Lemieux, & Sicoli, 2001; Schreiber & Lyddon, 1998).

CM inherently violates the relational process, which explains the increased risk of developing insecure attachments styles in adulthood, which often lead to poor mental health outcomes (Hankin, 2005; Muller, Gragtmans, & Baker, 2008; Swanson & Mallinckrodt, 2001). CM survivors with insecure attachment report more PTSD symptoms than survivors with secure
attachment (Muller, Sicoli, & Lemieux, 2000). Ogle, Rubin and Siegler (2015) found that insecure attachment styles, reported by adults with CM histories, predict more severe symptoms of PTSD and describe the variance in symptom severity when compared to other risk factors. These studies and others explore how insecure adult attachment increases trauma symptomatology in adulthood from CMS (Muller, Thornback, & Bedi, 2012; Roche, Runtz, & Hunter, 1999). Specifically, these findings suggest that individuals with histories of CM may be particularly vulnerable to the development of PTSD due to the disrupted formation of secure attachment (Goodman, Quas, & Ogle, 2010).

A history of CSA is associated with higher levels of trauma symptomatology and lower levels of attachment security in adult attachment relationships as well (Asplemeire, 2007). CSA survivors often report high levels of both types of insecure adult attachment (Limke, Shower, & Ziegler-Hill, 2010). Shapiro and Levendosky (1999) posits that most of the effects of CSA on interpersonal functioning were due to avoidant adult attachment, which had a significant direct effect on interpersonal conflict. Laine (2006) found that CSA survivors’ maternal attachment played a buffering role in the relationship between trauma severity and marital dissatisfaction.

Research suggests that CSA trauma severity has a direct effect on marital dissatisfaction. Carson, Gertz, Donaldson, and Wonderlich, (1990) and Herman (1981) showed CSA females have higher levels of triangulation and hold unresolved emotional attachments within their families of origin. These studies and the work of James and Nasjleti (1983) also show that CSA survivors share less spousal intimacy, show less support and have an increased risk of unhealthy emotional attachments to their partner. Partners of CSA survivors often state that isolation, pain, anger, frustration, dissatisfaction, and communication problems are major relationship concerns

Like CSA, CPA survivors report high rates of both types of insecure adult attachment and a lower rate of secure adult attachment than their non-abused counterparts. Of which nearly 85% could be classified as avoidant adult attachment style (Finzi et al., 2000, 2001, 2002; McLewin & Muller, 2006; Muller et al., 2008; Bacon & Richardson 2001; Howe, 2005). This seems to be true even when controlling for gender, social support and other forms of abuse (Unger & De Luca, 2014). Reinhert (2009) states that CPA is related to longer-term maladaptive and dysfunctional psychological and behavior outcomes (McLewin & Muller, 2006). There are also noted gender differences. Females reported a significant positive relationship between avoidant attachment to their mother and CPA. CPA male survivors tend to use externalized coping strategies, while females tend to internalize and often will triangulate others (Crittenden, Claussen & Sugarman, 1994). Both have an increased risk for substance use if CPA and insecure adult attachment are present (Reinhert, 2009). CPA is also associated with more negative views of both self and other and lower perception of social support (McLewin & Muller, 2006; Mullet et al., 2008).

Again, there is a limited amount of research on witnesses of domestic violence. In a review of the literature, Martin (2002) states that witnessing domestic violence undermines the child’s developmental need for safety and security, resulting in the child being chronically overwhelmed. MacIntosh (2002) further adds this pattern likely develops into disorganized
attachment for the child, as he/she struggles to reconcile both the need for comfort and the source of fear. This pattern may be the possible source for an intergenerational cycle of DV described in the Zeanah et al. (1999) study.

As is seen throughout the literature, attachment appears to mediate the impact of CM. Research suggests CM is correlated with heightened sensitivity to threat, social mistrust, mood-related changes and describes why childhood abuse often is related to couple dysfunction and poor relationship quality (McCarthy & Taylor 1999; Colman & Widom, 2004; DiLillo et al., 2009). Young adults with CM histories were found to use more insults and physical violence in their romantic relationships than non-abused counterparts (Styron & Janoff-Bulman 1997). Conversely, if a CM survivor reported having a close and confiding partner, they had a lower risk of depression, better overall mental health outcomes, engagement in social support, and higher levels of relationship quality (Whiffen, Judd, & Aube, 1999; DuMont, Widom, & Czaja, 2007). Also, Evans (2014) found males with CM histories, who reported higher levels of spousal support, had decreased trauma symptomatology. Similarly, Ngyugne et al. (2016) found if both partners reported CM histories, it was associated with higher relationship quality. Other studies have shown higher levels of family cohesion and secure attachment with secondary attachment figures, moderated adverse effects of CM (McGee & Wolfe, 1991; Morimoto & Sharma, 2004; Cicchetti & Rizley, 1981; McGee & Wolfe, 1991). Though this body of literature is small, it suggests the positive influence of secure attachment on CM outcomes. Overall there is still a lack of direct meditational exploration in the CM and adult attachment literature (Wright, Crawford, & Del Castillo, 2009).
**Relational violence and aggression.** The literature suggests adult attachment is a significant predictor of RV. Some research suggests a circular relationship, whereas insecure attachment precedes RV, and RV creates insecure adult attachment (Logan, 2006; Rothbaum, Weisz, Pott, Miyake, & Morelli, 2000, Oka & Whiting, 2011; Stith, McCollum, & Rosen, 2011). Other research proposes that RA, in the absence of violence, affects survivors as much or more than RV (Arias & Pape, 1999; Follingstad, Rutledge, Berg, Hause, & Polek, 1990; Sackett & Saunders, 1999).

There has been an increase in the research investigating the interactional pattern of adult attachment and RV in a relational context (Oka & Whiting, 2012; Godbout, Dutton, Lussier, & Sabourin, 2009). Bond and Bond (2004) suggest when both partners are insecurely attached the risk of RV increases as they both are more likely to attempt to regulate attachment through violence. Mutually aggressive couples are particularly vulnerable to violence when attempting to manage conflicts constructively and prevent escalation in the context of the relationship, which is consistent with other research findings (Goldstein, 2011; O’Leary et al., 1989). Knobloch, Solomon and Cruz (2001) suggest that lack of trust and insecure adult attachment may result in preoccupation with the relationship and promote the cyclic nature of the violence.

While the literature often has focused on relational violence, Carroll et al. (2010) argues that RA, even more than RV, strikes at the core of attachment needs, or the need to belong. Their study suggests that higher levels of love withdrawal and social sabotage (RA behaviors) were associated with of lower levels marital quality and stability for both partners. Furthermore, Oka et al., (2014) added to this finding by describing RA as a maladaptive attempt to manage closeness. Along with White, Smith, Koss, & Figueredo (2000), Oka et al. (2014) suggests
attachment, in her study conceptualized as attachment behaviors, is the key mediator in the relationship between RA and RV. As such, the Oka et al. (2014) study provides the initial framework for the current study.

**Gender differences.** The current study looks at both partners within the couple relationship, therefore it is important to understand that both genders may use RA and RV to manage closeness; however, the use of RA and RV appears to differ between males and females. Female survivors of RV are more likely to describe themselves as having insecure adult attachment styles (Alexander, 2009; Gidycz, Coble, Latham, & Layman, 1993). Similarly, males who perceived higher levels of partner closeness (a secure attachment behavior) show decreases in RV (Lawson, 2008). Whereas, the level of insecure adult attachment correlated to the degree and severity of violence perpetrated by males (Mikulincer, 1998a). Burk and Seiffge-Krenke (2015) found 20% of their dyadic sample was characterized by unilaterally relationally violent females, and “moderately” aggressive/violent males were about 20% of the sample. However, this finding was linked to the idea of the stereotypes of male dominance and female submissiveness (Herrera, Wiersma, & Cleveland, 2008). Additionally, research on the double standard of violent behaviors, female violence is often not taken seriously or is seen and used as a defensive strategy; whereas, male violence self-reported to be used in anger and is criticized and abusive (Sears, Byers, & Price, 2007 O’Keefe, 2005).

Additionally, Sullivan, Lawerence, Pasch and Bradbury (2015) indicated that, for husbands and wives, aggression was associated with supportive behavior from self and partner. Oka et al. (2014) also highlight gender differences in couples dynamics, finding that the “total effect of women’s negative attachment behaviors on men’s physical aggression was stronger than
the total effect of men’s attachment behaviors on their physical aggression (direct and indirect).”

