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# Effects of Exposure to Abuse and Violence in Childhood on Adult Attachment and Domestic Violence in Women's Same-Sex Relationships

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EFFECTS OF EXPOSURE TO ABUSE AND VIOLENCE IN CHILDHOOD ON  
ADULT ATTACHMENT AND DOMESTIC VIOLENCE IN WOMEN'S SAME-SEX  
RELATIONSHIPS

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## ABSTRACT

### EFFECTS OF EXPOSURE TO ABUSE AND VIOLENCE IN CHILDHOOD ON ADULT ATTACHMENT AND DOMESTIC VIOLENCE IN WOMEN'S SAME-SEX RELATIONSHIPS

There is an abundance of previous research proving that childhood abuse and adult domestic violence is an increasingly serious problem (Smith Slep, & O'Leary, 2005). However, while studies have shown that lesbian intimate battering occurs as frequently, if not more than, heterosexual domestic violence (Gosselin, 2003; Niolon, 2002), it remains understudied. Therefore, this study not only examines the relationship between childhood abuse and intimate lesbian violence but also secure and insecure attachment styles. Children who witness domestic violence or who are victims of emotional, physical, or sexual abuse are likely to repeat or engage in violent relationships later in life (O'Keefe, 1997; van der Kolk, 2009). Victimized children are also at a greater risk of developing unhealthy, insecure ways of relating (Siegel & Hartzell, 2003).

Unexpectedly, childhood abuse or exposure to domestic violence was not found to directly impact adult aggression, but it did influence attachment style. As predicted, women who were victimized or exposed to violence in childhood were less inclined to feel close in their intimate relationships and were fearful of rejection. It was also found that lesbian women who were securely attached experienced less aggression in their intimate relationships. Limitations, implications for therapists, and recommendations for future research are discussed.

## ACKNOWLEDGEMENTS

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## DEDICATION

Dedicated in memory of Dr. Robert Massey  
(1943 – 2013)

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## **CHAPTER I**

### **Introduction**

The purpose of this study is to explore the relationship between exposure to family violence in childhood and aggression in adult lesbian relationships. Because of the multiple issues involved, the research will be conducted from a family-systems perspective in order to examine childhood abuse and adult intimate/domestic violence as well as attachment styles in relationships. It is anticipated that insecure (fearful, preoccupied, or dismissing) adult attachment styles and a history of family violence will be associated with an increased risk of abuse in lesbian partnerships. Conversely, secure adult attachments and absence of a history of family violence will be associated with a lower likelihood of violence existing in adult intimate relationships. Because of the limited research in this area, this study is intended to raise awareness and to provide some understanding of the complexity of adult lesbian relationships in women who have trauma in their backgrounds and multifaceted interpersonal relating styles.

### **Violence**

#### **Family Violence**

Family violence is viewed as a major public-health concern (Smith Slep & O'Leary, 2005) partly due to its increasing prevalence and also because of the serious,

long-term impact it has on the development of children. Tens of millions of United States (U.S.) families experience physical abuse in the home each year. According to national surveys, 12% of families have partner aggression (Smith Slep & O'Leary, 2005). Couples who have difficulty expressing themselves or who regularly bear negative emotions, such as anger, are more prone to experience domestic violence (Harned, 2001). Psychological and verbal abuse often leads to physical violence and can escalate to partner homicide (Anderson, 2005; Schumacher & Leonard, 2005).

Although there are numerous studies on child abuse and domestic violence within heterosexual families, there are few designed to examine the psychological and behavioral impacts such violence has on adult lesbian couples (Balsam, Beauchaine, & Rothblum, 2005). Most of the research is focused on female victimization in heterosexual relationships and not on same-sex persecution. Few researchers have examined traumatic victimization among lesbian relationships. Concomitantly, the majority of the body of literature highlights examination of the impact abuse has on children raised in heterosexual families rather than in homosexual ones. What is known is that domestic violence exists in all types of interpersonal relationships regardless of age, gender, or sexual orientation (Almeida, Woods, Messino, & Font, 1998; Kwong, Bartholomew, Henderson, & Trinke, 2003).

### **Domestic Violence**

Many stressors can potentially lead to violence in intimate relationships. These include finances, history of aggression or retaliatory behaviors, age, attachment issues, socialization, ethnic minority status, alcoholism/drug addiction, and homophobia, to

name a few (Henderson, Bartholomew, Trinke, & Kwong, 2005; Peterman & Dixon, 2003). Quite often, victims of violence in intimate relationships become violent as well, either due to self-defense or as retaliation. For instance, Hemming, Jones, and Holdford (2003) found that the majority of women accused of domestic violence were actually responding in self-defense. Carrado, George, Loxam, Jones, and Templar (1996) reported that 21% of females and 27% of males reported reciprocal violence in heterosexual couples. Their research implies that women and men can both be aggressors in intimate relationships.

### **Lesbian Intimate Violence/Domestic Violence**

Only recently has there been attention to viewing females as initiating or retaliating with aggressive behaviors in intimate relationships (Richardson, 2005). Historically, femininity has not been associated with female aggression since women have been stereotyped as passive and non-violent. Richardson (2005) reviewed studies from the late 1970s and early 1980s and discovered contradicting results in that women tended to be both victims and perpetrators of domestic violence, meaning that they are not only able but also willing to injure other people. Interestingly, he found that females responded more aggressively in private, rather than publicly, when provoked by male partners. This clearly suggests the need to review past and current research in order to give direction to future studies. More recent research indicates that mutual violence exists in approximately 10% of couples overall (Anderson, 2005).

If a pattern of aggression exists, it is likely that violence will continue to be used as a coping mechanism (Schumacher & Leonard, 2005). Consequently, it is essential to

understand when aggressive behaviors begin. For instance, lesbian youths who are targets of violence due to sexual orientation have experienced chronic aggression by the time they reach adulthood. Balsam and Szymanski (2005) have suggested that the result is that such victims tend to accept abuse in relationships and/or participate in the abuse cycle. Lesbian women, gay men, and bisexuals disclose more incidents of psychological, sexual, and physical victimization during childhood and adulthood when compared to heterosexual individuals. Balsam and Szymanski (2005) reported that lesbian adults are more often victimized than are heterosexual women. They also revealed that their parents abused many of them after homosexuality was discovered. These reasons may contribute to statistics on domestic violence being higher in same-sex relationships and highlights oppressions on the familial, social, and cultural levels.

While it is estimated that nearly 10% of the population are gay or lesbian (Lemon, 2001; Niolon, 2002), this has not been a group that has been widely studied (Green, 1996). In fact, it was not until the 1980s that research was conducted on same-sex couples (Farley, 1996; Peterman & Dixon, 2003). The National Crime Prevention Council report has indicated that violent behaviors in same-sex relationships are under-researched and that these partners are not receiving adequate professional attention from police and the mental-health-care system (Lemon, 2001). However, it has been consistently reported that domestic violence occurs just as often in homosexual relationships as it does in heterosexual ones (Gosselin, 2003; Niolon, 2002). McClennen, Summers, and Daley (2002) found that 25% to 50% of lesbian couples were violent towards one another. This was similar to what Balsam and Szymanski (2005) observed. Forty percent of their respondents were victims of lesbian domestic violence. Given the

dual stigma of being a lesbian and in an abusive relationship, lesbian intimate violence will likely continue to be under-reported in comparison to heterosexual domestic violence. As communities become better educated about lesbian battering and more aware of its impact on individuals and couples, it is hoped that societal prejudice and violence will be diminished.

### **Child Abuse**

In the U.S., the co-occurrence for child abuse and neglect and domestic violence is thirty to sixty percent (Appel & Holda, 1998; Edelson, 1999). Another study reported that over 50% of children who were physically and/or sexually abused also experienced domestic violence in the home (Kellogg & Menard, 2003). Children exposed to violence may be more likely to become perpetrators of aggression and develop more symptomatology, such as low self-esteem, depression, aggression, and anxiety, than children who were not exposed to violence (Athens, 2003). Recent research has suggested that childhood victims of violence and/or exposure to family violence can be offenders or victims (Kwong et al., 2003). Children who are subjected to violence may learn to use aggression as a means of conflict resolution in relationships and may incorporate feelings of anger, shame, and guilt into their personality structures (van der Kolk, 2009). Victims who fail to regulate emotions, especially anger, later lean towards being the aggressor and become more tolerant of adult intimate abuse (Bandura, 1977; 1973; Schumaker & Leonard, 2006; & Stanley, Bartholomew, Taylor, Omar, & Landolt, 2006). Besides displaying aggressive behaviors, children who are exposed to or victims

of abuse develop poor communication skills and ineffective coping styles (van der Kolk, 2009).

Abused youths and the impact violence has on its victims in relation to types of attachment have been interests of this researcher for many years. In working with both juvenile and adult victims and offenders, the necessity of prevention and education is paramount. In doing couples and family therapy, it is clear that unresolved wounds of the past become prominent issues in adult intimate relationships. Such calcified wounds often lead to ineffective communication, higher levels of distress, greater frustration, and increased risk of domestic abuse. Subsequently, while wanting to avoid old patterns that have emerged from past relationships, victims frequently recreate relationship dynamics (or attachment styles) that perpetuate and maintain violence (Siegel & Hartzell, 2003).

The general public has some awareness of the impact domestic violence has on children (Appel & Holda, 1998; Edelson, 1999). More and more same-sex couples are raising children, resulting from invitro fertilization, adoption, providing foster care, or having children from previous heterosexual relationships. In 2005, the U.S. Census Report noted that 20% of 776,943 same-sex couples were raising children (Census Report, 2005). Given research findings that indicate domestic violence is equally prevalent in heterosexual and gay couples (Gosselin, 2003; Niolon, 2002) these youngsters may be at risk of being exposed to domestic violence but existing research has not adequately addressed this population. Consequently, there is an urgent need for research and the development of preventative measures. If the issue of violence goes unaddressed, members of lesbian households will be further stereotyped and discriminated against while the progeny of such relationships grow up learning

dysfunctional ways of relating. Thus, mending and strengthening family relationships becomes the goal.

### **Attachment Styles**

Evidence suggests that exposure to violence leads children to be suspicious of trustworthy and safe relationships (Siegel & Hartzell, 2003). Just as abusive parents are controlling, children, too, cultivate a need to dominate others and their environments in attempts to feel (falsely) secure. Children subjected to violence may have difficulty developing empathy for others. They are more often involved in partner violence later in life (Smith Slep, & O'Leary, 2005). How resilient or traumatized a child is stems partly from the type of attachment style to primary caretaker(s). Attachment is a complimentary dance, a process of interrelating intimate messages that develops over numerous experiences and exchanges (Fraiberg, 1987). The two types of adult attachment styles that will be examined in this research are secure and insecure. Insecure attachment styles will consist of fearful-avoidant, preoccupied, and dismissing (Collins, 1996; Henderson et al., 2005). An insecure-disorganized/disoriented childhood attachment style may later turn into an insecure-fearful-avoidant adult attachment style; insecure-ambivalent/resistant may turn into insecure-preoccupied; and insecure-dismissing would remain insecure-dismissing in adulthood (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969, 1982; & Crowell & Treboux, 1995). For the purpose of this study, because of the instrument used (The Revised Adult Attachment Scale, Collins, 1996), fearful-avoidant, preoccupied, and dismissing are the categories used for insecure types of relationships.



Typically, the type of attachment style established in childhood will remain into adulthood (Bowlby, 1969; Davies, 2004). While there is some fluidity in relating to others, attachment styles are relatively constant. Adults who had encouragement, empathy, warmth, and affection during childhood are more likely to be able to securely attach to primary figures and less prone to have violent relationships in adulthood (Marcus & Swett, 2002). Markowitz (2001) noted that children with good communication and social skills were more resilient and more inclined to have secure attachments in adult relationships. However, adults who need repeated reassurance and attention and are partnered with someone who is more personally independent may be at a greater risk for intimate violence (Harned, 2001). Feelings of insecurity, inadequacy, jealousy, or rejection (unhealthy attachment styles) can trigger partner violence since they place a direct or indirect pressure on one's partner to compensate for such feelings (Landolt, Bartholomew, Saffrey, Oram, & Perlman, 2004; Stanley et al., 2006).

### **Need for Research**

Domestic violence in lesbian relationships involves emotional, psychological, physical/sexual abuse, financial, and/or social control over an intimate partner (Almeida & Durkin, 1999). Very few researchers have fully examined traumatic victimization amongst same-sex relationships. Most studies have been focused on chronic histories of violence and trauma within the heterosexual population. Studies that examine domestic violence in lesbian relationships are limited for a variety of reasons, such as lack of representative samples and failure to fully assess sexual orientation or relationship dynamics (Balsam et al., 2005; Frieze, 2005). Comprehensive studies are needed to

examine history of aggression, traumatic experiences, attachment styles, family/ contextual dynamics, and relationship histories. Existing research on lesbian domestic violence has also been limited by the use of non-standardized measures, inadequate research designs, and not clearly defined criteria. Additionally, there are fewer lesbian partnerships than heterosexual ones, thus making research participants less available (Frieze, 2005). Lesbian couples often intentionally portray their intimate relationships as being healthy rather than being forthcoming about conflict, let alone violence.

Although legal and social support exists for heterosexual victims of domestic violence, there remain many heterosexual victims who remain isolated due to fear and shame. This is confounded for same-sex victims of intimate violence due to the additional stigma associated with the type of relationship. In addition, sexual and ethnic minorities are further ostracized and apprehensive about trusting others outside of the family unit. Despite the continued rise of lesbian domestic violence statistics, the availability of appropriate services remains poorly publicized (Merlis & Linville, 2006; Peterman & Dixon, 2003). Traditional, heterosexual-oriented laws and social services do not protect or empower same-sex victims and their families. Furthermore, since the rights of domestic partnerships vary from state to state, many choose not to seek help due to the fear of exposure, discrimination, further victimization, and legal ramifications (Frieze, 2005). It is crucial for researchers and social-service professionals to better understand the relationship dynamics and cultural issues involved to more appropriately intervene with lesbian domestic violence.

Examination of the long-term effects of childhood victimization, lesbian adult victimizing or offending behavior, and learned attachment styles has been scarce. It is

known that children who have been exposed to childhood or family violence are likely to become involved in abusive adult relationships (Davies, 2004; McClennen et al., 2002). While attachment styles are relatively consistent over time, they can change, especially when primary relationships change. It is hoped that this author's research will provide new information and provide further incentive to carefully examine chronic histories of abuse and its impact on adult lesbian relationships.

### **Conceptual Definitions**

#### **Lesbian Intimate/Domestic Violence**

Lesbian domestic violence or adult (18 or older) intimate violence can involve verbal, emotional, psychological, physical, and/or sexual abuse or coercion (Merlis & Linville, 2006). Intimate violence can be in the form of intimidation, threats, put-downs, beating, pushing, shoving, throwing objects, using weapons, blocking an exit, isolating or entrapping a partner, driving fast in a vehicle, forcing a partner to engage in unwanted sexual activity or sexual exploitation, or gaining economic control in order to dominate a partner. Almeida and Durkin (1999) add that domestic violence can be "coercive and controlling behavior to limit, direct, and shape a partner's thoughts, feelings, and actions" (p.313). Intimate/domestic violence can occur in heterosexual, bisexual, and same-sex relationships.

#### **Child Abuse**

Child abuse can entail physical, sexual, or emotional/psychological aggression, as well as exposure to domestic violence (see domestic violence definition above). These types

of abuse involve verbal and nonverbal behaviors to juveniles under the age of seventeen. Physical abuse is intended to harm a child by hitting, kicking, pushing, punching, shoving, throwing objects, or using weapons (Johnson, Kotch, Catellier, Winsor, Dufort, Hunter, & Amaya-Jackson, 2002). Sexual abuse is when an adult or someone at least five years older than the child (Briere & Runtz, 1990) forces or coerces a minor to engage in or perform sexual acts, such as felacio, fondling, vaginal/anal/penile/digital/object penetration, sodomy, exhibitionism, rape, sexual exploitation, or exposure to pornography or sexual activity (Balsam et al., 2005). Emotional or psychological abuse can harm a child by words, threats, isolation, control, intimidation, or jealousy (Gosselin, 2003). Not supporting or encouraging dreams and goals as well as disrespecting another's feelings can also express emotional or psychological abuse.

### **Attachment Styles**

Adult secure and insecure attachment styles will be examined. Secure attachment can be expressed or enhanced by touch, massage, hugging, intimacy, or kind and encouraging words. Attachment strengthens with consistent and repeated quality time together, affirmation, and validation. Insecure attachment bonds may be expressed in fearful-avoidant, preoccupied, or dismissing behaviors (Landolt et al., 2004). Secure attachment styles in romantic relationships are described as being close, reciprocal, trustworthy, and dependable. Secure attachment styles can provide safe-havens that help develop and maintain healthy intimate relationships (Ainsworth et al., 1978; Bowlby, 1982). Fearful attachment styles in adult romantic relationships may be evident in a partner's fear of intimacy and dependence and can involve jealous behaviors (Collins, 1996; Henderson,

et al., 2005). Individuals with preoccupied attachment styles may want to be close with a partner but also be anxious, pensive, or inattentive. Dismissing attachment styles involve fear of abandonment, uncertainty about security of relationship, and unavailability to one's partner.

## **CHAPTER II**

### **Literature Review**

This chapter contains exploration of how child abuse and/or exposure to domestic violence during childhood affects how one learns to relate to, trust, or attach to adult intimate partners. There will also be discussion pertaining to learned adult attachment styles and adult intimate violence. Although the literature has been historically focused on heterosexual couples, as the chapter progresses this researcher will provide links regarding the dynamics of domestic violence in lesbian relationships.

In this research, the variables studied are lesbian domestic violence, history (or not) of child abuse and/or exposure to domestic violence, and two different types of attachment styles (secure and insecure). Three theories that will be specifically discussed are Attachment Theory, Social Learning Theory (SLT), and the Cultural Contextual Model to help the reader make better sense of learned behavior, emotional connection, type of attachment, and how partners identify with gender and roles in lesbian couples.

In gaining a comprehensive view of the occurrence and severity of lesbian intimate partner abuse, it is crucial to discuss the impact of homophobia and oppression, as well as the issues of power and control. In addition, the lack of protective laws or legal recognition of same-sex relationships cannot be ignored when researching conflict and power issues in lesbian relationships, since they contribute to isolation and disempowerment. Other issues that directly and indirectly affect how lesbians relate to

one another are respect, safety, security, trust, and understanding (Speziale & Ring, 2006). While age and alcohol and/or substance abuse are important contextual variables that affect attachment styles and risk of domestic violence (Frieze, 2005; Prescott, 1975) they will not be directly examined in the present study but should be considered in future research.

Violence has been a major global epidemic for decades with tens of millions being victimized yearly in the United States alone (Prescott, 1975; Smith Slep & O'Leary, 2005). It can be seen in riots, gang-related activities, initiation into clubs, terroristic threats, bombings, hijackings, war, and domestic relations. During the 1970s, the phenomenon of mutual battering, with women defending themselves against men, was identified (Potoczniak, Murot, Crosbie-Bennett, & Potoczniak, 2003). The most frequent form of domestic violence is common couple battering (Johnson & Ferraro, 2000). Common couple violence arises after a partner exhibits verbally and physically aggressive behavior as a means of relating in the relationship (Archer, 2000; Frieze, 2005; & Schumacher & Leonard, 2005). As long as there is social and familial acceptance of violence, it will remain at epidemic levels.

### **Need for Research**

There have been few studies to thoroughly examine domestic violence amongst lesbian couples (Balsam et al., 2005). The literature published about domestic violence is predominantly about males being abusive with little focus on female aggression (Frieze, 2005). In 1993, Bryant reviewed 425 social work articles from 1977 to 1992 dealing with violent behaviors, primarily family violence (VanSoest & Bryant, 1995). Not until

1981, did Bryant locate articles inclusive of domestic violence in gay and lesbian relationships. Research about lesbian domestic violence is scarce in part because lesbian women fear publicly confirming sexual orientation, may be uncertain of sexual orientation, and have trepidation of discrimination, negative stereotyping, and further victimization. Additionally, there are fewer lesbian couples than heterosexual couples, thus making their plight less visible.