Overall, these findings suggest two valuable concepts worth further exploration: although violence is frequently two-sided, male and female contributions to the process may be different, and violence can be a maladaptive strategy common within attached adults. The current study aims to expand on the research gender differences and multiple forms of RA and RV in couple relationships.

**Attachment behavior.** Where it is evident in the literature that attachment style is a key relational construct, new research is arguing for the importance of identifying relationship-specific attachment behavior (Johnson & Greenman, 2013; Knapp, Sandberg, Novak & Larson, 2015) as a means for understanding relational interactions, including RV and RA (Oka et al., 2014). Johnson (2008) describes how this process is similar in a romantic relationship as in childhood, with demonstrated accessibility and responsiveness in both partners, leading to a secure base. A secure attachment with one’s partner involves engaging in meaningful interactions, confiding in each other and taking emotional risks. Unsurprisingly, couples with secure attachment and more secure attachment behaviors report higher relationship quality (Feeny, 2008; Sandberg, Novak, Davis & Busby, 2016). Increased levels of perceived attachment behaviors have been found to predict secure attachment styles in adulthood as well (Sandberg, Busby, Johnson, & Yoshida, 2012); these adult relationships are more satisfying and have increased levels of trust.

Knapp et al. (2015) suggest attachment-behaviors influence relationship satisfaction beyond attachment styles. Additionally, they found that family-of-origin quality, which is often poor in abusive families, is associated with attachment behaviors in adulthood, for both partners
in a relationship. The Knapp et al. (2015) study further reported that family history, like childhood abuses, impact attachment behaviors (see also, Dinero, Conger, Shaver, Widaman & Larson-Rife., 2008). Sandberg, Bradford, and Brown (in press) report attachment behaviors predict relationship satisfaction beyond and in addition to attachment styles. Therefore, the current study will use attachment behavior and its conceptualization in the analysis.

Throughout the literature review, it is clear that there is a significant and possibly circular, relationship between CM and relational aggression and violence. There is support that insecure attachment leads to increased risks of relational aggression and violence. However, these variables have not been explored together. This study aims to better understand these relationships.

Statement of Purpose

The current study examines the relationship between three types of abuse in childhood—witnessing domestic violence, physical abuse and total in-home violence, sexual abuse—and couple relational violence. Using serial multiple mediation approach, this study examines the mediating roles attachment behaviors and romantic relational aggression.

This current study’s theoretical and structural foundation parallels the work of Oka and colleagues (2014), which found lower levels of attachment behaviors (for men and women) and higher levels of relational aggression (for men and women) were positively associated with physical aggression (Oka et al., 2014). In the current study, partner reports of relational violence and relational aggression were used, because as previously noted, partner reports of violence tend to be more accurate depiction of the relational dynamic. Self-reported variables will be used in the analyses relating to attachment behaviors and childhood maltreatment. This study will use
an actor-partner interdependence model (APIM; Kenny, Kashy, & Cook, 2006) and serial multiple mediation (Hayes, 2013) to address the following research questions (See Figure 1):

1. It was hypothesized that actor/partner childhood abuse experiences would be associated with relational violence for male and female partners.

2. It was hypothesized that both actor/partner attachment behaviors would mediate the relationship between abuse types and actor/partner violence.

3. It was hypothesized that both actor/partner relational aggression would mediate the relationship between abuse types and actor/partner violence.

4. It was hypothesized that both attachment behaviors and romantic relational aggression would mediate links between abuse types and relational violence for male and female partners. Both actor and partner mediating paths were anticipated to show significant mediation.

Methods

Sample

Participant data was collected using the online RELATionship Evaluation (RELATE; Holman, Busby, Doxey, Klein, & Loyer-Carlson, 1997) from 2011 to 2014, at which time the final revised BARE questionnaire was added. The RELATE is an online questionnaire that had more than 300 items during this time period, pooled from established measures. RELATE is offered to both those in relationships and those who are not, as an evaluative tool to improve current and future relationships. The items ask about individual and partner characteristic that are relevant to romantic relationships. Participants are referred to RELATE by educators, therapist, clergy or family and friends. There was no additional compensation to participate in the survey than a better understanding of their relational dynamics through an output given after the
The instructions state for each partner to fill out the assessment separately, although the researchers cannot control this. Four components of RELATE ask about individual, couple, family and social context for both themselves and their partners. This study includes only couples that through the RELATE assessment consented to have their data analyzed.

**Participants**

There were 1,658 paired couples in this study. Of the couples 98.6% of males and 96.5% of females report heterosexual preferences, .5% males and 1.4% females report bisexual preference and .9% and 2.1% of females reported homosexual preferences, with 22 male and 2 females not disclosing this information. When asked “what is your current relationship to the person about whom you will answer ‘partner’ questions for?” .9% male and .8% reported casually/occasionally dating, 29.5% of male and 28.9% of females reported serious dating relationship, 39.5% of males and 40.2% of females reported engaged or committed to marry, 29.3% of males and 29.1% of females reported married, .7% of males and 1% of females reported friends not dating, .1% of males and .1% of females reports just acquaintances, with 21 males and 5 females did not report the relationship.

The majority of individual identified as single, never married (male=42.7%, female=41.5%), married, first (male=24.1%, female=23.7%) cohabiting (male=22.4%, female=21.4%), divorced (male=5.4%, female=7.3%), remarried (males=4.7%, female=5.2%), married but separated (male=.5%, female=.7%), widowed (male=.2%, female=.3%), with 3 males and 20 females not disclosing this data. Couple who were married reported being married less than a year (male=31.2%, female=30.1%), 1 to 5 years (male=31.0%, female=30.2%), 6 to
10 years (male=11.1%, female=11.4%), 11 to 20 years (male=11.8%, female=12.9%), 21 or more (male=14.9%, female=15.4%). When asked how long the couple has been dating or dated before marriage, 19 males and 2 females did not disclose; however, others indicated 1 year or less (male=40.4%, female=41.7%), 1 to 5 years (male=52.5%, female=51.4%), 6 to 10 years (male=6.2%, female=6.2%), and 11 or more years (male=.9%, female=.7%).

The mean age for males was 31.35 (SD= 10.51), ranging from 18 to 79; the mean age for females was 29.10 (SD=9.63), ranging from 18 to 75. Of these, 19 couples had missing gender information for at least partner. The major of the couples self-identified as Caucasian (male=85.5%; female=82.2%), then African (male= 3.9%; female=3.2%), Latino (male= 3.9%; female=3.8%), Asian (male= 3.4; female=6.2%), Biracial/Mixed (male=2.5%; female =4.0%), Native American (male= 0.4%; female=0.4%), and Other (male=0.3%; female=0.3%). Out of the 1,685 couples, 51 males and 22 females chose not to disclose their race or ethnicity. Of the males 131 (7.9%) did not disclose religious affiliation; however, 38.2% identified as Latter-day Saints, 22.7% Protestant, 18.2% none, 14.2% Catholic, 3.5% Jewish, and 3.2% Other, Islamic, Buddhist, or Hindu. Of the females 136 (8.2%) did not disclose religious affiliation; however 38.4% identified as Latter Day Saint, 26% as Protestant, 14.7% Catholic, 14.6% none, 3% Jewish, 1.4% other, 0.9% Buddhist, 0.6% Hindu and 0.4% Islamic.

Most participants had some college—currently enrolled (male=26%, female=32.1%), then have a bachelor’s degree (male=24.4%, female=22.3%), graduate or professional degree—completed (male=20.5%, female=8.2%), some college—not currently enrolled (male=11%, female=7.4%), graduate or professional degree—not completed (male=7.3%, female=20.5%), associate’s degree (male=5.5%, female=6.8%), high school diploma, GED or less than high
school (male=6.2%, female=2.8%), and did not disclose education level (male=1.3%,
female=0.1%). Among the males 2.4% of the 1,658 did not disclose income information, where
28.1% of the reporting males made <$20k; 16.1% from $20k-$39,999; 15.2% from $40k-
$59,999; 9.6% from $60k-79,999; 7.2% from $80k-$99,999; 5.1% from $100k-$119,999; 4.1%
reported no current income; 3.6% from $160k-$199,999; 3.2% from $120k-$149,999; 3%
greater than $300k; 2.6% from $200k-$299,999; and 2.2% from $140k-$159,999. Among the
1,658 females in this study 0.8% did not disclose income information, where 38.5% of the
reporting females made <$20k; 15.6% from $20k-$39,999; 12.5% from $40k-$59,999; 11.7%
reported no current income; 8.4% from $60k-79,999; 4.6% from $80k-$99,999; 2.7% from
$100k-$119,999; 1.4% greater than $300k; 1.2% from $120k-$149,999; 1.1% from $140k-
$159,999; 1.1% from $160k-$199,999; and 1% from $200k-$299,999.

Measures

Childhood abuse types. The three types of abuse categories come from the Family
Violence Scale. Each construct is a summation of two items in the scale, coded with higher score
indicating higher levels of abuse. The scale ranged from “Never” to “Very Often.” Witnessing
Parental Domestic Violence (MDV and FDV) is a summation of following two items: “How
often was your father violent toward your mother?” and “How often was your mother violent
toward your father?” Physical Abuse and Total In-Home Violence is a two item observed
variable (MPAV and FPAV): “How violent toward you was the person you selected in the
previous question?” and “Considering all of your experiences while growing up in your family,
how would you rate the general level of violence in your home?” Sexual Abuse (MSA and FSA)
was a summation of: “How often was the person you selected in the previous question sexually
abusive toward you?” and “How often was someone outside your family (not your partner) sexually abusive toward you?” As the first question is a followup to the participants selecting a specific family member being abusive, only those who selected a person would answer the question. As only 147 males and 252 females answered the first question, the majority selected “-1 Does not apply.” These responses were recoded to 0. There were 6 females and 5 males that did not respond to this question, these were coded missing “99.” There were 3 females and 1 male that selected a family member in the prompting question but did not give answer to how often, these responses were also coded missing “99.” Confirmatory factor analysis was used for males and females (See Table 1).

**Attachment behaviors.** Following precedent of Oka et al. (2014), attachment behaviors in this study was a latent construct measured by items from the self-reports in the Brief Accessibility, Responsiveness, and Engagement (BARE) Scale (Sandberg, et al., 2012). The BARE measures three sub-scales of specific attachment behaviors: accessibility, responsiveness, and engagement, examine attachment specific to the current romantic relationship. The study used self-report of attachment as Oka et al. (2014) stated “self-perceptions of attachment have a bigger impact on one’s propensity for violence than partner perceptions of the self’s attachment.” There are five items used in this scale, some of these items are: “I am rarely available to my partner”; “I listen to my partner when my partners shares her/his deepest feelings”; “It is hard for me to confide in my partner.” The scoring ranges from 1 “Never True” to 5 “Always True,” scores were reverse coded so that higher scores indicate higher levels of secure attachment. Sandberg et al. (2012) has shown this measure to have good reliability (Cronbach’s between .66 and .85; test–retest of .60 to .75) and construct validity with good model fit (CFI/TLI above .95.
and RMSEA below .05). Confirmatory factor analysis was used for males (MAT) and females (FAT) (see Table 1), with Cronbach’s alpha for males being .49 and .49 for females.

**Romantic relational aggression.** The current study, again used the same latent constructed measured items by Nelson and Carroll’s (2006) Couples Relational Aggression and Victimization Scale (CRAVIS) to measure romantic relation aggression. The CRAVIS was specifically a modification of the Self-Report of Aggression and Victimization measure (Morales & Crick, 1998), to measure relational aggression in romantic relationships. However, the current study departs from Oka et al. (2014) analysis as this used the partner scale for analysis, as reporting on partners seems to be a more accurate representation than if the person reports on self (Oka et al., 2014). There are seven items used in this scale, some of these items are: “My partner has threatened to end our relationship in order to get him/her to do what I wanted”; “My partner has intentionally ignored me until I give into his/her way about something”; “My partner has spread rumors or negative information about me to be mean.” The scoring ranges from 1 “Never” to 5 “Very Often.” Items were recoded so that higher scores on the scale indicate higher levels of romantic relational aggression. Confirmatory factor analysis was used for males (MRA) and females (FRA) (see Table 1), with Cronbach’s alpha for males being .84 and .81 for females.

**Relational violence.** Following the framework of Oka et al. (2014) partner reports of relational violence were used for this analysis as literature suggests that the violent partner is more likely to misrepresent their own violent behaviors (Whiting, Oka, & Fife, 2012). Thus, partner reports are more accurate representation of the violence (Cui, Lorenz, Conger, Melby, & Bryant, 2005; Sugarman & Hotaling, 1997). Relational violence was measured using a latent construct of partners report on three items from the physical assault scale of the Revised Conflict
Tactics Scale (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). These were the only items from the CTS-2 that were included in the larger RELATE measure. These items are: “My partner threw something at me that could hurt,” “My partner pushed or shoved me,” “My partner punched or hit me with something that could hurt.” The scale ranges from (0) “This never happen”, “Not in the past year but it did happen before,” “Once in the past year,” “Twice in the past year,” “3–5 times in the past year,” “6–10 times in the past year,” and “11–20 times in the past year” and (7) “More than 20 times in the past year.” Confirmatory factor analysis was used for males (MRV) and females (FRV) (see Table 1), with Cronbach’s alpha for males being .82 and .68 for females. It is also important to note that in this community sample, as is common, not all the items of abuse, aggression, and violence were highly endorsed (please see Table 3 for specific details).

**Analytic Strategy**

It is important when examining people in a relationship that researchers use an appropriate approach to the non-independence of the data (Friedlander, Kivilghan, & Shaffer, 2012; Oka & Whiting, 2013; Wittenborn, Dolbin-MacNabb, & Keiley, 2012). As such, the primary analytic approach is an Actor-Partner Interdependence Model (APIM; See Figure 1). This type of structural equation modeling (SEM) method takes into account the relatedness of the couples scores, by using the couple itself as the unit of analysis (Kenny, Kashy, & Cook, 2006). The analysis was conducted in Mplus 7.1 (Muthen & Muthen, 2012). In the model, I examined the relationship of each partner's self-reported history of childhood abuses, to their own and partners self-reports of attachment behaviors, to the outcome variables of partner reported scores of romantic relational aggression and relational violence (See Figure 1). Confirmatory factor
analysis was performed for each of the three latent outcome variables and a summation of scores after confirmation for the three predictor variables. To confirm indirect mediation effects after the final model was chosen, bootstrapping (at 5,000 draws; Hu & Bentler, 1999) was used to examine the relationships of childhood abuses and relational violence through attachment and relational aggression. Age, income, and educational level were included as covariates and controlled.

The goodness of fit was determined using comparative fit index (CFI; Bentler, 1990), the non-normed fit index (NNFI or TLI in Mplus; Bentler & Bonett, 1980), the root mean square error of approximation (RMSEA) and Standardized Root Mean Square Residual (SRMR). For CFI greater than .95 and TLI between .9 to 1.0 are characterized as having a good fit (Hu & Bentler, 1999), where RMSEA less than .08 is acceptable, better under .06 and ideal under .03 and SRMR less than .08, and closer to zero indicates good fit. Model fit was determined by constraining paths. If model fit worsened with the addition of a constraint, it was removed, and equivalence of other paths was tested. If model fit did not worsen with each constraint, it was retained as other constraints were tested for the final model. After a final model had been selected (using fit indices described in Hu & Bentler, 1999), mediation was tested using bootstrapping (Hayes, 2013) to examine the indirect effects.

**Results**

Frequencies and descriptive statics for each categorical indicator for each of the latent variables, for both males and females, were estimated prior to fitting the full model. The measure model, see Figure 1, indicates high level of model fit with a $\chi^2= 871.103$, $df=495$, $p=.000$, $CFI=.96$, $TLI=.94$, $RMSEA=.03$, 90% C.I. (.25 to .031), $p=1.0$ and $SRMR=.05$. Additionally, factor
loadings for all latent variables were within the range of .446 to .845 meaning these latent variables are capturing the indicators accurately (See Table 1). The following are the standardized estimate results for both the direct and indirect pathways (see Table 2).

**Direct Effects**

This model indicates good model fit with a $\chi^2= 1036.557$, $df=639$, $p=.000$, CFI=.96, TLI=.94, RMSEA=.025, 90% C.I. (.023 to .028), $p=1.0$ and SRMR=.05 (See Figure 2).

**Sexual abuse.** The only significant path found was between females with a history of sexual abuse and females report of males’ violence in the relationship ($\beta=.112 (.048)$, $p=.021$). This suggests a history of childhood abuse for females may increase the likelihood of her being in a violent relationship, where this is not the case for males.