Several obstacles exist in studying lesbian domestic violence. For instance, a clear definition of what constitutes lesbian domestic violence is lacking (see end of Chapter 1 for definition of intimate violence against women). The stereotype that domestic violence in lesbian partnerships is less serious because both partners are presumed to be equal in strength is damaging and inaccurate and fails to appreciate the psychological impacts of partner violence. Additionally, there is a dearth of empirical data. What information is provided in the literature is mostly anecdotal. The studies tend not to contain thorough comparisons and contrasts between lesbian and heterosexual groups. Furthermore, study samples are usually small and unrepresentative, or the studies are too inclusive of other variables (i.e., including hate crimes). Finally, the instruments and measures used are often non-standardized and the authors did not provide clear descriptions of the research methodologies (Balsam et al., 2005; Herek, 2006). For these reasons, the results can be misleading, and it remains unclear what has actually been examined.

Misnomers and stereotypes, such as thoughts about butchness or more masculine traits as contributing to aggression, can interfere with the ability to conduct accurate research and offer accurate data (Balsam et al., 2005; Merlis & Linville, 2006). Old



assumptions about size and appearance do not fully capture or explain relationship dynamics with aggressive lesbian couples. Professionals referring to the abuser as “he,” whether out of habit, ignorance, or overt discrimination, is inaccurate and misleading. Additionally, women are capable of abusive behavior and may deny responsibility (Danger, 2003; Merlis & Linville, 2006). Consequently, better research is needed.

Due to poorly conducted studies and limited research, it is difficult to advocate for adequate funding for services for lesbian domestic violence victims, offenders, and their children. Subsequently, there is a lack of recognition of what services are actually needed for the lesbian community (Frieze, 2005). It seems that heterosexually based models (Almeida & Durkin, 1999; Stanley et al., 2006) and generic or generalized models (Merlis & Linville, 2006) do not meet the needs for lesbian victims of domestic violence; therefore, further exploration into the culture and dynamics of lesbian relationships is required. This is the only way to educate the general public and persons who work with lesbians who are in violent relationships and to thus prevent the cycle of abuse from continuing.

### **History of Domestic Violence**

During the 1960s, feminists began raising society’s awareness that domestic violence was a common problem in heterosexual relationships (Merlis & Linville, 2006). The first safe haven was opened in England in 1971 for abused women. In 1972, the first U.S. shelter for female victims of domestic violence was developed by the Women’s Advocates Minnesota Inc. since there was a growing need to help domestic violence survivors. From 1992 to 1996, the Juvenile Bureau of Statistics (JBS) noted that eight

out of 1,000 women and one out of 1,000 men were battered in heterosexual and same-sex relationships. Fifteen to 20% of married or cohabitating couples in the U.S. have had a least one incident of domestic violence (Schumacher & Leonard, 2005). Many researchers have found that domestic violence exists equally or to a higher degree in same-sex relationships versus heterosexual ones (Fortunata & Kohn, 2003; Merlis & Linville, 2006; & Petermen & Dixon, 2003).

Four known causes of family violence are long-term use of alcohol, social isolation of family, depression, and intergenerational transmission of violence (Davies, 2004; van der Kolk, 2009). Other reasons identified as causal factors for interpersonal aggression are sexual desires, sexism, youthfulness, need to dominate partner, maintaining stereotypic roles in the relationship, patriarchal societies, proving love for the other, seeking independence, and criticism (Almeida & Durkin, 1999; O'Leary & Williams, 2006). Social control, sensationalizing violence, challenges with verbal expression, and attention-seeking behaviors are other reasons related to violence. Also, researchers have found that chaotic homes, drug involvement, limited finances, histories of victimization, insecure attachments, and poor parenting abilities can be attributed to physical aggression (Frieze, 2005; Harned, 2001; Prescott, 1975).

The violent offender usually feels insecure about herself and the relationship and subsequently takes her felt inadequacies and need for control out on the victim (Stanley et al., 2006). By being violent, the perpetrator experiences a sense of superiority by projecting his/her shortcomings onto the victim. The aggressor has a fear of rejection and abandonment. The offender expects the victim to meet his/her needs while disregarding her partner's needs. The batterer typically tends to behave in an impulsive manner while

failing to consider the consequences. The abuser lacks appreciation of the intrinsic value of the partner when fighting for dominance and submission (Felson, 2002).

### **Types of Violence**

Johnson and Ferraro (2000) identified four types of violence: common couple violence, intimate terrorism, violent restraint, and mutual violence control. In common couple violence both partners tend to be abusive on rare occasions, and thus typically do not worsen over time. In the second type, intimate terrorism, there is a greater risk for the partner to be injured, and it tends to escalate throughout the relationship. The third kind of violence is violent restraint, and this tends to be in self-defense. Lastly, mutual violence control is when both partners try to dominate the other to gain more power and control through intimate terrorism. Interestingly, research has concluded that when one partner stops hitting the other partner follows suit (Schumaker & Leonard, 2005). Intimate violence can be cyclical in terms of the offender acknowledging and admitting her abusive nature, but, when feeling vulnerable or angered again, she retaliates and places blame back on the victim. In turn, the perpetrator does not fully take responsibility and continues to repeat the pattern of violence and justifies doing so (Almeida & Durkin, 1999; Merlis & Lenville, 2006). Characteristically, victims remain in a relationship out of fear of retaliation and not being ready to end the relationship (Frieze, 2005).

A widespread understanding of heterosexual female victims of domestic violence has emerged due to years of research (Frieze, 2005; Rothenburg, 2003). Feminist researchers began studying domestic violence in the 1970s and 1980s. One of the first,

most commonly quoted pieces of work was by Lenore Walker in *The Battered Woman* (1979) in which she portrayed women as helpless victims from interpersonal violence (Rothenburg, 2003). While the book provided information about female victimization, research since then has shown a broader view of domestic violence. Historically, feminist theorists examined power differentials, implying that men always have control over women. This view is not always accurate (Potoczniak et al., 2003). Would feminist theorists categorize the battered woman in a lesbian relationship as the wife and the female perpetrator as the husband? Feminists have mistakenly presumed that domestic violence occurs mostly in heterosexual relationships and is not as common in same-sex ones, especially female-to-female relationships. In addition, they often minimize the complicated emotional attachments in abusive relationships (Goldner, 1999; Merlis & Linville, 2006). For instance, a strong emotional and romantic connection can coexist with a coercive and abusive relationship. Incorrect stereotypes about gender role norms, a butch-femme dichotomy, and internalized homophobia keep same-sex domestic violence invisible and make it difficult for victims and offenders to receive help.

### **Causes of Violence**

Goldner (1999) believed that aggression and victimization were “multiply determined” (p. 327) and cannot be understood without incorporating various perspectives. For instance, there are ethical, legal, and political issues involved in same-sex partnerships to take into consideration when seeking understanding of violent behavior. In addition, the psychological makeup of each partner affects how they relate to one another. Goldner (1999) acknowledged that there are often “contradictory truths”

(p. 329) within a couple's accounts of domestic violence and that the aggressor needs to be morally challenged without ostracizing her. Mental-health professionals need to intricately deconstruct how the victim and the offender have been socialized. Furthermore, it is important to learn how each partner rationalizes aggression, tells her narrative, and understands positive aspects of the relationship.

### **Emotional and Psychological Abuse**

It has been said that psychological aggression may be more detrimental than physical abuse (Henderson et al., 2005) and has more symptomatology as a result (Harned, 2001). Pierce (1970) referred to microaggression as a means of psychological abuse resulting from degradation, rejection, and humiliation. An example of microaggression is a lesbian woman being ostracized at home, work, and in the community. Microaggression can also be done in subtle ways such as gay slurs or insults, holding onto a purse as a racial minority walks by, or seeing a confederate flag outside of a school (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, & Equilin, 2007). Microaggression has a negative effect on the emotional and psychological well-being of a person. Quite often the impact of emotional abuse is overlooked due to its lack of visibility, but the harmful effects can be long-lasting and traumatizing (Frieze, 2005). It is not uncommon for emotional abuse to escalate into more serious forms of physical and sexual coercion that can lead to spousal/partner homicide (Jenkins & Aube, 2002; Merrill & Wolfe, 2000; Potoczniak, Murot, Crosbie-Bennett, & Potoczniak, 2003; & Stanley et al., 2006). Felson (2002) found verbal aggression to exist in the majority of, if not in all, domestic-violence episodes.

## **Women and Violence**

Traditionally, research has indicated that men are typically more violent in relationships than women (Graham-Kevan & Archer, 2005; Tjaden & Thoennes, 2000). It is believed that men tend to seek dominance more than women, likely due to biology and sociology (Stanley et al., 2006). In heterosexual relationships, men have justified their abusive behaviors by saying that the women have been controlling, intentional, and self-focused (Graham-Kevan & Archer, 2005). There are some who challenge the view that men are more abusive than women; although this is contrary to public belief (Frieze, 2005). One of the first groups of researchers to suggest this was Strauss, Gelles, and Steinmeth (1980) who observed that both men and women are perpetrators of aggression in intimate relationships. This was also supported by Richardson's (2005) review of literature from the late 1970s to the early 1980s which indicated that men and women were equally likely to behave aggressively in intimate relationships or in general. Archer's (2000) study revealed that women were more likely to use one or more forms of violence, but men were more injurious than females (Richardson, 2005). It appears that women are not only fighting back but may actually be more intimately aggressive than once thought.

Richardson (2005) reported that the dynamics of a relationship, rather than gender, were more important in determining the aggressor. She stated that more recently the academic world is considering females as being initiators of or retaliating with aggressive behaviors. The reluctance to view women as abusive is due to two reasons. First, femininity is not associated with aggression; therefore, people are reluctant to view women as abusive. Secondly, women have been stereotyped as being passive in

relationships. This makes it unlikely that they would retaliate with aggression. Unlike what feminists theorists have believed, Richardson proposed that women are both victims and offenders in regard to domestic violence since they are willing and capable of inflicting harm on others.

Graham-Kevan and Archer (2005) noted three primary reasons why women participated in aggressive behaviors with their partners: fear for physical safety, reciprocity or self-defense, and coercion or pressure to be aggressive by the partner. After being a repeated victim of intimate violence, a partner learns to respond in self-defense or retaliation. Research conducted found that 21% of women admitted engaging in reciprocal violence (Graham-Kevan & Archer, 2005). Unless families and society change their views about violence and teach different ways of relating, more and more women will feel justified in using aggression as a means to cope and will pass this to their children.

### **Children Exposed to Domestic Violence and Victims of Child Abuse**

Children who have witnessed domestic violence between their parents are at greater risk of developing emotional and behavioral problems (Siegel & Hartzell, 2003); even more so than when exposed to community or stranger-to-stranger violence and (Davies, 2004; Schwartz & Proctor, 2000). Children who witness brutality are more inclined to use aggression because they believe it is an acceptable way to resolve conflict. Children's abilities to self-regulate and build genuine attachments are compromised when they are exposed to or become victims of chronic violence. Victimized children tend to gravitate to immediate gratification and toward maintaining

control. It is not uncommon for these youths to become involved in criminal activity (Grogan-Kaylor & Otis, 2003). These abused minors lack perseverance skills and the tenacity to wait for long-term benefits. Furthermore, such youths rely on behavior rather than verbal or analytical coping skills. While abused children may not seem routinely unkind, they can come across as self-focused and insensitive towards others.

Families are generally the primary socialization agents and teach children ways to cope. One of the first and most violent environments can be the family (Balsam et al., 2005; Goldner, 1999). If children are exposed to violence over time, aggression becomes a defense mechanism as children grow, and they begin to believe that violence obtains positive outcomes (Schwartz & Proctor, 2000). Children begin to learn in the contexts of violence when relating to others, and exposure to an aggressive interactive pattern diminishes their inhibitions and internalized norms against aggression. When a parent uses physical discipline on a child some writers have proposed that, she may learn the following four lessons: (1) what she has to avoid to prevent such punishment, (2) she associates love with violence since it seems okay to hit a child for whom love may be professed, (3) she believes physical discipline is necessary to promote appropriate behavior, and (4) she experiences that if a goal or object is important or valuable to another person, it is permissible to use violence (Strauss, 1980; 1991). Some caretakers do not stop with physical discipline and take it too far. It has been reported that 5% of children experience severe parental abuse (Smith Slep & O'Leary, 2005). Ultimately, when a child is exposed to violence in his/her family of origin, the child may internalize an emotional and interpersonal/social meaning to it, thus increasing the risk of aggressive behavior later in life.



While there are common and overlapping symptomatic features of childhood mistreatment, there are a few differences. For instance, psychological abuse has been associated with low self-esteem, suicidality, dissociation, and interpersonal sensitivity (Briere & Runtz, 1988; 1990). Child sexual abuse has been linked to fearfulness, depression, anger, academic difficulties, inappropriate sexual behavior and maladjustment, dissociation, isolation, suicidality, self-mutilation, and risk of re-victimization. Physically abused children have been found to have issues with anger, impulsivity, delinquency, increased autonomic arousal, sexual problems, and poor self-image. Abuse survivors can ultimately carry guilt and shame, a sense of undeservedness, and can be critical of themselves and others (Briere & Runtz, 1990).

Research indicates that there is an overlap of child abuse and domestic violence, but such studies are sparse (Hartley, 2002). A review of 31 studies evidenced that child maltreatment and domestic violence co-existed in 30 to 60% of the families. Other studies have indicated a forty percent of co-occurrence. There are many factors that contribute to how abuse impacts a child. These include family dynamics, socioeconomic status, neighborhood, and resiliency (Grogan-Kaylor & Otis, 2003). Stress and violence in the parental relationship reduces the victimized partner's ability to effectively cope with a child. In homes with domestic violence, there is a greater risk of the victimized spouse overreacting to a misbehaving child and of becoming abusive him/herself (Smith Slep & O'Leary, 2005).

It is common knowledge that abused children and children who witness domestic violence are negatively impacted. Victimized children tend to later exhibit violent or withdrawn behaviors, have symptoms of depression, anger, and anxiety, and develop

delinquent behavior (Johnson & Ferraro, 2002; van der Kolk, 2005). Other symptomatology chronically abused children may experience are Posttraumatic Stress Disorder (PTSD), emotional distress and dysregulation, reactivity, fear, hypervigilance, somatic complaints, memory difficulties, and socialization issues. Emotionally mistreated youths may experience ostracism, rejection, and peer bullying (Schwartz & Proctor, 2000). Children who experience an early onset of violent behaviors tend to become more aggressive over time and can develop antisocial and criminal behaviors (Grogan-Kaylor & Otis, 2003). Athens's work (2003) supported this correlation of traumatic abuse in the family of origin of violent criminals. His work will be further discussed in Chapter IV as it pertains to learned violence, the integration of violence into one's sense of self, and how violent offenders relate to others in relationships and in the community. Exposure to spousal domestic violence has been linked to sibling aggression and adult abuse in intimate relationships. Childhood histories of physical, emotional, and/or sexual abuse have also been associated with adult violence by both victim and offender (Markowitz, 2001; Wisdom & Maxfield, 2001).

Lesbian minors are targets for aggression when disclosing sexual orientation and for not conforming in appearance or expressions of sexuality (Balsam et al., 2005). The mistreatment can begin with parents or caretakers, siblings, other relatives, peers, teachers, and later occur with adult intimate partners. Studies have suggested that sexual minorities are more victimized than heterosexuals. This may be why there is more domestic violence in same-sex relationships. However, lesbian minors may likely struggle in relating to their families if homosexuality is not supported or understood.

Balsam and colleagues (2005) found that lesbians, gay men, and bisexuals experienced more incidents of psychological, physical, and sexual abuse in childhood and adulthood than did heterosexual individuals. A recent study has found that over 80% of lesbian victims of domestic violence were raised in abusive homes (McClennen et al., 2002). This kind of childhood home environment may teach adult lesbians to manage family conflict through violence and can cause them to have low self-esteem. If a violent home atmosphere is compounded with internalized homophobia, a lesbian may project her negative self-image onto her partner and, again, increase the risk for intimate aggression. McClennen and colleagues (2002) found that “communication and social skills, substance abuse, intergenerational transmission of violence, fake illness, internalized homophobia [self hatred], and status differentials” (p. 277) are contributing factors that lead to lesbian intimate violence. The researchers also noted that multiple forms of abuse, such as physical, emotional, and/or financial, were common among lesbian partners.

### **Attachment Theory**

Alicia Lieberman and Selma Fraiberg were two researchers who developed a scientifically based approach to understanding and explaining Attachment Theory (Marvin, 2008). Fifty years ago, John Bowlby wrote *Child Care and the Growth of Love* as he began developing his version of Attachment Theory, which has been highly debated over the years (Koops, Kahr, Bowlby, & King, 2004). A fundamental principle of Attachment theory is that people of any age must have one primary attachment figure above all other relationships. In addition, it is necessary to have more than one bonding

relationship. This is illustrated by Bowlby's attachment pyramid in which the primary attachment figure (often the mother) is at the very top of the pyramid, the secondary attachment figure is in the middle, and friends and other family members are at the bottom.

Infants are born with attachment capabilities, but are not yet attached. The first twelve to eighteen months are crucial in developing safe, secure, emotional bonds with a primary figure (Fraiberg, 1987). Children's internal working models are usually established by age three (Davies, 2004). Mary Satler Ainsworth found that a secure base allows the child to be protected and receive consistent nurturance while encouraging the child to explore the environment and come back to the base (attachment figure) as needed. Children need to begin building attachments early in life since it becomes more difficult to do so later (Marvin, 2008). However, again, there should only be a few primary figures to whom the child is expected to attach. Typically the baby's mother and/or father or caretaker(s) are the primary attachment figures, and it is hoped that these bonds remain until death. During the first four years of life, toddlers seek to negotiate and cooperate within a close bond, which allows for the development of competency and self-reliance. Toddlers and children will often try to maintain relations with attachment figures even to their own detriment. Fifty years of attachment research has indicated that love and empathy from parent to child creates secure attachment. In this manner, the child learns how to internally how to self-regulate emotions and behavior (Bowlby, 2005; Siegel, 1999; Siegel & Hartzell, 2003;). Attachment entails a biological component involving the parent protecting the child and assisting the child in feeling safely organized (Marvin, 2008). Healthy development results when both parents and children

have mutually satisfying relationships that are continuously warm (Koops et al., 2004). Parenting a child in need requires protecting, comforting, delighting, and helping to organize the child's feelings. Ignoring or dismissing attachment triggers can cause emotional and behavioral problems resulting in long-term psychological or physical harm (Marvin, 2008). It is crucial to accurately read a child's cues and to sensitively and appropriately attend to them. According to Bowlby (2005),

attachment is a strong causal relationship between an individual's experiences with his parents and his later capacity to make affectional bonds, and that certain common variations in the capacity, manifesting themselves in neurotic symptoms and personality disorders, can be attributed to certain common variations in the ways that parents perform their roles. (pp. 160-161)

Attachment is a complimentary dance, a process of interrelating intimate messages; that develops over numerous experiences and exchanges (Fraiberg, 1987).

Healthy children and adults learn how to comfortably change roles as situations change (Bowlby, 2005). Secure attachment allows children to become self-reliant, trusting, and cooperative adults, provided the parent is sensitive to the infant or child's "signals and communications" (Fraiberg, 1987, p. 135). Securely attached individuals can take the initiative with self-confidence, but can also ask for assistance and support during times of distress. Confident, happy humans have at least one or more humans who are emotional safe havens. These individuals receive continuous support, love, and encouragement and can return home even as an adult to be recharged (Koops et al., 2004; Marvin, 2008). Throughout life, adults also benefit from returning to their social networks in which they grew up.

Winnicott (1995) wrote about the relationship between “good enough” parenting, the home environment, and larger society and their impact on the developing individual. Parents have the responsibility to physically and emotionally nurture or “hold on” to their child in order to help the child acquire the skills to identify and connect with larger social groups. Initial caretakers need to be able in Winnicott’s (1995) terms, to adequately “hold” the child while the child learns the skills needed to successfully participate and “contribute in” at each increasingly larger circle of social support (extended family, school, neighborhood, and community, as well as other ethnic national and international communities). If this process of adequate holding onto and letting go is repeated at each level, the individual will learn to contribute responsibly to support individuals or groups at each of these levels. Environmental failure at any level or exposure to abuse, oppression, or neglect can cause injury. Winnicott believed that parents’ unavailability, due to reasons such as mental illness or divorce, could cause children to aggressively or passively make attempts to have the world rectify its wrongs. The longer children are exposed to unsafe conditions, such as family violence or parents’ emotional instability, the harder it may be for them to find a balance of dependence and individuality, running the risk for antisocial behavior. Davies’ (2004) review of research indicated that antisocial children had punitive and inconsistent parenting, did not have enough positive interaction with parents, and were frequently unsupervised. Sensitive and consistent parenting and a stable environment support emotional growth in an individual. Emotionally mature adults help their children to process events and learn to understand others (Siegel & Hartzell, 2003). This enables them to contribute responsibly to and

become a member of society and possibly one day, create a family of their own (Winnicott, 1995).