**Physical abuse and total in-home violence.** There were two significant paths found with females with high scores of physical abuse and total in-home violence in childhood; specifically, an increase in physical abuse and total in-home violence was related to a decrease in both her own attachment behaviors ($\beta=-.183 (.056)$, $p=.001$) and to her partner's expression of his attachment behaviors ($\beta=-.137 (.063)$, $p=.028$). Again, higher levels of attachment behaviors indicate more secure and healthy partner attachment. This suggests increased levels of physical abuse and total in-home violence for women are associated with a decrease in both partners’ expression and self-perception of healthy and secure attachment behaviors. Similarly, higher scores of physical abuse and total in-home violence for males was related to his partner’s report of his relational aggression ($\beta=.107 (.059)$, $p=.070$), suggesting that as his physical abuse and total in-home violence level increases so does, his partners report of his relational aggression.
Witnessing parental domestic violence. No significant results were found for either males or females who witnessed high levels of parental violence.

Control variables. For males, increased levels of income were significantly associated with self-reported decreases in expression of attachment behaviors ($\beta=-.118 (.061), p=.047$). Additionally, increases in both male ($\beta=-.095 (.077), p=.000$) and female ($\beta=-.088 (.048), p=.065$) levels of education showed trend level decreases in the likelihood of female relational violence.

Attachment behaviors. Females reporting higher levels of secure and healthy attachment behaviors was significantly and negatively correlated with relational aggression for both the males ($\beta=-.475 (.086), p=.000$) and females ($\beta=-.194 (.062), p=.002$). Increases in positive attachment behaviors were significantly associated with lower reports of both partners’ romantic relational aggression. Similarly, higher levels of healthy attachment behaviors for him were significantly and negatively related to his report of her relational aggression ($\beta=-.377 (.059), p=.000$). Increased reports of positive attachment behaviors were significantly associated with decreases in males reporting relational aggression from the female partners. Moreover, her attachment behaviors were associated with decreases in partner reports on female relational violence ($\beta=-.148 (.092), p=.090$). These findings suggest the higher levels of healthy attachment behaviors mediate the relationship between some childhood abuses and relational aggression, and seemingly, attachment behaviors play an important function.

Romantic relational aggression. Reports of male relational aggression were significantly associated with increased report of male relational violence ($\beta=.414 (.180), p=.021$). No other significant relationships were found for romantic relational aggression.
Indirect Effects

The model results suggest that attachment and relational aggression do not fully mediate the relationship between childhood abuses and relational violence; therefore the indirect effects were tested using bootstrapping to examine these effects. Two significant indirect paths were found, both through females’ physical abuse and total in-home violence. The first indirect effect from female physical abuse and total in-home violence is to partner reports of female relational violence ($\beta=.065 (.024), p=.007$) and the second is to partner reports of male relational aggression ($\beta=.087 (.035), p=.012$). As these findings were the summation of the paths, this shows none of the specific indirect pathways were individually statistically significant, but a combination of them is. Meaning no specific pathway in the model was found to mediate any of the pathways significantly, but there was an overall effect on those outcomes.

Discussion

As the current study builds on the work of Oka et al. (2014), it was expected to find similar associations in the relationships among attachment behaviors, romantic relational aggression, and relational violence. However, as the current study used partner reports of romantic relational aggression, I would expect to find some differences in these relationships as well. As expected, there were both similarities and differences. Additionally, the current study examined how adverse childhood maltreatment experiences could help to explain better the associations among variables previously reported by Oka et al. (2014) and provide new insight to these associations.
Hypothesis 1

*It was hypothesized that actor/partner childhood abuse experiences would be associated with relational violence for male (M) and female (F) partners.*

This hypothesis was partially supported. One of the most poignant findings of this study was females who report higher levels of childhood sexual abuse (CSA) reported more violence from their partners. This finding holds even in the presence of attachment behaviors (ATT) and romantic relational aggression (RRA). However, no other types of childhood abuses were found to have significant direct paths to relational violence (RV). Finding only a significant path for FCSA suggests we, as a field, may understand even less about its association with relational violence than previous literature has claimed. The relationship between FCSA survivors and dysfunctional and/or violent adult relationships is well-documented (Paolucci, Genuis, & Violato, 2001; Rumstein-McKean & Hunsley, 2001; Hunter, 2006; Mullen, Martin, Anderson, Romans, & Herbison, 1996; Williamson, 2009); and this study confirms these finding for women. However, it is not known why this relationship would be non-significant for men. Perhaps there is some protective factor that is accounted for by attachment that is unique to the males. Though a very controversial debate exists within the literature (Hamberger & Larsen, 2015), it may also be that women are simply more likely to experience physical aggression in romantic relationships, regardless of what the mediating variables proposed in this study (Domestic Violence Resource Center, 2011; Selic, Pesjak, & Kersnik, 2011; Walton et al., 2009). It is important to highlight that only FCSA, and no other forms of CM, for either partner, was significantly related to relational violence.
**Hypothesis 2**

_It was hypothesized that both actor/partner attachment behaviors would mediate the relationship between abuse types and actor/partner violence._

Hypothesis 2 was also partially supported by the data. The current study found for both male and female self-reports of attachment behaviors that there was a significant negative association with FPAV (female physical abuse and total in-home violence). This means reported higher levels of FPAV were correlated with lowers levels of positive attachment behaviors reported by either partner.

In previous research, Knapp et al. (2015) suggested that family-of-origin quality and family history do affect attachment behavior. Additionally, the literature supports the relationship between childhood physical abuse (CPA) and increased victimization of abuse experiences as an adult (Bensley, Van Eenwyk & Wynkoop-Simmon, 2003; Renner & Slack, 2006). Other research suggests CPA and witnessing domestic violence (DV) in childhood experiences are related to increases in the level of violence reported in the adult survivor’s own home (Sahin, Baloglu, & Unalmis, 2010). The findings were, in part, consistent with the previous literature, namely reports of positive attachment behaviors for the couples who are lower when the females report higher levels of physical abuse and total in-home violence.

However, one of the main contributions of the current study is to extend the findings of Oka et al. (2014), namely, that that attachment behaviors have a mediating influence on the relationship between FPAV and MRV (male relational violence). As previously noted, the relationship between attachment and relational aggression is likely an important stepping stone toward actual relational violence (Oka et al., 2014). It is possible this pattern is more clearly seen
in regards to male violence as there are several studies that suggest males use more violent tactics—grabbing, beating, burning, strangling/choking, use of weapon—and that women are more likely to report to others (police, hospitals, etc.) about the violence (Melton & Sillito, 2012; Feder & Henning, 2005; Phelan et al., 2005; Gondolf, 2012). Oka et al. (2014) posit “while partner violence may be two-sided, men and women may have different contributions to the pattern. Both partners must take responsibility for their contributions to that pattern (pg. 14).”

It is also important to discuss that, the current study, did not find any significant results for witnessing of parental violence (DV). This means that DV did not predict attachment behaviors, romantic relational aggression or relational violence. This is somewhat surprising. Previous literature supports significant negative associations in the intergenerational cycle of DV, specifically in the modeling of poor attachment behaviors (Zeanah et al., 1999). The literature suggests violent adult relational outcomes for those that witness domestic violence in childhood (Arbetter, 1995; Miller, Handal, Gilner, & Cross, 1991; Purvin, 2003; Maker et al., 1998). One potential explanation for the lack of significant findings could be the way witnessing domestic violence was measured in the current study. Perhaps the two questions were not precise enough to access the aspects of domestic violence in childhood that are most clearly related to relationship violence in adulthood. Also, it may be that the ameliorating influence of attachment behavior accounted for the influence of witnessing abuse as a child may have on later romantic relationship aggression.

Another similarity to the findings of Oka et al. (2014), was a significant negative association between female attachment behaviors and romantic relational aggression, for both partners. Females who self-report less positive attachment behaviors were more likely to report
higher levels both self-reported and partner-reported RRA. Similarly, male self-reported attachment behaviors were negatively associated with partner-reported FRRA. As males expressed more insecure attachment behaviors, they reported an increase in their partner’s relational aggression toward them. Thus, the more insecure they feel in their relationship, as manifested through fewer attachment behaviors, the more RRA they reported. This association is supported by the literature (Allison, Bartholomew, Mayseless, & Dutton, 2008; Pistole, 1994). These results, too, seem consistent with the literature reports lower levels of attachment behaviors predict relationship satisfaction, beyond and in addition to attachment styles (Sandberg, Bradford, & Brown, in press).