Conflict is an emotion that is commonly experienced, and the goal is to learn how to regulate it effectively (Bowlby, 2005). It is necessary for children to be able to openly and impulsively express feelings of anger and jealousy. When parents respond with patience, love, and tolerance, their children learn self-control and acceptance. A common cause of anger and anxiety in children is because they crave to be cared for and loved. Intense emotions are the result of how attachments are formed, maintained, disrupted, and/or renewed. Childhood relational experiences either encourage or hinder a belief in and ability to develop and maintain an emotionally bonding secure relationship. Youths are sensitive to the attachment figure's tone, facial expressions, and body language. If one or both parents reject or do not respond to the child's needs, the child will feel insecure and anxious. Additionally, if parents threaten to leave the child or family, threaten to harm him/herself or family members, or instill in a child a sense of responsibility for the parent's well-being or health, the child may become over-dependent, immature, depressed, or develop a phobia throughout life. The sense of abandonment, yearning, and anger becomes deeply embedded into one's core being and teaches the child that people are not trustworthy. Children deprived of emotional bonds lack inhibitions to regulate or manage aggressive behavior (Fraiberg, 1987). As adults, chronically impaired emotional bonds can lead to personality disorders, criminal behavior, depression, intense anger, anxiety, suicidality, psychosis, and sociopathic behavior. When deviant patterns in childhood relationships occur, such as neglect or

mistreatment, the survivors may become cruel, be sexually promiscuous, develop addictions, and/or have unstable work histories (Marvin, 2008).

To understand the impact of a disrupted or insecure attachment, it is necessary to know the child's age, to whom the child is attached, as well as the length and frequency of the separation (Bowlby, 2005). If the attachment is disrupted in the first two years of life, there may be intellectual impairment as well as emotional. Unhealthy attachment can cause a child to become overly clingy, demanding, indifferent, or defiantly independent. In an unhealthy attachment style the caretaker exerts pressure and premature responsibility onto the child for the caretaker's feelings. This can create resentment in the child, and throughout life the (adult) child becomes overly self-sufficient and untrusting of being reliant on others.

Ainsworth and others identified one type of secure and two types of insecure attachment styles in children (avoidant and ambivalent). Main and colleagues later found a third type of insecure attachment style (disorganized/disoriented) (Davies, 2004). Children who are insecure-avoidant tend to be self-reliant, have blunted or restricted affect, and do not express separation anxiety. Insecure-ambivalent/resistant children may want to be emotionally connected to the parent but feel uncertain whether the parent will be available at times and in ways that meet the child's actual needs. Such children likely focus more on the parent's demeanor and less on exploring the world. A youth who has an insecure-disorganized/disoriented attachment typically expresses contradictory behavior when exposed to Ainsworth's Stranger Situation, and presumably in daily life, such as smiling at his/her mother but turning away as she approaches. When the



parenting is inconsistent, possibly due to unresolved trauma, the child experiences internal conflict and has difficulty self-regulating (Davies, 2004).

Interestingly, a child may have an insecure attachment with one parent but a secure attachment with another parent or caretaker (Davies, 2004). Based upon parenting and environmental conditions, children can adjust to trauma in a healthy or unhealthy manner. For example, a child whose parent has a drug addiction and is alternatively neglectful and aggressive may adapt by being mistrusting of others, self-reliant, and aggressive. Whereas another child, who grew up in a violent community and moved to a safer neighborhood with a school system that has better resources may be motivated to learn and adapt positively to his/her new surroundings. A child that has supportive elements in his/her environment can develop resiliency and learn to face distress, seek help, and grow from difficult experiences. On the other hand, a child that has a trauma history, lacks a safe haven, and is less resilient is more inclined to develop a negative sense of self, view relationships as conflictual and rejecting, learn to have unrealistic expectations of others, and engage in aggressive behaviors (Davies, 2004).

A child's attachment needs can instill fear in the parent because of his/her unresolved relational issues (Fraiberg, 1987). When a parent abandons or neglects an infant, the infant is incapable of self-soothing and becomes disorganized and disoriented. If this continues through the next few years, the child attempts to control his/her environment, often unsuccessfully, and becomes self-reliant and distrusting of others. Cortisol, a stress hormone, is released in the brain and has a direct effect on neuron growth in a child, impacting memory and emotional processing of experiences (Marvin, 2008). Traumatized children develop hyperarousal or dissociative response patterns to

any kind of stress, even minor stress. Children under the age of three who are separated from their parents for extended periods of time, or permanently, are more inclined to be aggressive and emotionally scarred (Koops et al., 2004).

Distorted cognitions and feelings arise from deprived or prolonged separation from attachment figures in early childhood and lead to delinquent character development (Bowlby, 2005; Koops et al., 2004). Trauma caused by separation from a parent (i.e., ill parent, divorce, incarceration) is correlated to the age of the child, who attends to the child during the separation, where the child is left, how often the child is left, the child's disposition and temperament as well as the quality of the bonding relationship. Parenting traumas are unwittingly passed from one generation to the next (Davies, 2004; Marvin, 2008). Poverty continues to remain the strongest predictor for relational attachment difficulties. Insecure or anxious children require corrective emotional experiences that are nurturing, healthy, and safe. Empathy is crucial in the healing process if the child is traumatized by a disrupted or unavailable attachment. When children experience that their parents cannot be relied upon to consistently respond to their needs in supportive, trustworthy ways, they develop insecure attachment styles. As mistreated survivors later engage in intimate relationships, these relationships can either heal or maintain problematic attachments. It is often during intimate relationships or while parenting that insecurely attached adults seek professional help. Unfortunately, for adults the neurological damage is already done; the healing process requires repeated secure emotional experiences. On the other hand, those who grew up with secure, healthy attachments can often pass this on to their offspring without much effort (Koops et al.,

2004). Securely attached adults tended to have parents that were understanding and respectful of their children (Collins & Read, 1990).

There are three types of insecure adult attachment styles: fearful-avoidant or unresolved, preoccupied, and dismissive (Davies, 2004; Henderson et al., 2005).

Insecure-fearful-avoidant adults often have childhood histories of unresolved trauma, fear loss or rejection, and may avoid painful memories. As children their attachment style would have been classified as insecure-disorganized/disoriented. Adults with insecure-preoccupied attachment patterns can be described as being overly concerned or worried about how others view them and excessively dependent on or idealize their parents. During childhood their attachment style would have been classified as insecure-ambivalent. The third insecure adult attachment style is dismissive. Dismissive adults may portray their current relationships with their parents as distant or un-loving and may see little value in emotionally close relationships. Dismissive adults would be described in childhood as having an insecure-avoidant attachment style (Davies, 2004).

Attachment is one element that sustains intimate relationships after the initial excitement wears off (Palmer, 2006). Secure and insecure attachments impact an adult's ability to be close or dependent on an intimate partner. If a caregiver was inconsistent, inaccessible, or rejecting, the adult will struggle with feelings of trust and ambivalence with intimate closeness due to fear of being hurt and vulnerable (Siegel & Heitzell, 2003). Insecure attachment styles cause relationship distress. Over time a couple relates in a manner that maintains the anguish that was learned at a perceptual, precognitive level during childhood in unsettling or traumatizing situations. A disorganized attachment pattern emerges when a partner anxiously seeks closeness, yet fearfully guards, herself.

A sense of closeness is longed for, but is also threatening to the partner. Insecure and disorganized interpersonal patterns may be created in lesbian relationships due to repeated discrimination and marginalization by families and society. Subsequently, the lesbian partners may not be responsive or emotionally available to support each other. A lack of secure attachment can be seen in such relationships by the expression of negative emotions, such as anger, or by the absence of feelings, as in withdrawal or guardedness (Hazan, 2003).

Konrad Lorenz considered bonds to be intimate and long-lasting ties that fuse couples, families, and social groups (Fraiberg, 1987). Lacking the ability to attach becomes evident when relationships become transient and disposable. Such individuals lack a conscience, seem indifferent, and struggle with having feelings. Those who do not have emotional bonds with others are often found in psychiatric hospitals, alcohol/drug rehabilitation centers, and/or prison. Unattached females may turn to prostitution and develop substance addictions. Parents with the inability to attach can be cruel or emotionally numb towards their children. Those who feel emotionally disadvantaged tend to seek power over others, often through verbal or behavioral violence.

On a positive note, attachment styles are not static, but rather malleable, and can be healed through uplifting, loving relationships (Palmer, 2006). If someone with a history of trauma has engaged in adult relationships that are distressing, time is needed for secure bonds to be formed. Repeated nurturing and supportive interactions can aid in the development of earned security and diminish negative interpersonal coping styles. Sexual intimacy also helps form emotional and physical bonding (Hazan, 2003). It is essential for couples to share with each other their emotional and bonding needs. This

will allow for positive, encouraging, and empathetic responses that help soften and heal one's heart as well as allow couples to experience and safely share vulnerable emotions. Furthermore, healing reduces the risk of emotional, physical, and sexual aggression in relationships.

People tend to describe their partners with positive attributes in happily satisfying relationships whereas, in unhappy relationships, negative characteristics are attributed to one's partner and positive ones to oneself. Positive or negative emotional tones have repeatedly been found to be highly correlated to marital stability (Schumaker & Leonard, 2005). The expression of negative emotions, such as anger, increases the likelihood of domestic violence occurring (Frieze, 2005). Those who struggle with expressing thoughts and feelings experience interpersonal stress (Harned, 2001). In contrast, communicating positive emotions and displaying empathy, warmth, and affection, as well as fully listening and validating, actually decrease the risk of aggression (Frieze, 2005).

Developmental neurologist, James Prescott (1975) concluded that pleasure-prone personalities tend not to be violent. Prescott argued that our early years of development produce a neuropsychological predisposition for either aggressive or pleasure-seeking behaviors during childhood and adult years. For example, infants who remain hospitalized for extended periods of time and who are not regularly touched or held in an affectionate manner typically will rock or head bang. Consequently, neglectful or aggressive caretakers are unaware of the brain dysfunction that occurs in their children and its causes. This later mediates aggressive behavior.

Prescott (1975) formulated Somatosensory Affectional Deprivation (SAD) theory. He stated that touch and body movement provide sensory nutrition that aids in brain

development. Healthy brain development results in children and adults being able to experience pleasure, peace, and affection. Lack of touch and body movement in infant and toddler years generates brain dysfunction and can impede the development of the cerebellum, limbic system, and frontal lobes. These brain regions help regulate emotions, sensory, and physical/motor (re)activity and behaviors. Numerous symptoms arise from having little or no affection, including depression, impulsivity, and aggressive behavior. Later in teen and adult years, drug and/or alcohol use or abuse and sexual deviation can be seen. Prescott refuted the contention that harsh discipline or pain builds strong moral character; rather he asserted that meeting a child's emotional and physical needs helps the child persevere later in life when experiencing strenuous times.

There is a natural inclination to seek and secure emotional connections with others. These emotional bonds occur in relationship with caretakers, siblings, peers, and dating partners. Positive attachments provide safe havens, aiding in well-being and the development of intrapersonal and interpersonal relationships. The emotional accessibility and nurturing responsiveness of caretakers are crucial elements for children to feel safe, loved, and accepted. Parents who are nurturing and loving raise children who are less violent and have better self-control (Briere & Runtz, 1990). Insecurely attached adults often struggle with relaying their life stories in an organized manner (Siegel & Hartzell, 2003). They particularly have difficulty with relaying childhood memories (Marvin, 2008) whereas securely attached adults are more able to coherently convey their life's narrative.

### **Social Learning Theory (SLT)**

Albert Bandura's (1973) Social Learning Theory (SLT) is helpful in understanding behavior modification and aggression. SLT is specifically focused on attitudes, behaviors, and emotional responses people have towards one another. People learn through observing and mimicking behaviors, attitudes, and emotions of others (Bandura, 1977). Observational learning requires attention, retention, motor reproduction, and motivation. The individual learns to connect words or images to certain behaviors, and this becomes coded information (retention), which later serves as a guide for future behaviors. SLT implies that violence is a learned behavior that has been reinforced by one's environment rather than being inherent in the individual (Bandura, 1977). This is a shortcoming of the theory, in that unique personality characteristics or the possibility of genetic predisposition are not examined or valued. However, SLT is valuable to this study in providing an understanding of how a history of violence in childhood can impact an adult's ability to cope with conflict that could potentially lead to domestic violence. This is so because SLT theorists emphasize attention, memory, and motivation while connecting cognitions and emotions to behavior.

SLT implies that children learn through observing their parents or caretakers; in particular they identify with the caretakers' gender and roles (Kwong et al., 2003). Therefore, a female observing her father behave violently towards family members may become an offender later in life. When a child is raised in an abusive home, the youngster learns through observation that aggression is an appropriate way to handle interpersonal conflict. SLT supports the cycle-of-violence theory implying that children exposed to abuse are at risk of experiencing violence later in life (Athens, 2003; Wisdom

& Maxfield, 2001). Markowitz (2001) found that children who observe, learn, and experience abusive behaviors use aggression in adulthood as a means to cope with conflict. Being raised around violence, within a family or community and/or via the media, increases the probability of becoming involved in future aggression.

Subsequently, learned aggression produces reinforcement or anticipated rewards that decrease tension and increase power (Bandura, 1973). Behaviors are thus adopted and repeated when the results are valued, i.e., perpetrators get victims to comply with demands in relationships by using violence. Bandura believed that family aggression is the most prominent way a child learns violence.

Kwong and colleagues (2003) found SLT applicable in their research. They showed that aggression in a family-of-origin was predictive of violence in adult intimate relationships. Witnessing parental domestic violence or being a victim of abuse will impact men's and women's attitudes towards each other and how they view traditional, heterosexual roles as well as the rights those in such relationships have in society. Yet what happens with the lesbian population who learn about violence as children and how they view their roles in relationships? People process information based upon their social experiences and these experiences influence how they will later mediate behavior related to stress or trauma (Briere & Runtz, 1988; 1990).

While SLT theorists contend that aggression is learned, they do not explain how feelings of internalized shame or guilt, i.e., being a victim of abuse or being in a lesbian relationship, affect relationship stress. Furthermore, how would SLT explain low self-esteem or feelings of inadequacy, such as believing that she is immoral for engaging in a same-sex partnership? Learning involves not only cognitions but emotions; therefore,



our personal experiences tend to provoke feelings and attitudes that later affect the way people behave. Another shortcoming of SLT is that it does not involve addressing enough of the dynamics involved with power and control, discrimination, and internalized feelings due to being rejected by society. New theories of violence are needed that are inclusive of same-sex interpersonal dynamics to hold perpetrators accountable, and to empower victims to make healthy choices while understanding issues of oppression and other multi-systemic facets.

### **Cultural Contextual Model (CCM)**

The Cultural Contextual Model (CCM) is a feminist, developmental, and family theory perspective to view culture as a critical element in understanding different types of behaviors in relationships, such as gender roles and violence (Stith, Rosen, & McCollum, 2003). It is a community-based model designed by Rhea Almeida nearly fifteen years ago. Culture can be both an asset as a means of learning about and connecting with others as well as a disadvantage when used to oppress women, children, and minority groups by allocating power to men and majority cultures. It is an accumulation of legacies and traditions that incorporate art, food, and language to unite the family unit over the generations (Almeida & Durkin, 1999). However, cultural traditions can also discriminate against family members. CCM is oriented towards understanding a person in his/her cultural context while raising social awareness about race, gender, class, colonization, heterosexism, and homophobia, and involves a psychoeducational approach prior to conducting therapy to help inform and sensitize clients about traditional heterosexual stereotypes. Minorities, such as gay and lesbian couples, are often viewed as second-class citizens who are often economically, politically, socially, and sexually

exploited. It is essential to research migration, belief systems, and family norms when examining intimate violence. Homophobia and racism, lack of equal education, employment, and housing rights, and limited medical and mental-health services further devalue same-sex couples on a daily basis.

When a person's personal space has been jeopardized, especially repeatedly, he/she may not think twice when compromising another's personal safety. It has been reported that over 80% of lesbian victims of domestic violence observed violence in their homes (McClennen et al., 2002). According to the CCM, when aggressive messages are sent from families, friends, peers, society, and some aspects of a culture support or sensationalize violence, a context is being set that enables an abusive cycle to exist and continue (Almeida & Durkin, 1999). Therefore, according to the CCM change occurs through conscious-raising awareness about the power men or majority groups own and the lack of power or choice given to minority groups (Stith et al., 2003). Women have been socialized to take responsibility for and resolve conflicts within relationships, often at their own expense. The message given to women is that they sacrifice their sense of self for the good of a relationship in order to seek approval and receive commitment from men. To go a step further, women are also reared to maintain the survival of their families and cultures (Almeida & Durkin, 1999). In the CCM approach it is crucial to understand the dynamics clients live via culture, history, and sociopolitical power. Relationships, gender roles, child-rearing norms, and beliefs about how to handle conflict are influenced by one's culture, religion, and societal norms. It is essential that those in power be accountable for abusing their power over others whether through intimidation, threats, violence, and/or control over finances and personal freedom.

In the CCM theory the importance of challenging and exposing the patriarchal view that male violence is a private, family matter is stressed (Stithe et. al., 2003). It is crucial to change male dominating patterns and oppressive belief systems and to empower women to not be the only ones relied upon to maintain family unity. Females who are survivors of intimate violence learn through CCM to dismantle discriminating family patterns that have been culturally sanctioned and embedded for the men (Almeida & Durkin, 1999). This is a lifelong process of relating in non-violent ways that eventually becomes internalized and is passed on to future generations.

The difficulty with CCM is that the dynamics are different in lesbian relationships because one or both females are violent and may not assume the traditional nurturing, passive role. CCM can aid in learning about the culture and how power is learned and maintained in a relationship, but it is necessary to look beyond gender when studying intimate violence in same-sex relationships. How women have been socialized and the value they place on themselves will aid in understanding why one is the victimizer and/or the victim in a lesbian relationship. It is essential to learn how power is maintained throughout the generations. For instance, an abusive parent may have become this way in order to gain power over the child after feeling disempowered in the intimate partnership. Abusive adults seek, but also resist, being close with others since they are uncertain about how to consistently have emotional needs met due to mistrust and disappointment, which, in turn, weakens their sense of self-worth. Couples and parents who are survivors of childhood abuse have learned to manipulate the family environment and interactions to have their needs met (Bavolek, 2000). While the CCM approach does not lead to exploring more about the dynamics and assumptions about lesbian relationships, the

model is valuable in recognizing social and family norms that discriminate against minorities. Another strength of the model is that it highlights hierarchal structures in society, communities, and families that trace how violence and victimization are learned.

### **Same-Sex Families**

There are differences between same-sex and heterosexual families. For example, household chores and finances are not necessarily divided according to culturally defined gender roles (Herek, 2006). In addition, same-sex couples tend to be more committed to equality, particularly if they have a healthy, mutually respectful relationship. However, participants in both types of relationships under normal circumstances share the commonality of their interests in having and raising healthy children. Research has shown that children raised by two parents do better than those reared in single-parent homes. In the 2000 Census, 34% of cohabitating lesbian couples and 46% of heterosexual parents had children under the age of 18 living in their homes (Bennett & Gales, 2004). The National Center for Lesbian Rights (2000) is one of many sources for documenting that children brought up by sexual minority couples are just as secure (Herek, 2006) as children raised in heterosexual families. Indeed, children reared in same-sex households have been found to be more flexible with their gender identities and accepting of differences in people. Most children raised in same-sex families identify as being heterosexual regardless of their parents' sexual orientations.

Chosen families are frequently created by lesbians. These tend to consist of former partners and friends. It is not uncommon for lesbians' selected families to replace their families of origin given that the created family is frequently more supportive of their

sexual orientation and lifestyle (Merlis & Linville, 2006). In a 2000 survey made up of 405 gay, lesbian, and bisexual participants from 15 US metropolitan cities 34% had at least one family member who had rejected them because of sexual orientation (Herek, 2006). Such rejection from one's family of origin creates feelings of abandonment and mistrust and further isolates sexual minorities. It also sets the stage for lesbians to accept mistreatment and disrespect from their intimate partners (Herek, 2006).

Families of homosexual teens may threaten, reject, and mistreat or abuse their children once they discover their children's sexual orientations. As a result, sexual minorities develop dual consciousness in the process of being socialized in a heterosexual world, but experience situations differently because of homophobia. As young lesbian adults leave their homes, they may be ambivalent about being open about sexual orientation. This causes these young women to live two separate lives and feel invisible at a developmental time when they want to be the focus of attention. This results in internal conflict that can build up over the years. Lesbians have to contend with multiple forms of discrimination due to being a female in a patriarchal society and being attracted to another woman (Balsam et al., 2005). Lesbians lack rights to establish their own marriages and families as well as rituals or legacies in most states.