What is puzzling, and is contrary to the general literature is the non-significant relationship from MATT to MRRA. No current literature has explored this confusing finding. One possible explanation may be the distinction between males and females in attunement to their aggressive behaviors. Another possible explanation is that males may not be using RRA in a relationally motivated way. Therefore, it may be that the women in this sample used relational aggression in an attempt to motivate males to change their level of attachment behaviors (Oka et al., 2014), but this is not the same for males.

**Hypothesis 3**

*It was hypothesized that both actor/partner relational aggression would mediate the relationship between abuse types and actor/partner violence.*

This hypothesis was also partially supported. First, the study found a significant association between males reporting PAV and their partner's reports of their RRA at trend level. When males report higher levels of physical abuse and total in-home violence, their partner’s
reported higher levels of relational aggression from them. This finding represents differences in
gender groups as females’ PAV was not related to RRA but was associated with lower levels of
attachment behaviors. These findings would suggest PAV is a significant factor in the path
toward relational violence; however, the current findings indicate differences in the associations
in the male and female groups.

Although this has yet to be tested within the literature, one explanation for MPAV’s
relationship to RRA could be supported through social learning theory. Social learning theory
suggests those that witness violence or any repeated aggressive behaviors are more likely to
repeat that behavior as an ascription of an intergenerational (Ehrensaft et al., 2003). Whereas,
females tend to internalize and will often triangulate others (Crittenden, Claussen & Sugarman,
1994). The findings around PAV in this study begin to distinguish male and female group
differences in both processes and outcomes of different types of childhood abuses.

The study also found a significant association between (partner-reported) male relational
aggression and relational violence. This is a critical finding and is consistent with the Oka, et al.,
(2014) study. Whether or not males self-reported (as in Oka et al. 2014) or partner-reported
higher levels of romantic relational aggression (as in the current study), MRRA was associated
with higher levels of partner-reported violence from the males. This suggests that male
aggression is significantly associated with men acting out in physically violent ways. It is critical
to highlight that RRA and RV, at least for males, may occur together. This finding is interesting,
as it seems to hold true regardless of whether the partner or actors is reporting the male RA.
These two findings suggest male and female group-specific effects and are consistent with
previous literature that suggests males and females use RA differently and may have different
precursors to its use in romantic relationships (Alexander, 2009; Gidycz, Coble, Latham, & Layman, 1993; Herrera, Wiersma, & Cleveland, 2008).

This finding also supports the concept that romantic relational aggression is associated with and is a distinct construct from relational violence, for males (Oka et al., 2014). Previous literature showed aggression/violence may be a way to manage distance and closeness in the relationship (Allison, Bartholomew, Mayseless, & Dutton, 2008; Pistole, 1994), while others have found that aggression/violence often occurs when a partner fears abandonment (Dutton & Kerry, 1999; Holtzworth-Munroe & Anglin, 1991). It is possible that males and females use RA indifferently to negotiate closeness in the relationship. Additionally, as other researchers posit, females are more bothered by relational aggression than males (Salmivalli & Kaukiainen, 2004), which could account for the association found in this study of MRRA and MRV, as in the current study both variables were measured by the females’ report of these experiences. Similarly, we might not see high rates of female to male violence because female violence is not taken as seriously as male violence (Sears, Byers, & Price, 2007; O’Keefe, 2005). Together this may help explain the male and female group differences for PAV in the current study.

**Hypothesis 4**

*It was hypothesized that both attachment behaviors and romantic relational aggression would mediate links between abuse types and relational violence for male and female partners. Both actor and partner mediating paths were anticipated to show significant mediation.*

The study found only two significant indirect relationships. Specific indirect effects between FPAV and MRRA were small and non-significant. However, the sum of the indirect effects, although also small ($\beta = .087$) was statistically different from zero, suggesting that when
all indirect effects were considered jointly, there was a significant link between FPAV and MRRA. Additionally, the specific indirect effects between FPAV and FRV were small and non-significant. Likewise, the sum of the indirect effects, although also small ($\beta = .065$) was statistically different from zero, suggesting that when all indirect effects were considered jointly, there was a significant link between FPAV and FRV. These finding likely indicate a small effects size of the data.

**Control Variables**

While not illustrated in Figure 2, it is interesting to note that males with higher incomes self-reported lower positive attachment behaviors. Theoretically, this connection is outside the scope of the literature review but, is worth noting for further exploration. Additionally, both males and females with higher levels of education were associated with lower levels of partner reports of female violence. The literature suggests those with less education tend to be more violent and that in cases of non-reciprocal violence, women perpetrated more than 70% of the time (Whitaker, Haileyesus, Swann, & Saltzman, 2007). Johnson (2008) found a negative association between intimate terrorism and educational level, as well as situational couple violence and educational level. The current study’s findings suggest education for either partner may reduce the occurrence of males reporting on FRV. It is of interest that the current study only found this association for reports of FRV and not MRV. As such, the data suggest this hypothesis was partially supported by the results.

The current study suggests mediation does indeed occur between these variables, it is also of interest where significance was not found (e.g., M/F-DV to RV, MSA to RV). This bares the question of what other factors may be at play in CM types and relational violence. Attachment
theory would suggest that CM compromises the attachment system, which has biological implications (see Appendix A). Whether it is learned behavior (modeling) or deregulation of the system that dictates healthy adult relationship, CM compromises that system (Dinero, Conger, Shaver, Widaman & Larson-Rife., 2008). With an altered attachment system, the use of aggression and violence may increase, in an attempt to negotiate closeness and connection (Johnson, 2008; Goldstein, 2011; O’Leary et al., 1989). I would speculate that some of the differences seen in the current study results of CM may have to do with sense of violation that occurs with different types of abuse, namely that CSA survivors often report high levels of internalized shame and self blame for the victimization (Webster & Harper, in review). CSA may differ from other forms of abuse in this regard. It may be that witnessing parental violence does not carry that same sense of personal “fault.” Those with an internalized shame schema may have rated the importance of attachment behaviors differently, thereby influencing the mediating paths. As others have suggested there is likely an intergenerational cycle to high shame based CM, that continue the transmission of poor attachment behaviors in adulthood (Elbow, 1982; Kantor & Jasinski, 1998; Straus, Gelles, & Steinmetz, 1980).

Clinical Implications

First, it is critical to acknowledge the ethical concerns for the clinical treatment of couples where violence is present in the relationship or where there is a history of violence. Stith et al. (2012) mention there is often a difference between how a clinician may wish to conceptualize or understand relational violence and what is best practice. In the more rare cases where the violence is unidirectional, dyadic therapy is often not best practice, as the victim can feel shamed, blamed and/or pressured to stay in that relationship (Loseke & Kurz, 2005). Being
vulnerable and open with an abusive partner can lead to greater risk of retaliation violence (Johnson, 2004).

Also, those couples who reciprocate violence have a higher risk of inflicting serious injury (Whitaker et al., 2007). Thus, it is essential that therapists screen for Intimate Partner Violence before beginning therapy. Todahl and Walter (2011) provide a systemic review of IPV research, guidelines, and screening methods that are seen as best practice. This researcher would also suggest that assessing for relational aggression is likewise crucial, as the current study suggests aggression maybe a stepping stone to violence. Unfortunately, a clinical screening tool for RA has yet to be developed. Clinicians are also responsible for knowing and understanding individual state laws regarding the treatment of IPV.

Second, like Oka et al. (2014) the current study found several significant relationships among attachment behavior, romantic relational aggression, and relational violence. Also like Oka et al. (2014), the current study used and suggests the conceptual framework of attachment theory to better understand relational aggression and relational violence in romantic couples. This attachment framework can help couples increase secure attachment styles and expression of positive attachment behaviors. As Oka et al. (2014) describes “relational aggression may take the form of colluding with the therapist to exclude a partner. Therapists may wish to identify this collusion as an en vivo example of relational aggression and help couples describe it in attachment terms, focusing on the hoped-for outcome of such behavior (pg. 14).”

This may be achieved by the use of experiential and attachment based questioning. For example, “at the moment right before you said (or did) the aggressive thing, what were you longing for from your partner?” Tilley and Palmer (2012) suggest that this type of questioning
can help a partner to see the aggression as a bid for closeness, where this may not have been understandable before. The patterned, pursue-distance cycle is directly and inherently connected to the couples attachment needs (Johnson, 2004). As previously suggested, this framework too can allow for each individual to take responsibility for their own pieces of a dysfunctional pattern.