### **Community and Socioeconomic Status**

Inequality and being economically disadvantaged considerably increase the risk for community and family violence (Molnar, Buka, Brennan, Holton, & Earls, 2003). Poverty, unemployment, broken and chaotic homes, and single-parent households generate higher rates of child abuse and increased rates of violent youths (U.S.

Department of Health & Human Services, 2001). Within ethnic SES minority groups, violence can become a way of life and goes unchallenged. This stems from major societal and political ideologies based upon the dominant societal norms and results in using violence as a form of social control and as a solution to society's criminal and financial problems. Such ideologies lead to winnowing out the less advantaged in society. This has been the case with black urban youths who continue to be murdered in epidemic proportions. Higher levels of social conflict pose greater threats of violence in communities (Felson, 2005). With regards to sexual minorities, sexual stigma places them in jeopardy for hate crimes and later retaliatory behaviors (Herek, 2006). Sadly, most societies promote, maintain, and sensationalize power differentials, inequality, and violence (Almeida & Durkin, 1999). Given the opportunity, prejudice diminishes when minorities interact with majority groups over time (Herek, 2006) since this allows different cultural groups to learn about and appreciate each other.

The more isolated people feel within their communities, society at large, or with extended family members, the greater the risk for family aggression to exist (Felson, 2002). Communities with social disorganization and high crime rates induce some youths to develop aggressive coping skills as a means to survive. It is important to realize that, during the adolescent years, the community and peers are more influential than family. Race, ethnicity, child abuse, drug trafficking, gang involvement, and violence in the media prompt negative emotions and behaviors for youths who learn to relate through aggressive means (U.S. Department of Health & Human Services, 2001).

### **Oppression and Power and Control**

Oppression occurs on a multitude of levels with regard to race, sex, sexual orientation, and class. Demeaning stereotypes and oppressive views encourage and support the mistreatment of others. Heterosexist bias and discriminating norms at the governmental level lay the foundations for rationalizing and justifying institutional violence and depersonalize personal aggression (VanSoest & Bryant, 1995). Stigmatization on multiple levels can cause victims to internalize shame and anger that inexorably affect self-image (Balsam et al., 2005). When this happens over time, the wounded individual may take her anger out on herself and/or others.

The hatred displayed towards lesbians and their families inevitably affects how lesbians relate to their partners (McClennen et al., 2002). Minority groups become angered by feeling marginalized and by experiencing repeated injustice (Davies, 2004). This can lead to interpersonal violence. Pierce's reference to microaggressions as a type of psychological aggression resulting from degradation, rejection, and humiliation can ultimately cause a person to internalize his/her rage (VanSoest & Bryant, 1995). Some examples of this are women or racial minorities being paid less, white-collar crime being distinguished from burglary, or penitentiaries being filled predominantly with minorities. If lesbians remain marginalized on the governmental, societal, and familial levels, they may remain angered at such injustice and either perpetuate violence or become further victimized by it.

Homonegativity towards lesbians is based on fear and viewing them as immoral due to religious and conservative sociopolitical beliefs (Potoczniak, Murot, Crosbie-Bennett, & Potoczniak, 2003). Homonegative views of lesbians consider them to have a

compromised moral character in comparison to heterosexuals, similar to how society has judged people with HIV/AIDS. Such opinions can form the cognitive bias for preventing lesbians from receiving protections from the law, such as civil rights and civil unions or marriages. Lesbians over time internalize homonegativity and their experiences of heterosexual discrimination. The stress can begin to strain the quality of their intimate relationships. The internalized pressure and tension have been found to be taken out on partners (Frieze, 2005). Lesbians may use shame and threat of exposure as a means to gain power and control over partners. Over time, intimidation and/or violence can become normalized on a societal and interpersonal level, compromising one's integrity and safety (Merlis & Linville, 2006).

### **Lesbian Domestic Violence**

Recent research indicates that lesbian domestic violence, as intimate partner violence in heterosexual couples, occurs across all socioeconomic levels, ethnicities, occupations, political and religious groups (Merlis & Linville, 2006). Twenty-five to 50% of lesbian couples reported experiencing intimate violence (McClennen et al., 2002). Graves, Sechrist, White, and Paradise (2005) related similar findings with 51% of lesbian partners having disclosed various types of violence, of which 23% had experienced severe forms of abuse, such as punching, kicking, and biting. In another study with 272 lesbian and bisexual couples recruited from Gay Pride events, 40% were perpetrators, and 44% were victims of partner abuse (Balsam & Szymanski, 2005). A conservative estimate suggests that 500,000 lesbians are victims of intimate violence each year. This statistic is equivalent to a lesbian being battered by her lover every minute of every day. Lesbian



battering is staggering, and it is an injustice to individuals, couples, families, and communities (Peterman & Dixon, 2003).

With lesbian domestic violence, one partner is attempting to injure or intimidate the other partner physically, emotionally, and/or psychologically (Merlis & Linville, 2006). Such destructive behavior can include common couple violence, self-defense, retaliation, or mutual control (Potoczniak et al., 2003). It is essential to look at the different patterns of intimate violence as well as the severity and rate of abuse. Many believe that domestic violence clearly entails issues of power and control (Almeida & Durkin, 1999; Merlis & Linville, 2006). Such power and control involve influencing and intimidating a partner into doing what she does not want to (McClennen et al., 2002). It is an unhealthy way of relating that is learned and expressed through emotional, physical, sexual, social, and economical means. Several examples of intimate violence include pushing, hitting, kicking, biting, pulling hair, clothing or body parts, throwing or slamming objects, stomping, punching, choking, blocking an exit, or employing a weapon (Merlis & Linville, 2006; Stanley et al., 2006). Additional means of abuse consist of being forced into performing or engaging in sexual acts, isolation from friends, family, work, or school, being threatened to be outed, yelled at or verbally attacked and degraded, devaluing feelings or opinions, controlling finances, or preventing or excluding partner from decision-making process. Typically the batterer feels insecure or has inadequate ways of retaliating and engages in these behaviors to dominate her partner and gain a (false) sense of security.

In research conducted on lesbians it was reported that 25% were victims of sexual abuse and 55% experienced partner abuse in the past or in their current relationships

(Potoczniak et al., 2003). Danger (2003), in researching 70 lesbian women, ages 18 to 64 (mean age 37), indicated a 50% co-morbidity rate of sexual assault and physical abuse. These statistics prove that domestic violence exists in lesbian relationships and that the rates may indeed be equal to or greater than heterosexual domestic violence rates (Potoczniak et al., 2003).

Despite these figures, most incidents of lesbian domestic violence are underreported due to silence, denial, social injustice, alienation, isolation, and fear of further oppression (Merlis & Linville, 2006). Lesbians themselves deny or minimize the severity of domestic violence (Balsam et al., 2005). Hundreds of thousands of cases go unreported due to the myth that same-sex domestic violence occurs less than opposite-sex domestic violence (Merlis & Linville, 2006). Lesbian couples often fail to realize what constitutes intimate violence as well as construct or maintain the misnomer that there is equal blame, less vulnerability, and less aggression. Restraining orders can be obtained in civil court in 50 states and the District of Columbia for mainly heterosexual couples and are at the discretion of the judge and prosecutor (Potoczniak, Murot, Crosbie-Bennett, & Potoczniak, 2003). Florida, Illinois, Ohio, and Kentucky have gender-neutral domestic violence statutes. However, Arizona, Delaware, Indiana, Michigan, Mississippi, Montana, North Carolina, South Carolina, and Washington specifically exclude gay men and lesbians from protection in their domestic-violence laws (Jablow, 2000). Alabama's common law finds sexual minorities to be in the wrong and unfit to be parents (Balsam et al., 2005).

It is necessary to understand the dynamics of lesbian relationships and be careful about not stereotyping according to gender roles. For example, to assume that the female

batterer fulfills the masculine role is oppressive for the lesbian relationship and males in general (Merlis & Linville, 2006). Simultaneously viewing the victim as feminine can be one-dimensional and cause ambivalence for the couple seeking help. Furthermore, this limiting view causes confusion for the lesbian who fills both roles, that of offender and victim. Additional misconceptions, such as the lesbian community being safe, united, and having clear boundaries, need to be corrected. It can be challenging enough for women to accept that someone of the same gender would violate personal safety, but with additional misconceptions it can be ever harder. In fact, boundaries are frequently blurred due to lesbians playing multiple roles in small communities, i.e., employer, friend, and chosen family member. This can cause outsiders in the lesbian community to disbelieve or make wrong assumptions about the couple experiencing intimate violence.

### **Impact of Lesbian Domestic Violence**

There are a multitude of symptoms resulting from being a victim of domestic violence. Such indicators include suicidal and homicidal tendencies, self-mutilation, depression, feelings of low self-worth, emotional instability, eating disorders, hysteria, Posttraumatic Stress Disorder, and psychosis (Frieze, 2005). These symptoms can lead women to use alcohol in order to avoid psychological distress. This can increase the risk of intimate partner violence. For example, a study of 104 self-identified lesbians disclosed a history of domestic violence in 39% of the relationships. Sixty-four percent of the offenders were alcohol or drug-involved prior to or during the violent episodes. Other aversive outcomes from power imbalances in relationships consist of shame, insecure attachments, and anger. Furthermore, victims develop low empathy the more

they are traumatized and may engage in adrenaline-induced or risk-taking behaviors (Briere & Runtz, 1990). Victims may become disrespectful of others, develop aggressive traits, and escape through alcohol and/or drug-use. This places the couple at risk for more emotional distress and violence.

### **Legal Issues for Lesbian Couples**

Due to oppressive and discriminatory laws, lesbian victims of intimate battering often feel disempowered to seek help (Potoczniak, Murot, Crosbie-Bennett, & Potoczniak, 2003). They fear having sexual orientation exposed, losing their homes and/or custody of their children, having fewer rights civilly with regard to real estate, taxes, alimony/partner support, and loss of employment as well as support from peers and family. It is not atypical for jurors and court systems to see lesbian victims as having low moral character in comparison to heterosexual victims. The domestic violence is viewed as being less serious and not as life threatening. This results in lesser penalties for offenders. Those in decision-making positions may have the mindset that lesbians deserve to be mistreated.

Those wounded who chose to come forward for help may have to confess to a crime due to sodomy laws (referring to oral and anal sex) before receiving protection (Potoczniak, Murot, Crosbie-Bennett, & Potoczniak, 2003). This poses a greater threat to those who are professionally licensed and could be judged as engaging in immoral or illegal activity and have their licenses compromised. However, in June 2003, the US Supreme Court in *Lawrence versus Texas* hearing ruled that sodomy laws concerning consensual adults were unconstitutional (Balsam et al., 2005).

As advocates fight for social equality, the public is becoming more supportive of civil unions and domestic partnerships, but not as much with legitimizing same-sex marriages (Herek, 2006). Over the years, while the political pendulum wavers, it seems as though society is increasingly taking an interest in same-sex relationships. In 2004, Massachusetts was the only state that permitted same-sex couples to marry, and in 2006 the Netherlands, Belgium, Spain, and Canada joined. At that time, South Africa also had legislation regarding same-sex marriages pending. When couples were allowed to marry in Massachusetts, there were 1,700 same-sex couples who filed with intent to marry during the first two days after the law was passed. There were also local governments that were briefly involved in granting marriage licenses to same-sex partners. From February to March 2004, there were 4,037 gay and lesbian partners who were married in San Francisco, and in February 2004, there were 68 couples in Sandoval County, New Mexico, who followed suit. In 2005, California Governor Arnold Schwarzenegger vetoed allowing same-sex marriages statewide from being legalized, but in May 2007 same-sex marriages were legalized again. San Francisco was at the forefront since they were the first to pass a domestic-partners statute in 1982, but, again, at a later time it was vetoed. Gradually courts stopped legitimizing same-sex marriages despite the interest or value this provided for families. As of October 2013, there are 14 states that legally recognize same-sex civil marriage and they are: California, Connecticut, Delaware, Iowa, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Rhode Island, Vermont, and Washington (Wikimedia Foundation, 2013). In addition the District of Columbia also legally recognizes same-sex civil marriages. In the Defense of Marriage Act (DOMA), marriage was defined as being between a man and a

woman and prohibited other states from recognizing same-sex unions that were previously sanctioned (Defense of Marriage Act, 2008).

Minimal legal protection was granted for same-sex couples through different terminology in numerous states. Domestic benefits, such as health insurance and second-parent adoptions, were passed in California, Connecticut, Massachusetts, New Jersey, Vermont, and the District of Columbia. By mid-2000, joint adoptions were being approved for same-sex unions. A few Tennessee courts are permitting second-parent adoptions, although they can later be contested after the death of a parent, and Tennessee-based companies, such as Vanderbilt and UPS, are offering domestic-partnership benefits.

Lack of recognition of lesbian marriages and non-discriminatory policies cause lesbian unions to be socially and economically vulnerable (Balsam et al., 2005). Heterosexual marriages reap the benefits of 1,138 federal laws created by the Federal Marriage Amendment that lesbian partnerships are not allotted. Lesbian unions are not protected by employment, housing, educational, and medical sanctions. Only one-fourth of the states have laws prohibiting housing and medical unfairness for sexual minorities (Herek, 2006). Legally married spouses are granted confidentiality privileges in courtrooms, but this is not necessarily the case in the states not legitimizing same-sex marriages. Lesbian couples are also frequently denied company benefits like family or bereavement leave, health insurance, and pension plans. When a lesbian partner becomes seriously ill or incapacitated, her partner is unable to make decisions about medical treatment and can be denied visitation. Most emergency rooms and intensive care units' policies allow immediate family members only. This can be rejecting for lesbian

partners. Surviving partners may be challenged in making funeral arrangements, from gaining inheritance rights, social security, or other death benefits. This can greatly impact the healing process and a sense of security. Herek (2006) found that surviving partners had greater psychological anguish due to disempowerment of making choices or attending ceremonies.

In the literature, there is repeated documentation that lesbians prefer long-term, committed relationships (Kurdek, 2004; Peplau & Spalding, 2000). Marriage offers individuals a stronger sense of self and mastery of interpersonal skills. Married spouses have greater psychological and physical health and develop deep emotional attachments when compared to unmarried couples. Lesbian couples experience more stress due to denial of rights and less family and social support. This increases the risk of intimate violence (Dohrenwend, 2000; Kiecolt-Glaser, McGuire, Robles, & Glasser, 2002). Married couples are less likely to divorce due to legal, family, and social issues and, therefore, may have more security in their relationships. According to the U.S. General Accounting Office report in 2004, non-citizens or couples without legal rights to marry are not protected, nor do they receive national or international recognition. This significantly impacts ability to travel and treats sexual minorities as second-class citizens. It seems that marriage can offer more rewards than barriers. This can lead to greater relationship satisfaction and lower the risk of hostile behavior.

### **Intervention and Resources**

Given the abundance of discriminatory views and actions of the law and society, it can be challenging for lesbian partners to find help when needed. The lack of recognition and understanding of lesbian couples' dynamics causes assessments, which are often quick and brief, and intervention to be potentially harmful, ineffective, and even lethal (McClennen et al., 2002). In 1992, Renzetti conducted research concerning help for lesbian victims of intimate battering (Potoczniak et al., 2003). He found that 69% viewed their friends as resources, 58% said counselors were beneficial, and 35% reported that their relatives were helpful. Lesser percentages were given for police officers, religious advisors, hotline counselors, and domestic-violence shelters. These facts are enlightening given that families and professionals should be protective and supportive. Until families, communities, and politicians view sexual-minority families as being equal to heterosexual families, lesbian couples will remain at greater risk for intimate abuse, relationship hardships, and isolation.

There is also a lack of financial support for programs designed to help lesbian victims and offenders (Merlis & Linville, 2006). In fact, more money is spent trying to cure lesbianism rather than to help intimate violence victims. In neighborhoods where more lesbians live there tend to be more services available to them than in ones with fewer lesbians. Given the institutional barriers, such as negative views of lesbian relationships and feeling devalued by being a female, as well as a lesbian, victims opt not to seek help and treatment. If battered lesbians continue to remain invisible, so will the offenders, making it even tougher for victims to have effective treatment programs. Lesbian intimate violence does not receive media attention or social awareness in



different treatment centers and causes victims and offenders to be isolated and fearful of reaching out for help. Merlis and Linville (2006) reported several factors that lesbians found to be helpful, when disclosing domestic violence: that members of both the lesbian and heterosexual communities acknowledge that domestic violence exists, that professional and personal support be available to both partners by the family, church, court, and other community resources, and that both partners are comfortable in discussing their issues. Failure to intervene differently enables the abuse cycle to continue and causes some victims to remain with their abusers.

The present study is based on a hope to contribute to the literature by better understanding how adult attachment styles are affected by abuse and how violence is passed from childhood experiences into adult intimate relationships. Does childhood abuse and learned adult attachment style have a relationship to adult intimate violence?

### **Research Questions**

The following is a listing of questions that are expected to be answered by the current study:

1. Does childhood emotional, physical, or sexual abuse and/or witnessing of domestic violence place female victims at risk of domestic violence in adult intimate relationships? Are women who were not emotionally, physically, or sexually abused in childhood and/or who had not witnessed domestic violence have a lesser likelihood of domestic violence in adult intimate relationships?
2. Are women with childhood histories of emotional, physical, or sexual abuse

and/or who witnessed domestic violence more likely to develop insecure (fearful-avoidant, preoccupied, or dismissing) attachment patterns in intimate relationships? Are women without childhood histories of emotional, physical, or sexual abuse and/or who did not witness domestic violence more likely to develop a secure attachment style with intimate partners?

3. Are women with a secure attachment in their intimate relationships less likely to experience adult domestic violence? Are those with insecure (fearful-avoidant, preoccupied, or dismissing) attachments in intimate relationships at a greater risk of experiencing domestic violence?

## **CHAPTER III**

### **Research Methods**

The purpose of the current study is to explore the relationship between experiencing child abuse or witnessing domestic violence in childhood, type of learned attachment style in adults, and the risk of domestic violence existing in adult intimate female relationships. Women were surveyed about whether or not they experienced emotional, physical, or sexual abuse and/or witnessed domestic violence as children. In addition, women were assessed to determine if they have experienced domestic violence in their current intimate relationship. It is anticipated that women who were abused as children or witnessed domestic violence are more likely to have an insecure (fearful-avoidant, preoccupied, or dismissing) adult attachment style and are more likely to have domestic violence in their current intimate relationship. Conversely, women who were not abused during childhood or exposed to domestic violence are more likely to have a secure adult attachment style and less likely to have domestic violence in their current intimate relationship.

### **Hypotheses**

1. It was hypothesized that women who were victims of childhood emotional, physical, or sexual violence and/or who witnessed domestic violence would experience greater frequency and higher mutuality of domestic violence in their adult intimate relationships than were those who did not experience or witness violence.

2. It was hypothesized that women who experienced childhood emotional, physical, or sexual violence and/or who witnessed domestic violence during childhood would feel less close or comfortable with intimate partners and more anxious or fearful of rejection in adult intimate relationships than were women who did not experience and/or who did not witness violence during childhood.

3. It was hypothesized that securely attached women would have a lower frequency and decreased mutuality of domestic violence in adult intimate relationships than women who were insecurely (fearful-avoidant, preoccupied, or dismissing) attached in adult intimate relationships.

### **Statistics and Variables**

Multivariate analysis of variance (MANOVAs) was used to examine the data in this study. MANOVAs are used when there are one or more categorical independent variables and two or more continuous dependent variables. It aids in determining if changes in the independent variables have significant effects on the dependent variables. MANOVAs analyze what interactions occur among the dependent and independent variables.

There is one independent, categorical variable in Hypothesis I: abuse history. This variable has two levels: abuse and non-abused groups. The abused group is defined as any participant having answered yes to physical, emotional, or sexual abuse, or exposure to domestic violence. The non-abused group is defined as any participant that has denied experiencing emotional, physical or sexual abuse, or exposure to domestic violence. The two dependent, continuous variables are frequency and mutuality of

partner violence. The continuous variables were scored as a one or more on the CTS-2. The higher the score the more that aggression has occurred.

Concerning Hypothesis II, the independent variable is abuse history, and there are three dependent, continuous variables: close, depend, and anxiety. They were scored on the RAAS as being able to depend on the intimate partner (close), comfort with closeness (depend), and experiencing fear or rejection (anxiety).