Lastly, the current study also suggests an important role of childhood abuses as it related to attachment behaviors, romantic relational aggression, and relational violence. Often, when working with adult survivors of childhood abuse or relationship violence victims, there is a tendency to treat them using the same trauma paradigm. This research would suggest the “sameness of trauma” approach may not be best practice. For example, I hypothesized in this study that witnessing parental domestic violence would have significant effects on how a person would express attachment behaviors toward their partner, when compared with the effects of individuals coming from highly physically abusive or generally highly violent homes. The theory that watching parents be violent to each other would affect individuals’ own adult attachment (Dutton, 2006) was not supported in the current study. Thus, it is clinically important to understand the specifics of the type of violence witnessed and whether those individuals directly felt endangered by those experiences or not. There seems to be key differences in how this plays out in their own adult relationships.

Unfortunately, there is limited research on specific best practices for working with adult survivors in the couples context. Webster (in review) found out of 75 years of publications in the Journal of Marital and Family; there were only 7 articles that discuss specifically working with adult survivors in the couples context. Some of these papers have theoretical underpinnings of
narrative therapy; emotion-focused couples therapy and group therapy. Thematically, Webster (in review) found 15 important clinical factors across these 7 papers, which includes a heightening the sense of therapeutic safety, involving the partner in therapy from the onset (unless otherwise constrained), addressing benevolent blame, and for dual survivors couples—the “double whammy” of emotional avoidance. This researcher would again suggest an attachment based framework for working with the complexity that surrounds adult survivor couples.

What is critical to understand both clinically and theoretically, is working with adult survivors of childhood abuse in a couple setting and working with couples that are using violence and aggression are both very complex and delicate clinical issues. The combination of their characteristics in a couple can be extremely complicated. Having a solid attachment conceptualization to guide this work, in this researcher’s opinion, is essential.

**Limitations**

The sample of this data set is a largely homogeneous group of heterosexual, Caucasian, Christian, college-educated individuals. This effectively makes it difficult to generalize the findings to any minority populations within the United States. Like Oka et al. (2014) mention, there is conflicted research on whether or not and how ethnicity and violence are related. And though there is evidence supporting higher levels of education reduce couple violence, the majority sampling of the current study may limit the amount of violence reported in the couples. Additionally, there could be differences in the reports of attachment and attachment behaviors for those that are in dating relationships vs. those who are married, and the current study does lump these categories together. It is important to note that this data was cross-sectional, non-longitudinal, and correlational. As such we cannot assume or allow predictions of causation.
Similarly, while this study has clinical implications, the sample is a community sample, not a clinical one. If the study were to sample from a clinical population, it would likely show higher rates of violence, and would be less skewed (Stith et al., 2011). It would also more likely show increased rates of insecure and unhealthy attachment styles and behaviors (Pielage, Luteijn, & Arrindell, 2005). Similarly, longitudinal data would likely show higher rates of violence and insecure attachment styles and behaviors, though a longitudinal study has yet to explore these relationships.

Secondly, the creation of the abuse types scale was constructed from limited questions embedded within the RELATE dataset. These limited questions may not capture the full entirety of the abuses that occurred. Specifically, the questions regarding physical abuse and total in-home violence come from the physical abuse scale within RELATE but are a combination of physical abuse and witnessing violence. Removing either question to create a more clear construct disrupted the model. Each question had so few who reported any type of abuse that was further limiting the model made it too unstable to run. This was a concern for each of the abuse constructs; for example, the sexual abuse scale only had 399 individuals that answered either one of the questions. Thus the sample for abuse survivors was small within the whole of the sample. This limited running the analysis variables as categorical latent variables, which may provide different results. The low abuse samples do, however, fit with the consistent concern of underreporting of all types of childhood abuses. Likewise, some of the scaled latent variables had lower crohnbach’s alphas, and therefore should be interpreted with caution, even though the confirmatory factor analyses seemed to support the use of these variables.
Similarly, the small sample of couples in the RELATE dataset who reported violence and had also reported on both romantic relational aggression and attachment behaviors limited the study, even though the reporting of violence in the sample matched that of national violence surveys (Tjaden & Thoennes, 2000). Further, while the study was able to control for some of the correlates of relational violence in this study, it did not control for all of them (i.e., alcohol and drug use).

There are some concerns regarding the model used. Though this article pushes forward the accumulative effects of these constructs, the model is complex. Due to its complexity, it will have to be simplified in the future to understand specific relationships furthermore clearly. Possible ways to clarify would run the same variables as a non-partner model, exploring more in-depth one partner’s experience. Additionally, running the APIM model with a single mediator of attachment behavior with the outcome of RRA or the outcome of RV, would be potential ways to simplify the model. Lastly, running the model with the CM variables collapsed, to examine more detail the mediation of ATT and RRA on RV. Each of these options would potentially provide more specific insight into these relationships.

Future Research

As the abuse variables in this study are somewhat limited, creating or using more specific and direct measures of different types of abuse would allow for further clarity in the relationships between attachment, aggression, and violence. Potentially looking at more than just abuse, but using adverse childhood experiences questionnaires (ACES; CDC, 2009), could also shed light on the frequency, duration and intensity of specific events that may alter the relationship between childhood experiences and adult relational violence.
It would be interesting to explore the relationship between attachment style and attachment behaviors in these relationships. Where the research supports that attachment behaviors predict more about couples’ relationship quality (Sandberg, Bradford, and Brown, in press), using attachment styles would fit this story into the greater context of current literature.

Specifically, the current study’s finding that males who reported higher levels of income self-reported lower levels of attachment behaviors is of particular interest. While there are studies addressing poverty and income as they relate to attachment styles, there are no studies to date exploring this specific relationship. Possibly looking at partner report instead of self-report of attachment behaviors or exploring other mediating factors could also be beneficial.

Most importantly, using a more diverse sample would allow for better generalization of the results. The possibility of exploring subjects of a clinical sample, and getting data from identified relatioal violence victims or identified childhood abuse survivors would likely change the perspective and relationship of these variables. Similarly, utilizing longitudinal data would allow for predictions of direction and causation. To further ascribe meaning and understand the use of aggression, violence and attachment behaviors conducting in-depth qualitative interviews would too, be of significant value.

**Conclusion**

Childhood abuse types, relational violence, aggression, and attachment are interrelated in important ways. The current study found results that are consistent with the current body of literature, but also found associations that challenge the current understanding of how attachment mediates this relationship. The study further supported the importance of looking at aggression as a stepping stone toward violence, but possibly only for males. It is clear from the study that
there are significant male and female group differences in the ways that childhood abuse may affect adult romantic relationships and what attachment behaviors may mean within that process. It is also clear that different types of childhood abuse have different outcomes as well. These differences are important and meaningful in the continuation of creating clinical best practices and facilitating healing.
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Appendix A: Physical Health Effects of Childhood Maltreatment

In addition to psychosocial effects, research suggest many physical health effects of CM. Felitti and colleagues (2001) found an increased risk for a broad range of conditions associated with four or more adverse childhood events, including ischemic heart disease, cancer, stroke, chronic bronchitis, emphysema, diabetes, skeletal fractures, and hepatitis. Researchers have found that women who report a history of childhood maltreatment experienced a variety of health concerns, including nightmares, sleeping problems, frequent tiredness, back, chest or face pain, headaches, genital or pelvic pain and discharge, problems urinating, binge eating, vomiting, loss of appetite, stomach pain, diarrhea or constipation (often irritable bowel syndrome), frequent or serious bruises, choking sensation, shortness of breath fibromyalgia, and chronic fatigue syndrome (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996; Dube et al., 2005 McCauley, Kearn, Kolodner, et al., 1997; Van Houdenhove, Neerinckx, Lysen, et al., 2001; Boisset-Pioro, Esdaile, & Fitzcharles, 1995; Drossman et al., 1990).

Another common physical health effect for CSA survivors is sexual dysfunction; it is estimated up to 82% of this population struggles in this way (Douglas, Matson, & Hunter, 1989; Herman, 1981; Ahmad, 2006; Pulverman, Lorenz, & Meston, 2015). Often CSA survivors wrestle with the desire to engage in romantic relationships even though they face fears of closeness and an inability to trust themselves (Alexander, 1992; Browne & Finkelhor, 1986). Also, sexual and emotional intimacy can trigger flashbacks and somatic memories, re-traumatizing the survivor (Finkelhor & Browne, 1985; Kendall-Tackett, Williams, & Finkelhor, 1993; Kinzl, Traweger, & Biebl, 1995; Pulverman, Lorenz, & Meston, 2015). These findings
point to higher levels of sexual dissatisfaction, contributing to higher rates of separation and divorce (Browne & Finkelhor, 1986; Courtois, 1988; Stephenson, Pulver, & Meston, 2014).