The independent, categorical variable in Hypothesis III is attachment style, with four levels: securely attached, insecure-fearful-avoidant attached, insecure-preoccupied attached, and insecure-dismissing attached. These groups are categorized with the RAAS as follows: securely attached if the participant scores high on close and depend and low on anxiety; insecure-fearful-avoidant attached if high scores on anxiety and low scores on close and depend; insecure preoccupied attached if low scores on depend and high scores on close and anxiety; and insecure dismissive attached if low scores on anxiety, close, and depend. The two dependent, continuous variables are frequency and mutuality of partner violence. The categorical variables were scored as existing on the CTS-2 if the answer is one or more; with the higher the number the more aggression has occurred.

### **Operational Definitions of Variables**

#### **Childhood Emotional/Psychological, Physical, or Sexual Abuse and Witnessing of Domestic Violence**

The Childhood Maltreatment Interview Schedule – Short Form (CMIS-SF) was used to measure whether or not emotional/psychological, physical, or sexual abuse and/or

witnessing of domestic violence occurred during childhood (Briere & Runtz, 1990). Each type of abuse was measured separately. Items one and three through six were given, but not included in the analysis for this study since they pertain to alcohol/drugs and feelings of being loved or cared for. The entire CMIS-SF was administered to preserve the integrity of the scale as developed to determine what type of childhood abuse (emotional/psychological, physical, sexual, or witnessing of domestic violence) did or did not take place for Hypotheses I and II. Briere (1992), Briere and Runtz (1990), and Balsam, Beauchaine, and Rothblum's (2005) have used the CMIS-SF in its entirety for assessing for emotional/psychological, physical, and sexual abuse and exposure to domestic violence. For the purposes of this study the instrument was used as it was designed.

The emotional/psychological mistreatment portion of the CMIS-SF consists of questions about a (foster/step/birth) parent insulting, criticizing, ridiculing, embarrassing, or making a participant feel like she was a bad child. For the purpose of this study childhood emotional/psychological abuse is determined to have existed if the participant was before the age of 16 and answered a three or more on question seven, parts B, E, F, and G. A score of zero (never) indicated that emotional/psychological abuse has not occurred. Deitrich (2003) decided to use all of the sections on question seven but required a score of six to substantiate psychological abuse.

To measure if childhood physical abuse had or had not taken place, the abuse would have had to occur before age 17, and the participant would respond with a yes or no on questions eight and eleven regarding acknowledging physical abuse on the CMIS-SF. A frequency of one or more times on question eight would suggest that child

physical abuse had occurred whereas a zero response would support that physical abuse did not occur. The CMIS-SF has questions about being hit, punched, cut, or pushed down that may have caused the child to bleed, have bruising or scratches, or broken bones or teeth.

Childhood sexual abuse was assessed by an answer of yes or no on the CMIS-SF on questions nine, ten, and eleven regarding acknowledging sexual abuse. The sexual offender would have had to have been five years or older and may or may not have used physical force during the abuse. The CMIS-SF instrument has questions (9, 10) about being kissed or touched in a sexual manner or being made to do this to someone else, as well as if the child was orally, anally, or vaginally penetrated by the offender.

Question two on the CMIS-SF is relevant to witnessing domestic violence since inquiry is made specifically into whether the child, before age 17, ever observed a parent hit or beat up the other parent. To conclude whether or not witnessing domestic violence during childhood happened the participant would have answered yes or no with a frequency of one or more times.

**Attachment Style: Secure and Insecure (Preoccupied, Fearful-Avoidant, or Dismissing)**

To test Hypothesis III the Revised Adult Attachment Scale (RAAS) was administered to assess for two levels of variables: (1) secure attachment style or three types of insecure attachment styles – preoccupied, fearful-avoidant, or dismissing (independent variables in Hypothesis III) and (2) comfort with depending on romantic/intimate partners, comfort with closeness with romantic partners, and

anxiousness or fear of rejection of intimate partners (dependent variables in Hypothesis II). The categorical independent variables are identified and scored as follows. A person who is securely attached will have a positive view of oneself and others, will want intimacy, and will be responsively available while finding comfort with independence. A midpoint score of 18 on the RAAS Close and Depend subscales and a score of below 18 on the Anxiety subscale is indicative of a secure attachment pattern (Collins, 1996). A fearful-avoidant attachment style in adult romantic relationships may be evident by a partner's fear of intimacy and dependence. The fearful-avoidant person may exhibit jealous behaviors (Henderson et al., 2005). A midpoint score of 18 on the RAAS Anxiety subscale with lower scores on Close and Depend subscales would be suggestive of a fearful-avoidant attachment style. Individuals with preoccupied attachment style may want to be close with their partners, but also be anxious, pensive, or inattentive. A low score on the RAAS Depend subscale but a higher score on the Anxiety and Close subscales would be indicative of a preoccupied attachment style. Dismissing attachment styles involve fear of being abandoned, having uncertainty about security of relationship, and being unavailable to one's partner at times. A dismissing attachment style would have a low score on all three subscales. Participants who score at the midpoint will be excluded from the sample, since this is what Collins (1996) did in order to have a clearly defined attachment style. The downfall is that this exclusion will cause this researcher to lose data points. The continuous dependent variables are scored as follows. Comfort with closeness is defined as scores on the subscale Depend. Comfort with depending on romantic/intimate partners is defined as scores on the subscale Close. Anxiousness or fear of rejection is defined as scores on the subscale Anxiety.



### **Adult Domestic Violence with Intimate Partners**

The entire Revised Conflict Tactics Scale-2 (CTS-2) was administered to measure the three types of domestic violence (Psychological/Emotional Aggression, Physical Aggression, or Sexual Coercion) in adult intimate relationships. However, two of the subscales were not examined: Negotiation and Injury since they are not directly relevant to the hypotheses in this study. The three subscales that were analyzed are Psychological Aggression, Physical Aggression, and Sexual Coercion. The dependent variables in Hypotheses I and III are frequency and mutuality of psychological, physical, and sexual aggression. The CTS-2 was used to measure the dependent variables in Hypotheses I and III.

The CTS-2 has eight Psychological Aggression items that pertain to verbal threats, hurtful statements, accusations, or leaving during times of conflict. There are twelve Physical Assault statements that refer to throwing, pushing, grabbing, kicking, slapping, using weapons, or burning an intimate partner. The Sexual Coercion section of the CTS-2 has seven questions that inquire about unprotected sex, as well as verbal or physical forcing of sexual relations. On the CTS-2 a score of zero (never) indicated that the participant has not experienced domestic violence in her current intimate relationship. Answers of one or more in any of the three subscales (Psychological, Physical, or Sexual) means that that type of domestic violence has taken place. The higher the score, the more aggression the participant has experienced in her relationship (Smith Slep & O'Leary, 2005). The scoring of the continuous variables on the CTS-2 was followed as developed by the researcher (Straus, Hamby, McCoy, & Sugarman, 1996).

In summary, the variables for the study are (a) abuse history (abused or non-abused), (b) characteristics of intimate partner violence (frequency and mutuality), (c) process in attachment - close, depend, anxiety, and (d) attachment style (secure, insecure-fearful-avoidant, insecure-preoccupied, and insecure-dismissing). They are operationally defined as follows.

Abuse history is operationally defined on the CMIS-SF by whether the participant responded in the affirmative with a frequency of one or more to questions eight for physical abuse; questions nine, ten, and eleven for sexual abuse; question two for domestic violence; or question seven, parts B, E, F, and G, with a rating of three or higher (3-6) for emotional abuse.

Frequency is operationally defined as answering affirmatively to any one or more acts in the three subscales: Psychological Aggression, Physical Assault, and Sexual Coercion on the CTS-2. There are two categories: frequency of partner (even numbered items) and frequency of self (odd numbered items) and they are rated 1-6 for how many times a behavior has occurred in the last year. For the purposes of this study frequency was scored as the sum of ratings on the Psychological Aggression, Physical Assault, and Sexual Coercion subscales for frequency responses.

Mutuality types are operationally defined as answering affirmatively to any one or more acts in the three subscales: Psychological Aggression, Physical Assault, and Sexual Coercion on the CTS-2. Mutuality types are classified in each case as the respondent only (coded as 1), partner only (coded as 2), or both (coded as 3). The questions on the CTS-2 alternate between first asking what the participant (odd numbered items) has done and then asking what the partner (even numbered items) has done. The items on the three

subscales were summed and rated 1-6 for how many times a behavior has occurred in the last year. For the purposes of this study mutuality was scored as the sum of the ratings of the items.

Close is operationally defined by summing the responses to items 1, 6, 8, 12, 13, and 17 on the RAAS. Questions 8, 13, and 17 are reversed scored. Depend is operationally defined by summing the responses to items 2, 5, 7, 14, 16, and 18 on the RAAS. Questions 2, 7, 16, and 18 are reversed scored. Anxiety is operationally defined by summing the responses to items 3, 4, 9, 10, 11, and 15 on the RAAS.

Secure attachment is operationally defined by high scores (18 or above) on Close and Depend subscales and a low score (below 18) on Anxiety subscale on the RAAS. Insecure-fearful-avoidant attachment is operationally defined by a high score (above 18) on Anxiety subscale and low scores on Close and Depend subscales (below 18) on the RAAS. Insecure-preoccupied attachment is operationally defined by a low score (below 18) on Depend subscale and high scores (above 18) on Anxiety and Close subscales on the RAAS. Insecure-dismissing attachment is operationally defined by low scores (below 18) on Depend, Close, and Anxiety subscales of the RAAS.

## **Method**

### **Participants**

Participants in the study were adult females (18 years and older) in committed relationships of one year or longer in duration. It was expected that adult females who have been in a relationship for one year or longer will have a stronger commitment. The women were living with a partner with or without minor and/or adult children in the

home. Participants in the target group had childhood histories of child physical, sexual, and/or emotional abuse and/or have witnessed domestic violence while those in the comparison group did not have had such abusive histories.

### **Preliminary Analysis**

Means and standard deviations were run on each variable. Each variable was examined for internal consistency (Chronbach alpha), and a correlation matrix was produced for all variables will be inter-correlated. A MANOVA was conducted for Hypothesis I to evaluate the degree to which a childhood history of emotional, physical, or sexual abuse or exposure to domestic violence impacts the prevalence and mutuality of partner violence. A MANOVA was performed for Hypothesis II to evaluate the degree to which a childhood history of emotional, physical, or sexual abuse or exposure to domestic violence impacts the ability to feel comfortable and securely attached. A MANOVA was conducted for Hypothesis III to determine the degree to which prevalence and mutuality of partner violence affects the type of attachment (securely, insecure-fearful-avoidant, insecure-preoccupied, or insecure-dismissing).

The statistical program G\*Power 3.1 (Faul, Erdfelder, Buchner, & Lang, 2009) was used to perform power analysis regarding the use of MANOVAs. The effect size of 0.25,  $\alpha$  error probability of 0.05, and power value of 0.80 was set for each analysis. A sample size goal of 180 participants (90 in abused group and 90 in non-abused group) was necessary to find a statistically significant difference between the two groups (abused and non-abused). The sample size was based on the analysis comparing the greatest number of groups, which is Hypothesis III, comparing four attachment style groups.

## **Method of Recruitment**

Participants were recruited from four main organizations and advertisements that reached out across the United States. One of the organizations started in 1994 and is member-based and provides direct services, education, and advocacy for social change for the lesbian, gay, bisexual and transgendered (LGBT) population. The organization helps community centers in 46 states and is located in five foreign countries. They serve over 600,000 people. Their focus is on empowering community centers to meet the social, cultural, health, and political needs of the LGBT population. In 1987 the second organization was started. It is a non-profit, community organization that helps with the development, leadership, and empowerment of the lesbian, bisexual, and transgendered (LBT) community. They offer professional and business networking, and social, recreational, and educational events. Participants obtained from both organizations were free to withdraw from the study at any given time without penalty. The researcher offered packages with materials about communication, equality, and conflict resolution for participants as well as provide a list of community resources, i.e., therapists, shelters, and hotlines. In addition, the researcher advertised in a newspaper catered to the LGBT population, as well as an online magazine geared towards lesbian women. The newspaper editor also distributed the advertisement via email to their followers.

## **Research Tools**

### **Demographic Questionnaire**

A demographic questionnaire was administered to elicit information about age, culture, level of education, employment status and occupation, income, place of residence: urban, suburban, or rural and state, length of current relationship, if living

together, and for how long, and religion or faith. It is known that, as people mature through age and over the course of long-term relationships, there is less risk of violence. Inquiring about the state of residence is relevant because few states legally recognize same-sex relationships, which may increase or decrease the level of distress in the relationship. In addition, more services are likely available and easier to access in urban areas when compared to rural or suburban areas. Individuals and relationships with more support are likely to weather difficult times better than if they are isolated. Being employed or being part of a religious or spiritual community can offer a sense of belonging, support, and family. Lower socioeconomic status and financial pressures can also contribute to relationship conflict.

### **Childhood Maltreatment Interview Schedule – Short Form (CMIS-SF)**

John Briere (1992) developed the Childhood Maltreatment Interview Schedule – Short Form (CMIS-SF). It was adapted from the original CMIS. It is an 11-item self-report questionnaire designed to assess for four types of childhood abuse: emotional, physical, and sexual abuse, as well as witnessing domestic violence. The instrument also measures frequency, duration, and severity of the different forms of abuse (Clemmons, DiLillo, Martinez, DeGue, & Jeffcott, 2003). Examples of questions are: “Before age 17, did you ever see one of your parents hit or beat up your other parent?” or “Before you were 17, did anyone ever kiss you in a sexual way, or touch your body in a sexual way, or make you touch their sexual parts?” The scores are not summed to form scales but rather provide information as to whether mistreatment during childhood years (age 17 or younger) has occurred (yes or no) and how often (fill in the blank how many times).

Question seven is intended to assess for emotional/psychological mistreatment and specifically states how often (0 = never, 1 = once a year, 2 = twice a year, 3 = three to five times a year, 4 = six to ten times a year, 5 = eleven to twenty times a year, and 6 = over twenty times a year). The respondent was also asked what age she was when the first incident of child abuse or domestic violence occurred and what her age was when it stopped. In addition, there are questions for the participant to rank (1 = not at all to 4 = very much) if she felt loved or cared about by the (foster) parent. The sexual abuse questions specify who the offender was, i.e., family member and who, friend, teacher, stranger, babysitter/nanny, or fill in the relationship and the offender's age.

Like most traumatic event reviews, there are no studies known to the authors regarding the overall reliability or validity of CMIS-SF. This is partly due to the fact that, other than the Psychological Abuse subscale (the sum of all scores within item number 7), all items simply ask about potential maltreatment experiences, are not summed to form scales, and can be used by various researchers in different ways according to their interests. There are, however, data on the Psychological Abuse subscale (e.g., Briere & Runtz, 1998, 1990) suggesting reasonably good alpha reliability. Further, the successful use of the CMIS-SF in various studies suggests predictive and construct validity. (front page of instrument, unnumbered).

One study that was focused on childhood maltreatment and court records of high-risk juveniles indicated an alpha coefficient of .76 for the CMIS-SF (Swahn, Whitaker, Phippen, Leeb, Teplin, Abram, & McClellan, 2006). Another research project that was concentrated on the victimization of lesbian, gay, bisexual, and heterosexual siblings

involved the CMIS-SF and yielded a Chronbach alpha of .93 (Balsam et al., 2005). Both studies support Briere's early report of good internal consistency.

### **The Revised Adult Attachment Scale (RAAS)**

The Revised Adult Attachment Scale (RAAS) was designed by Collins in 1996 and is an 18-item self-report questionnaire. There are three subscales: Close, Depend, and Anxiety; each one is comprised of six items. The Close Scale assesses a respondent's comfort with closeness and intimacy; the Depend Scale measures the extent to which a respondent feels he/she can rely on a partner during a time of need; and the Anxiety Scale appraises a partner's fear of being abandoned or unloved. The RAAS is similar to Collins and Read's (1990) Adult Attachment Scale (AAS), which also measures closeness, dependability, and fear of abandonment. The correlation between the original AAS and the RAAS was  $r = .98$  (Collins, 1996). Sample questions of the RAAS are: "I find it relatively easy to get close to people"; "I often wonder whether romantic partners really care about me"; "I know that people will be there when I need them"; and "I find it difficult to trust others completely."

The RAAS has a 5-point, Likert-type response scale ranging from 1 (not at all characteristic of me) to 5 (very characteristic of me). Each of the three subscales (Close, Depend, and Anxiety) are individually summed. For the purposes of constructing attachment types the levels of closeness, dependability, and anxiety are determined by the midpoint score. For example, a person's midpoint score should be near or above 18 on the Close and Depend subscales if he/she is secure and below the midpoint score of 18 on the Anxiety subscale if she/he has a secure attachment style. In other words, high scores



on Close and Depend and low scores on the Anxiety subscale would indicate a secure attachment style (Stein, Koontz, Fonagy, Allen, Fultz, Brethour, Allen, & Evans, 2002). A securely attached adult would be comfortable with closeness and depending on others and would not worry about being abandoned (Collins, 1996). A high score on the Anxiety subscale, but a low score on the Close and Depend subscales, implies an insecure-fearful-avoidant attachment style. An insecure-fearful-avoidant attached adult would not be comfortable with closeness or relying on others or being loved. A high score on Anxiety and Close, but low score on Depend, would be indicative of an insecure-preoccupied attachment style. An insecure-preoccupied adult would be uncomfortable with closeness and depending on others and fearful of being unloved or abandoned. An insecure-dismissing attachment style would have a low score on all three subscales, Anxiety, Close, and Depend. An insecure-dismissing individual would have a negative and untrusting view of others and would shy away from emotional closeness. Individuals with a preoccupied or fearful attachment style will have a negative sense of self whereas individuals with a dismissive style typically have a positive sense of self (Henderson et al., 2005). Participants that score at the midpoint will be excluded from the sample.

The standardized reliability of the three subscales using Cronbach's coefficient alpha was  $r = .77$  for Close,  $r = .78$  for Depend, and  $r = .85$  for Anxiety for her first study (Collins, 1996; Stein et al., 2005). She reported reliability coefficients of .82, .80, and .83, respectively, in her second study. Test-retest reliability over a three-year time frame was  $r = .72$ . Davila and Bradbury (2001) assessed wives and husbands at five different

time points using the RAAS and had average consistencies on the Close (.82 and .79), Depend (.82 and .83), and Anxiety (.86 and .82).

### **The Revised Conflict Tactics Scales (CTS2)**

The Revised Conflict Tactics Scales (CTS2) was developed by Murray Straus, Sherry Hamby, Sue Boney-McCoy, and David Sugarman (1996) and is a revision of the original Conflict Tactics Scale (CTS) by Straus and Gelles in 1986. The CTS2 is one of the most commonly used instruments to assess for intimate partner aggression, specifically examining how couples (married, cohabitating, and dating) handle conflict. The measurement has five subscales: (1) positive conflict resolution and negotiation, (2) abusive behaviors such as psychological aggression (formerly referred to as verbal aggression), (3) physical aggression, (4) sexual coercion, and (5) results of such violence, e.g., injury (O'Leary & Williams, 2006). There are six items for the Negotiation subscale, eight for the Psychological Aggression subscale, twelve for Physical Aggression, seven for Sexual Coercion, and six for Injury (Straus & Douglas, 2004). The CTS2 replaced words such as "his/her" with "partner" to be more inclusive of nontraditional relationships (Straus et al., 1996, p. 287). Two examples of questions are, "My partner showed care for me even though we disagreed" or "I pushed or shoved my partner." The CTS2 was revised in order to have "an increased number of items to enhance content validity and reliability; revised wording to increase clarity and specificity; better differentiation between minor and severe levels of psychological and physical aggression; replacement of the weakest of the original scales (reasoning) by a new scale to measure cognitive and emotional aspects of negotiating a conflict; simplified

format to facilitate use as a self-administered questionnaire; interspersal of items from each scale to reduce response sets and demand characteristics; additional scales to measure two important aspects of abuse of a partner: sexual coercion and physical injury” (Straus et al., 1996, pp. 306-307). Both the CTS and CTS2 are based on conflict theory. Conflict theory implies that conflict, but not violence, is an inevitable part of all intimate relationships. This apparatus is not designed to measure the person’s attitude or reasoning concerning conflict, nor does it assess the consequences related to behavior.

The CTS2 was used to appraise the respondent’s behaviors as well as the respondent’s perceptions of his/her partner’s behavior. There are 78 items with 5 subscales: physical, psychological, and sexual aggression; rates of injury; and rates of nonviolent negotiation behaviors. The respondent reports the frequency of the behaviors as never occurred, occurred once, twice, three to five, six to ten, ten to twenty, or twenty or more times. With the CTS2, whether the aggressive experiences happened in the last year or prior to this can be evaluated; however, even if a couple has been together only six months, the instrument can still be used. The way the authors score the measure is by converting the categories into single digits, such as never = 0, once = 1, twice = 2, 3 to 5 times = 3, 6 to 10 times = 4, 11 to 20 times = 5, more than 20 times = 6, and none in the past year but has occurred in the past = 7. For purposes of logical scoring, scores of 0 to 6 will be used to assess for current violence. A separate marker category for those answering 7 will be developed to show if violence may have occurred in the past but not currently. Items in each subscale are added together. “Lifetime prevalence is calculated by converting the never category to zero and all other categories to one, and then summing the items within subscales to indicate if a type of violence had ever occurred in

the relationship” (Simpson & Christensen, 2005, p. 425). The CTS2 has an internal consistency reliability that ranges from .79 to .95. The reliability coefficients are as high as or greater than the original CTS (Straus et al., 1996). Various researchers, such as Jones, Ji, Beck, and Beck (2002), Lucente, Fals-Stewart, Richards, and Goscha (2001), Newton, Connelly, and Landsverk (2001) have used the CTS2 and performed factor analysis to examine the validity of the apparatus with different populations (Simpson & Christensen, 2005).

### **Limitations and Methodical Problems**

Participants may have been uncomfortable or guarded and may present as being in healthier relationships than they actually are. A second limitation is that the questionnaires were based on self-report. Also, there is the risk of self-selection bias since this is a convenience sample rather than a random sample. This may have inhibited participants’ full disclosures in being fully honest about their relationships or current problems. Participants may also have feared legal repercussions of disclosing being an aggressor or of a partner being the aggressor.

This researcher realizes that many other variables, such as substance/alcohol abuse, laws, and oppression, are important to examine as they may influence presence of abuse and/or its frequency and intensity and may contribute to how statistical data is gathered. While such variables are mentioned in the literature-review section and will be recommended to be included in future studies, they lie beyond the scope of this project.

## **CHAPTER IV**

### **Results**

This chapter provides a discussion of the data, including the sample, descriptive statistics, and results of hypothesis tests.

### **Sample**

Permission was granted to conduct research on human participants by the Institutional Review Board (IRB) at Seton Hall University (SHU) (Appendix A), LGBT Community Centers (Appendix B), a lesbian networking center (Appendix C), a newspaper catered to the LGBT population and their email distribution, and an online magazine focused on the lesbian population.

It was not possible to calculate an accurate response rate of participating lesbian women per organization or advertisements as respondents anonymously returned packets through the mail. Two-hundred-seventy-three packets were mailed and 78 were returned. Advertisements likely reached thousands of women via emails, newspapers and newsletters, as well as an online magazine and newsletter that cater to lesbian women and/or gay men. Participants completed packets between July 2011 and May 2013. One participant did not return the Revised Adult Attachment Scale (RAAS) but did return the rest of the packet completed and another participant did not return the Conflict Tactics Scale – Revised (CTS-2) but returned the rest of the packet completed. Further, three

participants' scores on the RAAS made them invalid and had to be discounted.

Therefore, the results of the current study are based on the 78 returned packets minus four RAAS and one CTS-2 instruments.

One hundred percent of the sample identified as lesbian women ( $N = 78$ ) who answered the demographic questionnaire. Participants' ages ranged from 23 to 64 years old with a mean age of forty ( $SD = 12.74$ ). Sixty one lesbians (78.2%) identified as Caucasian, five (6.4%) as Hispanic, five (6.4%) as Jewish, three (3.8%) as African-American, and three (3.8%) as Native Americans. Ten participants (12.8%) had a high school education or equivalent, 36 (46.2%) completed a two- or four-year college degree, 25 (32.1%) had Master's degrees, and seven (9%) had advanced degrees as psychologists, physicians, or lawyers. The combined household incomes for participants were relatively evenly split above and below \$85,000. The majority of participants, 22 (28.2%) were from Tennessee. Twelve (15.4%) were from Maryland, 10 (12.8%) from Virginia, and the remainder from other states in the United States. Forty one (52.6%) resided in suburban neighborhoods, 26 (33.3%) in urban communities, and 11 (14.1%) in rural areas.

The mean for relationship length was 6.77 years ( $SD = 6.54$ ) with the shortest length being one year and the longest being 32 years. The mean length of participants living together was 5.34 years ( $SD = 6.31$ ). Seventy four percent had no children in the home. Of the 26% that did have children in the home 17.9% had one child, 1.3% had two children and 6.4% had three children. Approximately 20% were minors, 5% were adult children, and 1.3% had both minor and adult children living at home. Over half, 51.3%, did not belong to a religious or spiritual community. Eighty-one percent of those that did

identify with a religious or spiritual group were classified as Christians. On the demographic scale measuring extent to which lesbian women were out (1 = not at all through 7 = all), and the extent to which they felt welcomed (1 = not at all through 7 = very), in their religious/spiritual community the means respectively were 1.65 and 1.64. Thereby, there were over half of the participants who did not belong to a religious or spiritual group, causing the means to be low. However, of the ones who did belong to a religious or spiritual community many of them were open and felt such communities were welcoming of sexual minorities.

Table 1

*Demographic Characteristics of the Participants*

Characteristic	<i>n</i>	%	Cumulative Percent
Participants' ages			
21-30	17	20.6	23.1
31-40	18	23.1	51.3
41-50	20	25.7	76.9
51-60	12	15.5	92.3
61-70	6	7.7	100.0

Table 2

*Racial Background of the Participants*

Racial group	<i>n</i>	%	Cumulative Percent
Caucasian	61	78.2	78.2
African American	3	3.8	82.1
Native American	3	3.8	85.9
Hispanic	5	6.4	92.3
Jewish	5	6.4	98.7
Asian	1	1.3	100.0

Table 3

*Education Level of the Participants*

Highest education level	<i>n</i>	%	Cumulative Percent
Less than High School	1	1.2	1.3
High School	9	11.5	12.8
Years of College	36	46.2	59.0
Master's	25	32.1	91.0
Law Degree	1	1.3	92.3
PhD/PsyD/EdD/MD	6	7.7	100.0



Table 4

*Employment Status of the Participants*

Employment status	<i>n</i>	%	Cumulative Percent
Not Employed	11	14.1	14.1
Employed	67	85.9	100.0

Table 5

*Type of Occupation of the Participants*

Occupation	<i>n</i>	%	Cumulative Percent
Unemployed	8	10.3	10.3
Retired	3	3.8	14.1
Stay at home caretaker	1	1.3	15.4
Professional	22	28.2	43.6
Technical	3	3.8	47.4
General labor	6	7.7	55.1
Skilled labor	3	3.8	59.0
Administrative	2	2.6	61.5
Executive	19	24.4	85.9
Education	10	12.8	98.7
Artist	1	1.3	100.0

Table 6

*Income of the Participants*

Household income	<i>n</i>	%	Cumulative Percent
\$0-\$15,000	4	5.1	5.1
\$15,001-\$25,000	6	7.7	12.8
\$25,001-\$40,000	10	12.8	25.6
\$40,001-\$55,000	5	6.4	32.1
\$55,001-\$70,000	8	10.3	42.3
\$70,001-\$85,000	8	10.0	52.6
\$85,001-\$100,000	5	6.4	59.0
\$100,001-\$125,000	9	11.5	70.5
\$125,001-\$150,000	9	11.5	82.1
\$150,001-\$200,000	11	14.1	96.2
\$200,001-\$250,000	1	1.3	97.4
\$250,001-\$500,000	2	2.6	100.0

Table 7

*Residing State of the Participants*

State of residence	<i>n</i>	%	Cumulative Percent
Arkansas	1	1.3	1.3
California	2	2.6	3.8
Colorado	2	2.6	6.4
DC	4	5.1	11.5
Delaware	5	6.4	17.9
Florida	2	2.6	20.5
Maryland	12	15.4	35.9
Massachusetts	5	6.4	42.3
Michigan	1	1.3	43.6
Minnesota	2	2.6	46.2
Missouri	2	2.6	48.7
New York	2	2.6	51.3
New Jersey	2	2.6	53.8
North Carolina	1	1.3	55.1
Ohio	2	2.6	57.7
Pennsylvania	1	1.3	59.0
Tennessee	22	28.2	87.2
Virginia	10	12.8	100.0

Table 8

*Residential Area of the Participants*

Type of residential area	<i>n</i>	%	Cumulative Percent
Urban	26	33.3	33.3
Suburban	41	52.6	85.9
Rural	11	14.1	100.0

Table 9

*Relationship Length of the Participants*

Relationship length	<i>n</i>	%	Cumulative Percent
1 yr – 5 yrs	53	68.2	67.9
5 yrs, 1 mo – 10 yrs	11	14.3	82.1
10 yrs, 1 mo – 15 yrs	6	7.8	89.7
15 yrs, 1 mo – 20 yrs	4	5.2	94.9
20 yrs, 1 mo – 25 yrs	2	2.6	97.4
25 yrs, 1 mo – 30 yrs	2	2.6	100.0

Table 10

*Living Together of the Participants*

Time living together	<i>n</i>	%	Cumulative Percent
1 yr – 5 yrs	17	21.8	21.8
5 yr, 1 mo – 10 yrs	1	1.3	23.8
10 yrs, 1 mo – 15 yrs	1	1.3	24.4
15 yrs, 1 mo – 20 yrs	1	1.3	25.6
20 yrs, 1 mo – 25 yrs	2	2.6	28.2
25 yrs, 1 mo – 30 yrs	1	1.3	29.5

Table 11

*Number of Children of the Participants*

Number of children	<i>n</i>	%	Cumulative Percent
0	58	74.4	74.4
1	14	17.9	92.3
2	1	1.3	93.6
3	5	6.4	100.0

Table 12

*Age of Children of the Participants*

Age of children	<i>n</i>	%	Cumulative Percent
Not Applicable	58	74.4	74.4
Minor	15	19.2	93.6
Adult	4	5.1	98.7
Both (minor + adult)	1	1.3	100.0

Table 13

*Religious/Spiritual Community of the Participants*

Type of Religious/Spiritual Community	<i>n</i>	%	Cumulative Percent
None	40	51.3	51.3
Christianity/Non-Denomen.	10	12.8	62.8
Pagan	2	2.6	65.4
Metaphysical	2	2.6	67.9
Yoga	2	2.6	70.5
Catholicism	4	5.1	75.6
Jewish/Hebrew	3	3.8	79.5
Baptist	1	1.3	80.8
Episcopalian	2	2.6	83.3
Methodist/United Method	5	6.4	89.7
Unitarian	5	6.4	96.2

Presbyterian	2	2.6	98.7
Quaker	1	1.3	100.0

Table 14

*Out to Religious/Spiritual Community of the Participants*

Extent out to Religious/Spiritual Comm.	<i>n</i>	%	Cumulative Percent
Not applicable	40	51.3	51.3
Not at all	3	3.8	53.8
Few	5	6.4	60.3
Many	8	10.3	70.5
All	23	29.5	100.0

Table 15

*Welcomed in Religious/Spiritual Community of the Participants*

How Welcoming Religious/Spiritual Community is of Sexual Minority Couples			
	<i>n</i>	%	Cumulative Percent
Not applicable	40	51.3	51.3
Not at all	3	3.8	53.8
Little	6	7.7	61.5
Mostly	7	9.0	70.5
Very	23	29.5	100.0

### **Descriptive Statistics for Study Instruments**

The means and standard deviations were calculated for each of the dependent and independent variables. The independent variable, childhood abuse, was measured by the Childhood Maltreatment Interview Schedule – Short Form (CMIS-SF) (see Table 16). The other independent variable, attachment style, was broken down into secure and insecure, with insecure having three levels: secure, insecure-preoccupied, insecure-dismissive, and insecure-fearful-avoidant, and were measured by the Adult Attachment Scale – Revised (RAAS) (see Table 18).

The dependent variables, frequency and mutuality of partner violence were measured by the Conflict Tactics Scale – Revised (CTS-2). The means and standard deviation scores were computed for frequency of psychological aggression, physical abuse, and sexual coercion by self and mutuality of violence (see Table 17). The number of participants (N) in Table 16 consists of the different types of adult aggression followed by the mean scores for the participants in each group. The other dependent, continuous variables, measured by the RAAS are close, depend, and anxious (see Table 18). The internal consistencies of the instruments were computed in order to assess the level of confidence within the data to insure that this sample matched the samples the instruments were designed for. The internal consistency for childhood abuse measured by the CMIS-SF was .70, making the overall reliability acceptable. The internal consistency for measuring attachment styles using the RAAS had a Cronbach alpha of .45 which is on the border of poor to unacceptable. The CTS-2 was used to assess adult abuse for this study and there was an excellent overall reliability of .95.



Table 16

*Descriptive Statistics of the Participants' Scores on the CMIS-SF*

Variable	N	M	SD
Non-Abused Group	25	1.68	.47
Abused Group	52	1.32	.47
Domestic Violence	15	1.81	.4
Emotional	48	1.39	.49
Physical	19	1.76	.43
Sexual	23	1.71	.46

Table 17

*Descriptive Statistics of the Participants' Scores on the RAAS*

Variable	N	M	SD
Close	74	3.82	.78
Depend	74	3.25	.92
Anxious	74	2.23	.99
Style	74	1.73	1.10
Secure	47	.64	.49
Insecure	27	.36	.48
Preoccupied	10	.14	.34
Dismissive	07	.09	.34
Fearful-Avoidant	10	.14	.34

Table 18

*Descriptive Statistics of the Participants' Scores on the CTS-2*

Variable	N	M	SD
Frequency - Self			
Psychological Aggression	57	9.86	14.35
Physical Assault	09	.73	4.17
Sexual Coercion	03	.25	1.52
Mutuality			
Psychological Aggression	52	2.09	1.34
Physical Assault	05	.35	.82
Sexual Coercion	02	.12	.54

Correlation coefficients were computed among the variables in the demographic questionnaire. Table 19 presents the results of the correlational analysis. The correlations between relationship length and respondent's age was significant at  $r(76) = .49, p < .01$ , as well as with income  $r(76) = .23, p < .01$  and length of time living together  $r(76) = .96, p < .01$ . There was a significant correlation of educational level and extent out to the religious/spiritual community at  $r(76) = -.23, p < .05$ . In addition, there were significant correlations between belonging to a religious/spiritual community and extent out to this community at  $r(76) = .30, p < .01$  and the community being welcoming of sexual minority individuals/couples at  $r(76) = .93, p < .01$ .

Table 19

*Intercorrelations of the 13 Demographic Data Variables*

Subscale	1	2	3	4	5	6	7	8	9	10	11	12
1. Age	--	.01	-.14	.20	.49**	.43**	-.11	-.23*	.02	.08	-.14	-.20
2. Education Level		--	-.09	.20	-.03	-.04	.02	-.07	.00	-.21	-.23*	-.19
3. Employed or Not			--	.08	-.14	-.18	.15	.15	.16	-.05	-.16	-.21
4. Income Amount				--	.23*	.21	.03	-.01	.09	-.16	-.24*	-.21
5. Relationship Length					--	.96**	.02	-.09	.08	.15	-.03	-.03
6. Length Living Together						--	.00	-.08	.02	.18	-.01	-.02
7. Children in Home							--	.84**	.90**	-.02	.21	.17
8. Number of Children								--	.72**	-.00	.18	.17
9. Children's Ages									--	-.01	.19	.16
10. Belong to Religious/Spiritual Community										--	.30**	.32**
11. Extent out to Religious/Spiritual Community											--	.93**
12. Extent Welcoming												--

\*\* . Correlation is significant at the 0.01 level (2-tailed).

\* . Correlation is significant at the 0.05 level (2-tailed).

Age, Highest Educational Level, Employed or Not, Amount of Income, Length of Relationship, Length of Living Together, Children Living in Home or Not, Number of Children, Ages of Children, Belong to Religious or Spiritual Community, Extent Out to Religious/Spiritual Community, and Extent Spiritual Community is Welcoming of Sexual Minority Individuals/Couples.

### Evaluation of Assumptions and Exploratory Analysis

Table 20 provides correlations between the scales and subscales of the measures in the study variables. There were several significant findings between the subscales, both at the .01 and .05 levels. The correlation between the variables of being ridiculed or humiliated as a child and being embarrassed as a child were significant at  $r(76) = .81, p < .001$ . The correlation between sexual coercion by self and mutuality was significant at  $r(75) = .65, p < .001$ , suggesting that participants who scored high on engaging in sexually coercive acts also reported their partners as being highly sexually coercive. The correlation between close and depend scales was significant at  $r(75) = .67, p < .001$ . Therefore, low scores on close tend to be associated with low scores on depend. However, low scores on close and depend scales, respectively, tend to be associated with high scores on the anxious scale. And, high scores on close and depend tend to be associated with low scores on the anxious scale. Thus,  $r(75) = -.59, p < .001$  and  $r(75) = -.64, p < .001$ , respectively.

The correlation between criticize and depend scales were significant at  $r(75) = -.52, p < .001$ . These results suggest that those participants who scored high on being criticized as a child scored low on adult dependency and vice-versa. The correlation between psychological aggression by self and anxious scales were significant at  $r(74) = .23, p < .05$ . Lastly, a significant correlation was found between the variables embarrass and mutual physical aggression,  $r(75) = .28, p < .05$ , indicating that participants who scored high on the embarrass scale also scored high on the mutual physical aggression scale and vice-versa.

Table 20

*Intercorrelations Scores of the CMIS-SF, CTS-2, and RAAS*

Subscale	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Insult	--	.78**	.91**	.78**	.83**	.15**	-.08	-.04	.05	.11	.07	-.31**	-.50**	.46**
2. Criticize		--	.73**	.71**	.79**	.19	-.09	.22	.10	.25*	.16	-.30**	-.52**	.42**
3. Ridicule/Humiliate			--	.81**	.87**	.11	-.06	-.01	-.01	.16	.09	-.35**	-.48**	.44**
4. Embarrass				--	.79**	.16	-.05	.03	-.02	.28*	.02	-.27*	-.48**	.34**
5. Feel Bad Person					--	.08	-.06	.04	-.02	.20	.11	-.31**	-.51**	.36**
6. Pa-S-Freq						--	.31**	.20	.45**	.48**	.26*	-.11	-.25*	.23*
7. Ph-S-Freq							--	.11	.12	.50**	.53**	-.14	-.26*	.19
8. Sc-S-Freq								--	.12	.44**	.65**	-.18	-.19	.17
9. Pa-Mutuality									--	.29**	.15	-.04	-.19	.19
10. Ph-Mutuality										--	.50**	-.26*	-.51*	.32**
11. Sc-Mutuality											--	-.19	-.25*	.28*
12. Close												--	.67**	-.59**
13. Depend													--	-.64**
14. Anxious														--

\*\* . Correlation is significant at the 0.01 level (2-tailed).

\* . Correlation is significant at the 0.05 level (2-tailed).

Insult, Criticize, Ridicule/Humiliate, Embarrass, Feel Bad as a Person, Psychological

Aggression by Self – Frequency, Physical Assault by Self – Frequency, Sexual Coercion

by Self – Frequency, Psychological Aggression – Mutuality, Physical Assault –

Mutuality, Sexual Coercion – Mutuality, Close, Depend, and Anxious.

### Hypothesis Testing

In hypothesis I, it was predicted that women who were victims of childhood emotional, physical, or sexual violence and/or who witnessed domestic violence would experience greater frequency and higher mutuality of domestic violence in their adult intimate relationships than would those who did not experience or witness violence. A MANOVA was conducted to determine the effect on the frequency, by self and mutuality of violence, of psychological aggression, physical assault, and sexual coercion on the one dependent variable, abused group, with two levels: abused and not abused. There were no significant differences found among the dependent measures, Wilk's  $\lambda = .95$ ,  $F(3, 73) = 1.33$ ,  $p = .27$ . Thus, hypothesis I was not supported.

In hypothesis II, it was hypothesized that women who experienced childhood emotional, physical, or sexual violence and/or who witnessed domestic violence during childhood would be less close or dependent and more anxious with intimate partners than were women who did not experience and/or witness violence during childhood. A MANOVA was computed for hypothesis II, the Wilk's  $\lambda$  of .81 is significant,  $F(3, 73) = 5.91$ ,  $p = .01$ . These results suggest that the population means on the dependent variables, close, depend, and anxious, are not the same for the abused and not abused groups. The multivariate  $\eta^2 = .20$  indicates that 20% of the multivariate variance of the close, depend, and anxious variables is associated with the group factor. The Box's M Test was not significant  $F(6, 14798) = .71$ ,  $p = .64$ . The means and standard deviations on the dependent variables for the three groups are displayed in Table 22.