There is growing research on the neurobiological effects of CM as well. In a morphometric—a type of tissues sampling—analysis, among subjects with high abuse scores, Dannlowski et al. (2012) found heightened amygdala responsiveness to threat-related facial expressions, and reductions in gray matter volume in the hippocampus, insula, orbitofrontal cortex, anterior cingulate gyrus, and caudate. This suggests CM is related to marked functional and structural changes in the brain during adulthood. These are similar findings to the depression and PTSD neuroimaging literature, which suggests that CM has a similar impact on the brain as emotional disorders. Also, CM survivors are sick more often and have higher health care utilization (Felitti, 1991).
Appendix B: Figures and Tables

Figure 1. Hypothesized Model

Hypothesized SEM Model- Paths would be expected from each predictor.

Note: SA=Sexual Abuse, PAV=Physical Abuse and Total In-home Violence, DV=Witnessing Parental Domestic Violence
ATT BX=Attachment Behaviors, RRA=Romantic Relational Aggression, RV=Relational Violence
Figure 2. Results SEM Model

Final SEM Results

Note. Standardized coefficients (Standard Errors)
* p<.01 (bolded line); ** p<.05 (thin line); † p<.10 (broken line)
SA=Sexual Abuse, PAV=Physical Abuse and Total In-home Violence, DV=Witnessing Parental Domestic Violence
ATT BX=Attachment Behaviors, RRA=Romantic Relational Aggression, RV=Relational Violence
Table 1. Factor Loadings

<table>
<thead>
<tr>
<th>Attachment Behaviors (*reverse coded)</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am rarely available to my partner. *</td>
<td>.530(.033)</td>
<td>.514(.032)</td>
</tr>
<tr>
<td>It is hard for my partner to get my attention.*</td>
<td>.525(.033)</td>
<td>.446(.034)</td>
</tr>
<tr>
<td>I listen when my partner shares her/his deepest feelings.</td>
<td>.463(.035)</td>
<td>.567(.030)</td>
</tr>
<tr>
<td>It is hard for my partner to confide in me. *</td>
<td>.707(.027)</td>
<td>.751(.024)</td>
</tr>
<tr>
<td>I struggle to feel close and engaged in our relationship. *</td>
<td>.738(.026)</td>
<td>.766(.024)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Romantic Relational Aggression: My partner has...</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>threatened to end our relationship in order to get me to do what he/she wanted.</td>
<td>.581(.029)</td>
<td>.761(.025)</td>
</tr>
<tr>
<td>gone “behind my back” and shared private information about me with other people.</td>
<td>.485(.031)</td>
<td>.651(.023)</td>
</tr>
<tr>
<td>given me the silent treatment or “cold shoulder” when I hurt his/her feelings or made him/her angry in some way.</td>
<td>.592(.033)</td>
<td>.463(.032)</td>
</tr>
<tr>
<td>When...been mad at me, he/she has recruited other people to “take sides” with him/her and get them upset with me too.</td>
<td>.769(.024)</td>
<td>.619(.027)</td>
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<td>intentionally ignored me until I give into his/her way about something.</td>
<td>.669(.028)</td>
<td>.604(.027)</td>
</tr>
<tr>
<td>withheld physical affection from me when he/she was angry with me.</td>
<td>.677(.028)</td>
<td>.808(.022)</td>
</tr>
<tr>
<td>spread rumors or negative information about me to be mean.</td>
<td>.522(.034)</td>
<td>.497(.031)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relational Violence: My partner...</th>
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<th>Female</th>
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</thead>
<tbody>
<tr>
<td>threw something at me that could hurt.</td>
<td>.730(.033)</td>
<td>.797(.027)</td>
</tr>
<tr>
<td>pushed or shoved me.</td>
<td>.734(.034)</td>
<td>.744(.030)</td>
</tr>
<tr>
<td>punched or hit me with something that could hurt.</td>
<td>.773(.030)</td>
<td>.845(.022)</td>
</tr>
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</table>

*Note.* Full Model Fit: $\chi^2(495)=871.103; CFI=.96; TLI=.95; RMSEA=.03; SRMR=.05
**Table 2. Correlations**

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<thead>
<tr>
<th></th>
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<td>5</td>
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<td>.059</td>
<td>-.060</td>
<td>.137*</td>
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<tr>
<td>7</td>
<td>.719*</td>
<td>.264*</td>
<td>-.233*</td>
<td>.063</td>
<td>.090**</td>
<td>.095*</td>
<td>1.000</td>
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<td></td>
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<td>.672*</td>
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<td>.308*</td>
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<tr>
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<td>-.260*</td>
<td>-.508*</td>
<td>.561*</td>
<td>-.097†</td>
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<td>-.102**</td>
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<td>10</td>
<td>.003</td>
<td>.107**</td>
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<td>-.090</td>
<td>.043</td>
<td>.070</td>
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<td>.061</td>
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<td>.031**</td>
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<td>-.218*</td>
<td>.411*</td>
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<tr>
<td>12</td>
<td>.124*</td>
<td>.068†</td>
<td>-.006</td>
<td>.061</td>
<td>.069†</td>
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<td>.041</td>
<td>.022</td>
<td>-.081**</td>
<td>.126*</td>
<td>.256*</td>
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</tr>
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</table>

*Note.* M= Male; F= Female; RV= Relational Violence; RA= Romantic Relational Aggression; AT= Adult Attachment Behaviors; DV= Witnessing Parental Domestic Violence; PA= Physical Abuse and Total In-Home Violence; SA= Sexual Abuse.

†p<.10; **p<.05; *p<.01
Table 3. Descriptive Statistics of Latent Variables

<table>
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<tr>
<th>Table 3</th>
<th>Frequencies of Categorical Latent Variable Indicators, Means, and Standard Deviations</th>
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</thead>
<tbody>
<tr>
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<td>n</td>
</tr>
<tr>
<td>WITNESSING PARENTAL DOMESTIC VIOLENCE (DV)*</td>
<td>Male</td>
</tr>
<tr>
<td>How often was your father violent toward your mother?</td>
<td>838</td>
</tr>
<tr>
<td>How often was your mother violent toward your father?</td>
<td>854</td>
</tr>
<tr>
<td>How often was your father violent toward your mother?</td>
<td>852</td>
</tr>
<tr>
<td>HOW WOULD YOU RATE THE GENERAL VIOLENCE LEVEL IN YOUR HOME?</td>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
<td>1657</td>
</tr>
<tr>
<td>PHYSICAL ABUSE &amp; TOTAL IN-HOME VIOLENCE (PA)*</td>
<td>Male</td>
</tr>
<tr>
<td>How often was the person you selected in the previous question sexually abusive toward you?</td>
<td>1636</td>
</tr>
<tr>
<td>How often was someone outside your family (not your partner) sexually abusive toward you?</td>
<td>Female</td>
</tr>
<tr>
<td>How often was the person you selected in the previous question sexually abusive toward you?</td>
<td>1658</td>
</tr>
</tbody>
</table>
### Table 3. (Cont.)

<table>
<thead>
<tr>
<th>Attachment Behaviors (^d) (<em>reverse coded)</em></th>
<th>n</th>
<th>0%</th>
<th>1%</th>
<th>2%</th>
<th>3%</th>
<th>4%</th>
<th>5%</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am rarely available to my partner. (^\ast)</td>
<td>1305</td>
<td>8</td>
<td>0.6</td>
<td>26</td>
<td>2.0</td>
<td>88</td>
<td>6.7</td>
<td>633</td>
<td>58.5</td>
</tr>
<tr>
<td>It is hard for my partner to get my attention.(^\ast)</td>
<td>1305</td>
<td>3</td>
<td>0.2</td>
<td>31</td>
<td>2.4</td>
<td>121</td>
<td>9.3</td>
<td>631</td>
<td>48.4</td>
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<tr>
<td>I listen when my partner shares her/his deepest feelings.</td>
<td>1304</td>
<td>726</td>
<td>55.7</td>
<td>527</td>
<td>40.4</td>
<td>43</td>
<td>3.3</td>
<td>6</td>
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</tr>
<tr>
<td>It is hard for my partner to confide in me. (^\ast)</td>
<td>1303</td>
<td>14</td>
<td>1.1</td>
<td>80</td>
<td>6.1</td>
<td>135</td>
<td>10.4</td>
<td>545</td>
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<tr>
<td>I struggle to feel close and engaged in our relationship. (^\ast)</td>
<td>1301</td>
<td>21</td>
<td>1.6</td>
<td>104</td>
<td>8.0</td>
<td>150</td>
<td>11.5</td>
<td>543</td>
<td>41.7</td>
</tr>
<tr>
<td>Female</td>
<td></td>
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<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>I am rarely available to my partner. (^\ast)</td>
<td>1320</td>
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<td>0.6</td>
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<td>1.2</td>
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<td>4.8</td>
<td>498</td>
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<tr>
<td>It is hard for my partner to get my attention.(^\ast)</td>
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<td>0.3</td>
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<td>1.5</td>
<td>70</td>
<td>5.3</td>
<td>535</td>
<td>40.6</td>
</tr>
<tr>
<td>I listen when my partner shares her/his deepest feelings.</td>
<td>1319</td>
<td>865</td>
<td>65.6</td>
<td>420</td>
<td>31.8</td>
<td>30</td>
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<td>3</td>
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</tr>
<tr>
<td>It is hard for my partner to confide in me. (^\ast)</td>
<td>1317</td>
<td>12</td>
<td>0.9</td>
<td>70</td>
<td>5.3</td>
<td>105</td>
<td>8.0</td>
<td>506</td>
<td>38.4</td>
</tr>
<tr>
<td>I struggle to feel close and engaged in our relationship. (^\ast)</td>
<td>1319</td>
<td>35</td>
<td>2.7</td>
<td>129</td>
<td>9.8</td>
<td>104</td>
<td>7.9</td>
<td>485</td>
<td>36.8</td>
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</table>

### Table 3. (Cont.)

<table>
<thead>
<tr>
<th>Romantic Relational Aggression: My partner has…(^a)</th>
<th>n</th>
<th>0%</th>
<th>1%</th>
<th>2%</th>
<th>3%</th>
<th>4%</th>
<th>5%</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>threatened to end our relationship in order to get me to do what he/she wanted.</td>
<td>1637</td>
<td>1244</td>
<td>76.0</td>
<td>261</td>
<td>15.9</td>
<td>98</td>
<td>6.0</td>
<td>21</td>
<td>1.3</td>
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<tr>
<td>gone “behind my back” and shared private information about me with other people.</td>
<td>1635</td>
<td>1307</td>
<td>79.9</td>
<td>229</td>
<td>14.0</td>
<td>70</td>
<td>4.3</td>
<td>19</td>
<td>1.2</td>
</tr>
<tr>
<td>given me the silent treatment or “cold shoulder” when I hurt his/her feelings or made him/her angry in some way.</td>
<td>1043</td>
<td>325</td>
<td>31.2</td>
<td>366</td>
<td>35.1</td>
<td>255</td>
<td>24.4</td>
<td>72</td>
<td>6.9</td>
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<tr>
<td>When…been mad at me, he/she has recruited other people to “take sides” with him/her and get them upset with me too.</td>
<td>1043</td>
<td>815</td>
<td>78.1</td>
<td>143</td>
<td>13.7</td>
<td>62</td>
<td>5.9</td>
<td>13</td>
<td>1.2</td>
</tr>
<tr>
<td>intentionally ignored me until I give into his/ her way about something.</td>
<td>1043</td>
<td>675</td>
<td>40.7</td>
<td>229</td>
<td>22.0</td>
<td>108</td>
<td>10.4</td>
<td>23</td>
<td>2.2</td>
</tr>
<tr>
<td>withheld physical affection from me when he/she was angry with me.</td>
<td>1040</td>
<td>397</td>
<td>38.2</td>
<td>280</td>
<td>26.9</td>
<td>227</td>
<td>21.8</td>
<td>94</td>
<td>9.0</td>
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<tr>
<td>spread rumors or negative information about me to be mean.</td>
<td>1041</td>
<td>962</td>
<td>92.4</td>
<td>52</td>
<td>5.0</td>
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<td>0.5</td>
</tr>
<tr>
<td>Female</td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>threatened to end our relationship in order to get me to do what he/she wanted.</td>
<td>1656</td>
<td>1352</td>
<td>81.6</td>
<td>214</td>
<td>12.9</td>
<td>72</td>
<td>4.3</td>
<td>8</td>
<td>0.5</td>
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<tr>
<td>gone “behind my back” and shared private information about me with other people.</td>
<td>1656</td>
<td>1377</td>
<td>83.2</td>
<td>197</td>
<td>11.9</td>
<td>63</td>
<td>3.8</td>
<td>15</td>
<td>0.9</td>
</tr>
<tr>
<td>given me the silent treatment or “cold shoulder” when I hurt his/her feelings or made him/her angry in some way.</td>
<td>1050</td>
<td>470</td>
<td>44.8</td>
<td>324</td>
<td>30.9</td>
<td>187</td>
<td>17.8</td>
<td>50</td>
<td>4.8</td>
</tr>
<tr>
<td>When…been mad at me, he/she has recruited other people to “take sides” with him/her and get them upset with me too.</td>
<td>1051</td>
<td>919</td>
<td>87.4</td>
<td>86</td>
<td>8.2</td>
<td>31</td>
<td>2.9</td>
<td>11</td>
<td>0.7</td>
</tr>
<tr>
<td>intentionally ignored me until I give into his/ her way about something.</td>
<td>1048</td>
<td>800</td>
<td>76.3</td>
<td>156</td>
<td>14.9</td>
<td>65</td>
<td>6.2</td>
<td>19</td>
<td>1.8</td>
</tr>
<tr>
<td>withheld physical affection from me when he/she was angry with me.</td>
<td>1049</td>
<td>609</td>
<td>58.1</td>
<td>249</td>
<td>23.7</td>
<td>134</td>
<td>12.8</td>
<td>36</td>
<td>3.4</td>
</tr>
<tr>
<td>spread rumors or negative information about me to be mean.</td>
<td>1050</td>
<td>1004</td>
<td>95.6</td>
<td>33</td>
<td>3.1</td>
<td>13</td>
<td>1.2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Table 3. (Cont.)</td>
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<td></td>
<td>n</td>
<td>0</td>
<td>%</td>
<td>1</td>
<td>%</td>
<td>2</td>
<td>%</td>
<td>3</td>
<td>%</td>
</tr>
</tbody>
</table>
| Relational Violence: My partner…  
  Male |   |   |   |   |   |   |   |   |   |   |   |   |
| threw something at me that could hurt. | 1637 | 949 | 57.8 | 581 | 35.5 | 75 | 4.6 | 22 | 1.3 | 9 | 0.5 | 4 (+) | 0.2 | 0.52 | 0.74 |
| pushed or shoved me. | 1042 | 901 | 86.5 | 39 | 3.7 | 43 | 4.1 | 29 | 2.8 | 18 | 1.7 | 7 (+) | 0.7 | 0.34 | 0.99 |
| punched or hit me with something that could hurt. | 1041 | 929 | 89.2 | 34 | 3.3 | 38 | 3.7 | 17 | 1.6 | 8 | 0.8 | 15 (+) | 1.5 | 0.27 | 0.93 |
| Female |   |   |   |   |   |   |   |   |   |   |   |   |
| threw something at me that could hurt. | 1656 | 1004 | 60.6 | 514 | 31.0 | 113 | 6.8 | 17 | 1.0 | 7 | 0.4 | 1 (+) | 0.1 | 0.50 | 0.72 |
| pushed or shoved me. | 1051 | 942 | 89.6 | 32 | 3.0 | 42 | 4.0 | 15 | 1.4 | 12 | 1.1 | 8 (+) | 0.8 | 0.24 | 0.81 |
| punched or hit me with something that could hurt. | 1051 | 1022 | 97.2 | 10 | 1.0 | 8 | 0.8 | 4 | 0.4 | 5 | 0.5 | 2 (+) | 0.1 | 0.06 | 0.44 |

Note.  
\(^a\) 1=Never, 2=Rarely, 3=Sometimes, 4=Often, 5=Very Often;  
\(^b\) 0=Does Not Apply, 1=Never, 2=Rarely, 3=Sometimes, 4=Often, 5=Very Often;  
\(^c\) 0=This Never Happen, 1=Not in the past year, but happened before, 2=Once in past year, 3=Twice in past year, 4=3-5 Times past year, 5 (+)= 6 or more times in the past year;  
\(^d\) 1= Never True, 2=Rarely True, 3= Sometimes True, 4= Usually True, 5= Always True.