Analyses of variance (ANOVA) on the dependent variables were conducted as follow-up analysis to the MANOVA. The univariate ANOVA for the close score was

significant,  $F(1, 75) = 5.95, p = .05$ . The ANOVA for the depend score was significant at  $F(1, 75) = 17.53, p = .01$ . Lastly, the ANOVA for the anxious score was significant,  $F(1, 75) = 8.81, p = .05$ . Those participants who experienced childhood abuse were less likely to experience closeness and dependency with their intimate partners but rather experience more anxiousness. In contrast, women who did not experience childhood violence were more likely to report feeling close and dependency and less anxiousness with their intimate partners.

Table 21

*Means and Standard Deviations on the Dependent Variables for the Three Groups*

	<i>N</i>	<i>M</i>	<i>SD</i>
Abused			
Close	52	3.68	.76
Depend	52	2.97	.88
Anxious	52	2.46	.99
Not Abused			
Close	25	4.13	.75
Depend	25	3.82	.73
Anxious	25	1.77	.84

In hypothesis III, a prediction was made that securely attached women would have a lower frequency and decreased mutuality of domestic violence in adult intimate relationships than women who were insecurely (preoccupied, dismissing, or fearful-avoidant) attached in adult intimate relationships. A MANOVA was conducted to determine the effect on the four types of attachment styles (secure, preoccupied, dismissive, and fearful-avoidant) on the dependent variables (frequency and mutuality of psychological aggression, physical assault, and sexual coercion). The MANOVA for hypothesis III was significant, the Wilk's  $\lambda$  of .56,  $F(18, 181.51) = 2.28, p = .01$ . The multivariate  $\eta^2 = .18$  suggests that 18% of the multivariate variance of the dependent variables is associated with the attachment style factor. The results suggest that securely attached women had lower frequency and decreased mutuality of domestic violence in their adult intimate relationships. Table 23 displays the means and standard deviations on the dependent variables for the four attachment styles.

Analyses of variance (ANOVA) on the dependent variables were conducted for further analysis to the MANOVA. The univariate ANOVA for the frequency of physical assault was significant,  $F(3, 69) = 3.44, p = .02$ ; mutuality of physical assault,  $F(3, 69) = 6.58, p = .01$ ; and mutuality of sexual coercion,  $F(3, 69) = 3.26, p = .03$ . However, the ANOVA for the frequency of psychological aggression was nonsignificant,  $F(3, 69) = 2.11, p = .11$ ; also nonsignificant were frequency of sexual coercion,  $F(3, 69) = 2.14, p = .10$ ; and mutuality of psychological aggression,  $F(3, 69) = 2.48, p = .07$ . Therefore, attachment style predicted the level of physical assault and mutuality of physical assault and sexual coercion.



Post hoc analysis to the univariate ANOVA showed that women with an insecure-fearful-avoidant attachment style experienced greater frequency of physical assault and increased mutuality of physical assault and sexual coercion.

Table 22

*Means and Standard Deviations on the Dependent Variables for the Three Groups*

	Frequency		Mutuality	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Psychological Aggression				
Secure	7.13	12.63	1.83	1.40
Preoccupied	15.22	18.97	3.00	.00
Dismissive	6.86	5.05	2.57	5.05
Fearful-Avoidant	17.50	19.03	1.80	1.55
Physical Assault				
Secure	.00	.00	.04	.29
Preoccupied	.67	1.00	.56	1.01
Dismissive	.00	.00	.57	.98
Fearful-Avoidant	4.50	11.23	1.00	1.25
Sexual Coercion				
Secure	.00	.00	.00	.00
Preoccupied	.11	.33	.33	1.00
Dismissive	.00	.00	.00	.00
Fearful-Avoidant	1.00	3.16	.50	1.08

### **Summary**

Chapter IV reported the findings of the multiple regression analyses (MANOVAs) conducted to ascertain the validity of the hypotheses statements. The results showed that there was no significant relationship between childhood abuse and adult aggression in this sample. There were significant findings that showed that childhood violence had an effect on how close, dependent, and anxious women were in their adult intimate relationships. In addition, there was a correlation between attachment style and adult aggression in adult intimate relationships.

The descriptive statistics showed that the average age was 40.15 of the female, lesbian participants in the study. The majority of the women identified themselves as Caucasian (78.2%), were in an intimate relationship for one year or longer, and from different states.

Hypothesis I was not supported as the findings did not significantly support that exposure to domestic violence in childhood or experiencing childhood abuse had an effect on the frequency or mutuality of adult psychological, physical, or sexual aggression.

Hypothesis II was supported as the findings suggested that women who suffered childhood abuse or exposure to domestic violence in childhood were more likely to feel anxious with their intimate partners, whereas those who did not undergo childhood violence were more likely to feel close and dependent with their intimate partners.

Hypothesis III was supported in that women with secure attachment styles had lower frequency and decreased mutuality of aggression in their intimate relationships.

Further, women who reported great frequency of physical assault and increased mutuality of physical assault and sexual coercion had insecure-fearful-avoidant attachment styles.

## **CHAPTER V**

### **Conclusions**

This chapter will review the findings of the current study. The hypotheses are restated, whether they were supported or not, and descriptions of the instruments will be provided. The findings will be compared to previous research to determine where commonalities existed. Furthermore, limitations of this study will be discussed and recommendations for future research will be offered. Clinical implications will also be presented and explored.

### **Problem Restatement**

The purpose of this study was to explore the relationship between exposure to family violence in childhood, attachment style, and aggression in adult intimate lesbian relationships. It was predicted that a history of childhood family violence and an insecure adult attachment style would be associated with an increased likelihood of adult abuse. Conversely, those who did not experience child abuse or childhood domestic violence and had secure attachments would report less aggression in adult lesbian intimate relationships. This research project was aimed at answering the following questions: Does childhood emotional, physical, or sexual abuse and/or witnessing of domestic violence place female victims at risk of domestic violence in their adult lesbian relationships? Are women with childhood histories of emotional, physical, or sexual

abuse and/or who witnessed domestic violence more likely to develop insecure (fearful-avoidant, preoccupied, or dismissing) attachment patterns in intimate relationships? Does childhood violence impact how close, dependent, or anxious women are in the intimate relationships? Are women with a secure attachment style in their intimate relationships less likely to experience adult domestic violence?

Childhood emotional, physical, and sexual abuse and exposure to domestic violence are subscales of the CMIS-SF (Briere & Runtz, 1990). All subscales were measured with a response of yes or no with a frequency of one or more except for emotional abuse, which was rated with a frequency of three or higher. Adult secure and insecure (preoccupied, dismissing, and fearful-avoidant) attachment styles were measured via a Likert scale (1 = not at all like me to 5 = very characteristic of me) on the RAAS (Collins, 1996). Three subscales, Psychological Aggression, Physical Aggression, and Sexual Coercion, on the CTS-2 were used to assess for different forms of domestic violence (Straus et al., 1996). The characteristics of dyadic conflict were assessed by frequency and mutuality by answering a one or more, within the last year. Participants were given instructions for completing the following: the demographic questionnaire (Appendix D), the Childhood Maltreatment Interview Schedule – Short Form (CMIS-SF: Briere & Runtz, 1990) (Appendix E), the Revised Adult Attachment Scale (RAAS: Collins, 1996) (Appendix F), and the Conflict Tactics Scale – Revised (CTS-2: Strauss et al., 1996). These questionnaires were selected because they specifically measured childhood abuse or exposure to domestic violence, attachment styles, and adult violence. The instruments were able to be self-administered, required fifth grade education to read and understand, and were time efficient.

It was predicted in Hypothesis I that women who were victims of childhood emotional, physical, or sexual violence and/or who witnessed domestic violence would experience greater frequency and higher mutuality of domestic violence in their adult intimate relationships than were those who did not experience or witness violence. Hypothesis I was not supported.

Hypothesis II predicted that women who experienced childhood emotional, physical, or sexual violence and/or who witnessed domestic violence during childhood would feel less close or comfortable with intimate partners and more anxious or fearful of rejection in adult intimate relationships than were women who did not experience and/or who did not witness violence during childhood. Women who were abused or exposed to domestic violence in childhood were more likely to feel anxious and less close or dependent in their intimate relationships. Thus, Hypothesis II was supported.

Hypothesis III predicted that securely attached women would have lower frequency and decreased mutuality of domestic violence in adult intimate relationships than women who were insecurely (fearful-avoidant, preoccupied, or dismissing) attached in adult intimate relationships. Hypothesis III was supported in that women who were securely attached reported lower frequency and decreased mutuality of adult aggression in their intimate relationships.

This study furthers research in that it connects childhood abuse and adult aggression to attachment styles in lesbian intimate relationships. While violence, attachment styles, and lesbian relationships have been independently studied there is limited research with these different variables combined together. Emotional disconnect is a common reason for couples to enter into counseling (Balsam et al., 2005; Cloitre ,

Stovall-McClough, Zorbas, & Charuvastra, 2008), therefore, there is value in studying how conflict from childhood as well as adulthood impacts how one attaches intimately (Hazan, 2003). This study links how women were treated in childhood and adulthood and examines if they securely or insecurely attach in their intimate lesbian relationships.

### **Discussion of Hypotheses**

Hypothesis I was unexpectedly not supported. Research has shown that childhood victims of violence are likely to engage in adult abusive relationships. More specifically, O'Keefe (1997) found that the strongest predictor of adult violence was being exposed to violence earlier in life. The results for Hypothesis I may not have been significant because of the small sample size and the sample being non-clinical causing low variance in the RAAS and CTS-2 subscales. While childhood violence does not directly impact adult aggression, childhood violence does influence attachment style. Insecure attachment styles have been found to influence adult aggression.

Hypothesis II was supported in that women who were victims of violence in childhood were less inclined to feel close or comfortable and more anxious and fearful of rejection in their adult intimate relationships. Adult survivors of violence may have learned that relationships, especially intimate ones, are not safe and thereby feel anxious and fearful of closeness. Other researchers have suggested that unhealthy childhood attachment styles resulting from violence can lead to extreme distrust and over independence with intimate partners later in life (Bowlby, 2005; Siegel & Hartzell, 2003). For the participants in the abused childhood group eight of them fell into the preoccupied attachment style category, six in the dismissive, and nine in the fearful-

avoidant. The preoccupied and fearful-avoidant categories are described as having unresolved childhood trauma, being anxious, needy, or worried about rejection. People with dismissive insecure attachments tend to be distant and do not see the need for emotional closeness in intimate relationships.

Hypothesis III was supported, finding that women who felt securely attached had lower frequency and decreased mutuality of adult aggression. Those who felt safe in their intimate relationships may have been better able to communicate their needs and respectfully address their differences. Research has shown that fear of abandonment, anxiety, and insecure attachments have been consistently related to partner violence (Bartholomew & Moretti, 2002). Other research with heterosexual couples has suggested comparable findings concerning relationship violence resulting from desiring closeness but feeling anxious about being rejected or unloved (Bowlby, 1982; Roberts & Noller, 1998). Therefore, there are similar relationship factors between heterosexual and lesbian relationships concerning attachment and domestic violence.

### **Clinical Implications**

Due to the high incidents of reported child abuse, especially emotional abuse, it would be advantageous to learn ways to prevent children from being victims. For those who have been victimized in childhood identifying resources in adulthood is crucial, whether it be a safe person to express the trauma or learning how to emotionally regulate when experiencing triggers or insecurities. Attending couples' therapy can aid the victim in healing with the recovery process as they explore triggers, setbacks, and fears. A partner who can actively listen, understand, and empathize may be the first loving person to validate the trauma. This experience can help develop a secure attachment where trust



and acceptance ensue. If the non-victimized partner can relay in therapy how the other partner's triggers and reactions impact the relationship then the adult survivor may begin to learn healthier ways of relating. This exchange process could be quite beneficial for those intimate relationships where both women experienced childhood violence. The therapist can help assess each partner's attachment style and help them identify areas of growth to promote security and emotional connectedness. As emotional needs are met the potential for relationship distress or aggression will likely lessen and help break the cycle of violence.

Given that mutual violence can be more common than unidirectional violence (Lie, Schilit, Bush, Montagne, & Reyes, 1991) it is important to determine if aggression has become an accepted norm for partners. Women who were battered during childhood may have learned that aggression is an acceptable way to get others to behave in a manner they want (Athens, 2003, Bandura, 1973). Further, they may gravitate to violent communities as aggression becomes a way of life both within and outside of the home. Therapists need to assess what defense mechanisms are triggered that lead to domestic violence to help their clients have insight and develop more effective coping skills. For example, adult survivors of childhood violence and those rejected by their families and society, and now by their partners, may become anxious, fearful, and aggressive (Schwartz & Proctor, 2000; Sue et al., 2007; van der Kolk, 2005). These victims would also benefit from attachment work in therapy in order to learn healthier ways to attach. This type of work may empower victims to make healthier choices about lifelong partners.

Taking a multisystemic approach in conceptualizing and treating same-sex couples is crucial. A linear, traditional approach would be limiting and fail to include the unique intricacies of lesbian couples and their families. For example, helping lesbian women identify positive role models and organizations or communities that are embracing of sexual minorities can be meaningful and confirming. Quite often lesbians lack social integration and supportive networks. Isolated couples place high expectations on their relationships for fulfillment and happiness. Diversity in the types of relationships people have, whether it be with family members, co-workers, peers, or friends, meet a variety of needs. Those who have secure attachments tend to develop flexibility and a balance of interdependence in relationships. This healthy way of relating creates an environment of trust (Bowlby, 2005; Siegel, 1999) that allows intimate partners to have relationships with others, both individually and as a couple. Those who have insecure attachment styles often lack flexibility and have a neediness or tendency to want their partners to themselves (Henderson et al., 2005). Over time, these relationship insecurities and social isolation can lead to relationship unhappiness and conflict.

Therapists who offer a sense of universality to lesbian women, particularly victimized ones, have a better chance of their clients fully expressing their vulnerabilities and relationships weaknesses (Peterman & Dixon, 2003; Speziale & Ring, 2006). It is important to be affirming and discerning, but not judgmental, as a therapist. The therapist may be the first place a victim discloses childhood or adult trauma and the client may need to learn how to access gay-friendly resources, such as attorneys, physicians, accountants, or shelters. A primary goal of treatment is to aid lesbian women in developing mutually respectful, socially just, and empowering relationships so that they

do not seek dominance through power and controlling behaviors. This can afford the opportunity to promote healing, trusting, and secure attachments with significant others.

### **Limitations**

There were several limitations of the present study. First, the sample size was small, consisting of 78 participants despite a goal of 180. Secondly, they were not ethnically diverse, with the majority being Caucasian (78.2%). Few participants were from a rural area (11%) with over half coming from suburban and a little over a third from urban communities. It would be interesting to learn if more violence occurs in rural areas due to the lack of resources for sexual minorities. While a little over half of the participants did not report belonging to a spiritual or religious community, the ones that did reported feeling a strong sense of belonging and their communities welcoming of sexual minorities. It may have been helpful for the demographic questionnaire to assess how well couples felt socially integrated in their communities in general and not just religiously or spiritually. Higher levels of social isolation increase the risk for conflict or aggression (Balsam & Szymanski, 2005) which impacts attachment styles (Collins, 1996).

It is difficult to generalize the results because the sample was mostly from Tennessee, Maryland, and Virginia; they were well educated and employed; and of middle socioeconomic class. Almost 60% of the participants did not have children, which can contribute to less relationship and financial stress. There was diversity with regard to age, relationship length, and occupation.

A potential shortcoming of the study was how emotional abuse was assessed. Most of the 26 abused participants reported experiencing emotional abuse as a child. Emotional abuse was measured by the CMIS-SF if a participant felt insulted, criticized, ridiculed or humiliated, embarrassed in front of others, and/or made to feel like a bad person with an answered of three or higher. There were some that answered a three on one or two of the items and others who answered more items with a four or greater. This created a wide array of what constituted emotional abuse, possibly allowing for too many to qualify as being abused. Further, this study combined emotional, physical, and sexual abuse in childhood, as well as exposure to domestic violence, all under abuse. Therefore, the interpretations of the results are limited.

The results were limited by the sample size because by grouping emotional, physical, and sexual abuse and exposure to domestic violence, it prevented potential variability and subsequent analysis of specific types of abuse and their correlation to attachment styles and different types of domestic violence in lesbian intimate relationships.

Another possible limitation of the study was that lesbian women may have wanted to present as healthier than they are given that this population is already marginalized. Participants may have minimized or denied a past or current history of violence to prevent additional negative stereotyping about sexual minorities. It would have been helpful to assess participants' mental health and to determine how it affects their ability to relate to others.

Lastly, this research was based on participants answering questionnaires without being interviewed. Self-report measures are limiting because participants may not be

truthful in their responses, they may inflate or minimize the severity or frequency of their issues. Questionnaires allow the researcher to obtain the participant's perspective without interfering; however, the researcher is unable to observe the participant as is the case with an interview. For example, the CMIS-SF required the women to reflect upon childhood experiences in retrospect. Their memories may be inaccurate and distorted. Also, when inquiring about violence the women may not have felt comfortable being transparent about their present situations. Fear of exposure, whether as a victim, offender, or both, can prevent participants from being completely honest. To cross-validate participants' reports on measures it would have been beneficial to obtain information from their partners, children (if applicable and appropriate), other family members (biological or chosen), and friends.

### **Recommendations for Future Research**

Given the sample limitations, future research could include a larger, more diverse sample to offer generalizability. A more representative sample would include variety with regard to ethnicity, educational level, socioeconomic status, and religion. In addition, assessing the different types of communities, suburban, rural, or urban, and how this impacts couples' sense of social integration would be beneficial. There is research concerning type of community and domestic violence in heterosexual relationships but less so for same-sex ones.

Since this study combined emotional, physical, and sexual abuse and exposure to domestic violence in childhood it would be beneficial for future research to examine the different types of abuse independently and how it impacts adult attachment styles. In

addition, since many participants reported childhood emotional abuse a more concise definition of what constitutes emotional abuse and the level of severity, such as mild, moderate, or severe. How do triggers of past aggression impact how conflict is addressed, avoided, or mishandled? Furthermore, which impacts adult aggression more: a history of childhood violence or an insecure attachment style? To go a step further, which insecure attachment styles (preoccupied, dismissive, or fearful-avoidant) are more likely to exist in violent relationships? Unexpectedly, this study found that 26 participants with childhood histories of abuse were securely attached with their intimate partners. Consequently, examining if a safe haven or a healthy, loving relationship with an adult contributes to adult survivors developing secure attachment is warranted.

It would be advantageous to determine if women knew during childhood/teen years that they identified as lesbian and if they experienced discrimination, rejection, or abuse as a result of their sexual orientation. Chronic histories of mistreatment could contribute to how differences in intimate relationships are addressed. Future research could examine if discrimination from religious/spiritual communities, or peer rejection, in general increased the risk of insecure attachments and aggression in lesbians. It would be helpful to know if, and how, increased anxiety or avoidance inhibits closeness or dependency in intimate relationships.

It is recommended that future research further examine the issue of mutuality with domestic violence. Johnson and Ferraro (2000) wrote about two types of mutual violence, common couple violence (both partners are aggressive on rare occasions) or mutual violence control (both partners seek dominance to gain power and control). Since participants in this research study reported mutual violence in their intimate lesbian

relationships it would be helpful to know if this is an issue more of power and control (Almeida & Durkin, 1999) and/or social learning (Bandura, 1973).

This study highlighted the importance to explore how couples' emotional needs are met and what constitutes unmet emotional needs, as trust and security are partly established by emotional closeness. It would be worthwhile to understand what types of conflict lead to insecurity and aggression in intimate relationships. There is value in understanding what is required for partners to feel mutually respected, understood and validated, and safe while working through conflict. Future research regarding what builds interdependence and closeness in relationships is warranted. Once this is understood, clinicians can aid in developing a securely attached partnership that has flexibility to experience closeness and dependence.

### **Conclusion**

Family violence remains a public health concern as it exists in millions of families (Smith Slep & O'Leary, 2005). Children who have been subjected to violence are likely to use aggression as a means to resolve conflict. Couples who struggle with communication, argue, or who frequently feel angry are more inclined to have aggression in their intimate relationships (Felson, 2002; Harned, 2001). Although conflict is a natural part of healthy relationships it is crucial to cope with it and not avoid it. If a partner's prior childhood or adult experiences have taught her that conflict is dangerous, punishing, fearful, uncomfortable, or disempowering she may learn to avoid conflict at all cost. When disagreements are addressed in a mutually respectful way with resolution, partners can develop close, strong and secure attachments. When couples do not respectfully acknowledge or resolve their differences or become emotionally or

physically abusive they are likely to develop insecure attachment styles. Also, if avoidance is used as a means to ineffectively cope with relationship stressors an insecure attachment style may emerge.

Exposure to domestic violence or childhood abuse did not have a significant impact on the frequency and mutuality of adult aggression in intimate lesbian relationships in this study. However, experiencing childhood abuse or domestic violence did impact adult women's ability to be close with and dependent on their intimate partners. Women who experienced childhood trauma also tended to fear rejection by their intimate partner. In addition, women who were securely attached experienced lower frequency and decreased mutuality of psychological, physical, and sexual aggression in their lesbian relationships.

When providing couples' therapy that is aimed at conflict resolution it is worthwhile to help each partner learn how to emotionally and behaviorally self-regulate to reduce tension. Aiding couples in finding comfort in being vulnerable as they actively listen and seek to understand each other is key. This creates a safe environment to openly and respectfully express perceptions and feelings and receive validation. Learning how to compromise, accept responsibility, be non-defensive, and devise a plan of action are invaluable skills when working through disagreements. This study suggests that understanding a person's childhood history of exposure to violence, and subsequent attachment style, may be imperative in promoting healthy adult relationships. While many aspects of the relationships between these variables remain to be explored and understood, it is evident that continuing research in this area may be instrumental to



therapeutic efforts towards instilling hope for intimate partners and promoting healing and secure attachments in adult lesbian relationships.

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Appendix A  
Letter of Solicitation



COLLEGE OF EDUCATION  
AND HUMAN SERVICES

## SETON HALL UNIVERSITY

### LETTER OF SOLICITATION

Dear Potential Participant:

My name is Dawn M. Beatty and I am a doctoral candidate at Seton Hall University's Department of Professional Psychology and Family Psychology Ph.D. Program. I am conducting research titled, "Effects of Exposure to Abuse and Violence in Childhood on Adult Attachment and Domestic Violence in Women's Same-Sex Relationships." The purpose of the current study is to explore the relationship between experiencing or not experiencing child abuse or witnessing domestic violence in childhood, adult attachment style, and the risk of domestic violence existing in women's same-sex relationships.

The research includes completing three instruments plus a demographic questionnaire. Together they will take approximately 45 minutes to one hour to complete. Participants will pick up a package from CenterLink or Women In Network (WIN) centers, fill out the four questionnaires, and mail the package to the researcher in the enclosed postage paid, self-addressed envelope. The following questionnaires will be administered:

- The demographic questionnaire which elicits information about the participant's age, culture, level of education, employment status and occupation, income, place of residence, length of relationship, if living together, and for how long, and religion or faith.
- The Child Maltreatment Interview Schedule – Short Form (CMIS-SF) is being used to measure whether or not emotional/psychological abuse, physical, or sexual abuse and/or witnessing of domestic violence occurred during childhood (Briere & Runtz, 1990). An example question is: "Before age 17, did you ever see one of your parents hit or beat up your other parent?" When responding to any questions on the CMIS-F asking who engaged in certain behaviors with the participant please only put the role of the person, such as parent, step-parent, foster-parent, rather than the person's name.
- The Revised Adult Attachment Scale (RAAS) is a questionnaire being used to assess a participant's comfort with closeness and intimacy in her relationship, the extent to which a participant feels she can rely on her partner during a time of need, and a participant's fear of being abandoned or unloved (Collins, 1996). An example question is: "I find it difficult to trust others completely."
- The Revised Conflict Tactics Scale (CTS-2) is being administered to measure whether or not three types of domestic violence

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(emotional/psychological, physical, or sexual coercion) are occurring in adult intimate relationships (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). An example question is: "My partner showed care for me even though we disagreed."

The following websites offer information about equality, conflict resolution, and communication skills that may be beneficial to the participant. One website that focuses on building communities and advocating for social justice is <http://www.familyequality.org.html>. Another website providing information about resources and research regarding lesbian couples and families is <http://www.gottman.com/49850/Gay--lesbianResearch.html>. To find information about conflict resolution skills please go to [http://helpguide.org/mental/eq8\\_conflict\\_resolution.html](http://helpguide.org/mental/eq8_conflict_resolution.html). To learn about effective communication skills please visit <http://www.life123.com/relationships/communication/effective-communication-skills-3.shtml>.

Additional local resources such as hotlines, shelters, legal aid, and counseling will be provided in the packages. Some national organizations are: National Center for Lesbian Rights (415-392-6527; [www.nclrights.org](http://www.nclrights.org)), National Gay and Lesbian Task Force (305-571-1924), National Coalition Against Domestic Violence (800-799-7233), National Coalition of Anti-Violence Programs (212-714-1184; [www.safe4all.org](http://www.safe4all.org)), Gay and Lesbian National Hotline 888-843-4564, and Rape, Abuse, and Incest National Network (800-656-HOPE; [www.rainn.org](http://www.rainn.org)).

In order to participate in this study the participant must be 18 years or older and needs to be in a lesbian relationship for one year or longer. Pregnant women will be excluded from the study. Participation is voluntary and participants are free to withdraw from the study at any given time without penalty. There will be no identifying information on the instruments but the instruments/packages will be numbered prior to being sent to CenterLink or WIN so that the four questionnaires sent by an individual can be identified as pertaining to the same participant. Packages with the four questionnaires can be picked up at CenterLink and WIN participating locations and participants will mail the package upon completion. The return address has a locked mailbox and the researcher will be the only one who has access to the data. There are no names attached to the data. Individual answers will not be reported. Data will be analyzed and stored in a locked cabinet.

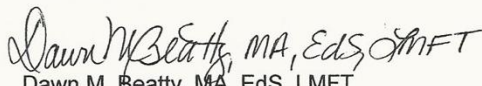
Please return packages to: Dawn M. Beatty, 106 Mission Court, Suite 904B, Franklin, TN, 37067. Any questions please contact Dawn M. Beatty by phone at 615-587-5490 or by email at [dbeatty@bellsouth.net](mailto:dbeatty@bellsouth.net). If you would like to contact the researcher's advisor, Dr. Robert Massey, you may do so through the Department of Professional Psychology and Family Therapy, Seton Hall University, 400 South Orange Avenue, South Orange, NJ, 07079; phone: 973-761-9451; email: [robert.massey@shu.edu](mailto:robert.massey@shu.edu). To contact the Institutional Review Board (IRB) with any pertinent questions about the



research or participant's rights please contact: Institutional Review Board, Presidents Hall Room 325, Seton Hall University, 400 South Orange Avenue, South Orange, NJ, 07079; phone: 973-313-6314; email: [irb@shu.edu](mailto:irb@shu.edu).

Your participation is greatly appreciated.

Sincerely,

 Dawn M. Beatty, MA, EdS, LMFT

Dawn M. Beatty, MA, EdS, LMFT  
Ph.D. Candidate at Seton Hall University  
Department of Professional Psychology and Family Psychology

Appendix B  
CenterLink Flyer

**PARTICIPANTS WANTED FOR RESEARCH STUDY:**

***Effects of Exposure to Abuse and Violence in Childhood on Adult Attachments  
And Domestic Violence in Women's Same-Sex Relationships***

~My name is Dawn M. Beatty and I am a doctoral candidate at Seton Hall University's Department of Professional Psychology and Family Psychology Ph.D. Program.

~The purpose of the current study is to explore the relationship between experiencing or not experiencing child abuse or witnessing domestic violence in childhood, adult attachment style, and the risk of domestic violence existing in women's same-sex relationships.

~The research includes completing three instruments plus a demographic questionnaire. Together they will take approximately 45 minutes to one hour to complete. The following instruments will be included in packets:

~The demographic questionnaire elicits information about the participant's age, culture, level of education, employment status and occupation, income, place of residence, length of relationship, if living together, and for how long, and religion or faith.

~The Child Maltreatment Interview Schedule – Short Form (CMIS-SF) is being used to measure whether or not emotional/psychological abuse, physical, or sexual abuse and/or witnessing of domestic violence occurred during childhood.

~The Revised Adult Attachment Scale (RAAS) is a questionnaire being used to assess a participant's comfort with closeness and intimacy in her relationship, the extent to which a participant feels she can rely on her partner during a time of need, and a participant's fear of being abandoned or unloved.

~The Revised Conflict Tactics Scale (CTS-2) is being administered to measure whether or not three types of domestic violence (emotional/psychological, physical, or sexual coercion) are occurring in adult intimate relationships.

~ Participants will pick up the packages from CenterLink centers, fill out the four questionnaires, and mail the packages to the researcher in the enclosed postage paid, self-addressed envelopes. Please return packages to: Dawn M. Beatty, 106 Mission Court, Suite 904B, Franklin, TN 37067.

~Inclusion Criteria:   ~Must be 18 years old or older.  
                                  ~Need to be in a lesbian relationship for one year or longer.

~Exclusion Criteria:   ~Pregnant women are excluded from the study.

~Participation is voluntary and participants are free to withdraw from the study at any given time without penalty.

~No identifying information will be on the instruments. While anonymous the instruments/packages will be numbered, so that the questionnaires can be identified as pertaining to the same participant.

~The return address has a locked mailbox. Data will be stored in a locked cabinet.

~Any questions please contact Dawn M. Beatty at 615-587-5490.

## Appendix C

### Women In Network Flyer

**PARTICIPANTS WANTED FOR RESEARCH STUDY:**

***Effects of Exposure to Abuse and Violence in Childhood on Adult Attachments  
And Domestic Violence in Women's Same-Sex Relationships***

~My name is Dawn M. Beatty and I am a doctoral candidate at Seton Hall University's Department of Professional Psychology and Family Psychology Ph.D. Program.

~The purpose of the current study is to explore the relationship between experiencing or not experiencing child abuse or witnessing domestic violence in childhood, adult attachment style, and the risk of domestic violence existing in women's same-sex relationships.

~The research includes completing three instruments plus a demographic questionnaire. Together they will take approximately 45 minutes to one hour to complete. The following instruments will be included in packets:

~The demographic questionnaire elicits information about the participant's age, culture, level of education, employment status and occupation, income, place of residence, length of relationship, if living together, and for how long, and religion or faith.

~The Child Maltreatment Interview Schedule – Short Form (CMIS-SF) is being used to measure whether or not emotional/psychological abuse, physical, or sexual abuse and/or witnessing of domestic violence occurred during childhood.

~The Revised Adult Attachment Scale (RAAS) is a questionnaire being used to assess a participant's comfort with closeness and intimacy in her relationship, the extent to which a participant feels she can rely on her partner during a time of need, and a participant's fear of being abandoned or unloved.

~The Revised Conflict Tactics Scale (CTS-2) is being administered to measure whether or not three types of domestic violence (emotional/psychological, physical, or sexual coercion) are occurring in adult intimate relationships.

~ Participants will pick up the packages from Women In Network center, fill out the four questionnaires, and mail the packages to the researcher in the enclosed postage paid, self-addressed envelopes. Please return packages to: Dawn M. Beatty, 106 Mission Court, Suite 904B, Franklin, TN 37067.

~Inclusion Criteria: ~Must be 18 years old or older.

~Need to be in a lesbian relationship for one year or longer.

~Exclusion Criteria: ~Pregnant women are excluded from the study.

~Participation is voluntary and participants are free to withdraw from the study at any given time without penalty.

~No identifying information will be on the instruments. While anonymous the instruments/packages will be numbered, so that the questionnaires can be identified as pertaining to the same participant.

~The return address has a locked mailbox. Data will be stored in a locked cabinet.

~Any questions please contact Dawn M. Beatty at 615-587-5490.

Appendix D  
Demographic Data Questionnaire

**Demographic Data Questionnaire**

1. How old are you?

Age \_\_\_\_\_

2. A) What cultural/ethnic group(s) do you identify with?

\_\_\_\_\_

B) What racial group(s) do you identify with?

\_\_\_\_\_

3. What is your highest educational level completed? Indicate all that apply.

a. Years of Grammar/Middle School \_\_\_\_\_

b. Years of High School \_\_\_\_\_

c. GED \_\_\_\_\_

d. Years of College \_\_\_\_\_

e. Years of Graduate School \_\_\_\_\_

f. Type of Degree:

Two-year/Associates: \_\_\_\_\_

Four-year: \_\_\_\_\_

Masters: \_\_\_\_\_

Law Degree: \_\_\_\_\_

MD: \_\_\_\_\_

PhD, PsyD, EdD: \_\_\_\_\_

4. Are you employed?

a. Yes

b. No

5. If yes, what is your present occupation? \_\_\_\_\_

6. What is your gross family income (annual)?

- a. \$0-\$15,000 \_\_\_\_\_
- b. \$15,000 - \$25,000
- c. \$25,000-\$40,000
- d. \$40,000-\$55,000
- e. \$55,000-\$70,000
- f. \$70,000-\$85,000
- g. \$85,000-100,000
- h. \$100,000-\$125,000
- i. \$125,000-150,000
- j. \$150,000-\$200,000
- k. \$200,000-\$250,000
- l. \$250,000-\$500,000
- m. \$500,000-\$1 million
- n. Over \$1 million

7. What state do you live in? \_\_\_\_\_

8. What type of residential area do you live in?

- a. Urban
- b. Suburban
- c. Rural

9. How long have you been in your current relationship?

\_\_\_\_\_ months \_\_\_\_\_ years

10. Do you live with your partner?

- a. Yes
- b. No

If yes, how long have you lived together?

\_\_\_\_\_ months \_\_\_\_\_ years

11. A) Are there children in the home?

- a. Yes
- b. No

B) If yes, how many children? \_\_\_\_\_



C) What are the ages of the children? \_\_\_\_\_

12. A) Do you belong to a religious or spiritual community?

- a. Yes
- b. No

B) If yes, please identify your religious or spiritual community.

\_\_\_\_\_

To what extent are you out in this religious or spiritual community regarding sexual orientation?

(Please circle number that fits you best.)

Not At All	To 1 to 2	To a Few	To Many	To All
1	2	3	4	5
				6
				7

C) To what extent is your religious or spiritual community welcoming of sexual-minority individuals and couples?

(Please circle number that fits you best.)

Not At All						Very
1	2	3	4	5	6	7

## Appendix E

### Childhood Maltreatment Interview Schedule Short Form

**Childhood Maltreatment Interview Schedule Short Form**  
**John Briere, Ph.D.**

*Please note: Use of this scale is limited to professional researchers. It is not intended as, nor should it be used as, a self-test under any circumstances.*

**Cut and paste, as needed, into word processor. Adapted from the full CMIS, published as an appendix in J. Briere (1992), *Child Abuse Trauma: Theory and Treatment of the Lasting Effects*. Newbury Park, CA: Sage Publications.**

**This instrument is freely available to all researchers. No permission is required, although Briere, 1992 should be cited.**

Briere, J., & Runtz, M. (1990). Differential adult symptomatology associated with three types of child abuse histories. Child Abuse & Neglect: The International Journal, 14, 357-364.

Briere, J., & Runtz, M. (1988). Multivariate correlates of childhood psychological and physical maltreatment among university women. Child Abuse & Neglect: The International Journal, 12, 331-341.

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**CMIS-SF**

Age \_\_\_\_\_

Sex: Male \_\_\_ Female \_\_\_

Race: Caucasian/White \_\_\_ Black \_\_\_ Asian \_\_\_ Hispanic \_\_\_ Other \_\_\_

Are you currently receiving psychotherapy or psychiatric treatment?

Yes \_\_\_ No \_\_\_

The following survey asks about things that may have happened to you in the past. Please answer all of the questions that you can, as honestly as possible.

1) Before age 17, did any parent, step-parent, or foster-parent ever have problems with drugs or alcohol that lead to medical problems, divorce or separation, being fired from work, or being arrested for intoxication in public or while driving?

Yes \_\_\_ No \_\_\_

If yes, what role did this person have? \_\_\_\_\_ (do not write the person's name).

About how old were you when it started? \_\_\_ years old

About how old were you when it stopped? \_\_\_ years old

[Check here if it hasn't stopped yet \_\_\_]

2) Before age 17, did you ever see one of your parents hit or beat up your other parent?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how many time can you recall this happening? \_\_\_\_ times

Did your father ever hit your mother? Yes \_\_\_\_ No \_\_\_\_

Did your mother ever hit your father? Yes \_\_\_\_ No \_\_\_\_

Did one or more of these times result in someone needing medical care or the police being called? Yes \_\_\_\_ No \_\_\_\_

3) On average, before age 8, how much did you feel that your father/step-father/foster-father loved and cared about you?

Not at all                      Very much

1      2      3      4

4) On average, before age 8, how much did you feel that your mother/step-mother/foster-mother loved and cared about you?

Not at all                      Very much

1      2      3      4

5) On average, from age 8 through age 16, how much did you feel that your father/step-father/foster-father loved and cared about you?

Not at all                      Very much

1      2      3      4

6) On average, from age 8 through age 16, how much did you feel that your mother/step-mother/foster-mother loved and cared about you?

Not at all                      Very much

1      2      3      4

7) When you were 16 or younger, how often did the following happen to you in the average year? Answer for your parents or stepparents or foster parents or other adult in charge of you as a child:

once a	twice a	3-5 times	6-10 times	11-20 times	over 20 times	
never	year	year	a year	a year	a year	a year
0	1	2	3	4	5	6

A) Yell at you	0	1	2	3	4	5	6
----------------	---	---	---	---	---	---	---

B) Insult you                      0   1   2   3   4   5   6

C) Criticize you                      0   1   2   3   4   5   6

D) Try to make  
you feel guilty                      0   1   2   3   4   5   6

E) Ridicule or  
humiliate you                      0   1   2   3   4   5   6

F) Embarrass you  
in front of others                      0   1   2   3   4   5   6

G) Make you feel  
like you were  
a bad person                      0   1   2   3   4   5   6

8) Before age 17, did a parent, step-parent, foster-parent, or other adult in charge of you as a child ever do something to you on purpose (for example, hit or punch or cut you, or push you down) that made you bleed or gave you bruises or scratches, or that broke bones or teeth?

Yes\_\_ No\_\_ If yes, what role did this person have? \_\_\_\_\_  
(do not write the name of the person).

How often before age 17? \_\_\_\_\_ times

How old were you the first time? \_\_\_\_\_ years

How old were you the last time (before age 17)? \_\_\_\_\_ years

Were you ever hurt so badly that you had to see a doctor or go to the hospital? Yes\_\_ No\_\_

9. Before you were age 17, did anyone ever kiss you in a sexual way, or touch your body in a sexual way, or make you touch their sexual parts?

Yes\_\_ No\_\_

Did this ever happen with a family member?

Yes\_\_ No\_\_

If yes, what role did this person have? \_\_\_\_\_ (do not write name of the person). At what ages? \_\_\_\_\_

Did this ever happen with someone 5 or more years older than you were?

Yes\_\_ No\_\_

If yes, with who (check all that apply):

\_\_\_ A friend. At what ages? \_\_\_\_\_

\_\_\_ A stranger. At what ages? \_\_\_\_\_

\_\_\_ A family member (What role did this person have? \_\_\_\_\_)  
(do not write the person's name). At what ages? \_\_\_\_\_

\_\_\_ A teacher, doctor, or other professional. (What role did this person have?  
\_\_\_\_\_) (do not write the person's name). At what ages? \_\_\_\_\_

\_\_\_ A babysitter or nanny. At what ages? \_\_\_\_\_

\_\_\_ Someone else not mentioned above  
(What role did this person have? \_\_\_\_\_) (do not write the  
person's name). At what ages? \_\_\_\_\_

Did anyone ever use physical force on any of these occasions?

Yes\_\_\_ No\_\_\_ If yes, what role did this person have? \_\_\_\_\_ (do not  
write the person's name).

Overall, about how many times were you kissed or touched in a sexual way or made to  
touch someone else's sexual parts by someone five or more years older before age 17?

\_\_\_ times

Overall, how many people (five or more years older than you) did this?

\_\_\_ people (the number of people, not the names)

10) Before you were age 17, did anyone ever have oral, anal, or vaginal intercourse with  
you, or insert a finger or object in your anus or vagina?

Yes\_\_\_ No\_\_\_

Did this ever happen with a family member?

Yes\_\_\_ No\_\_\_

If yes, with what role did this person have? \_\_\_\_\_ (do not write the  
person's name). At what ages? \_\_\_\_\_

Did this ever happen with someone 5 or more years older than you were?

Yes\_\_\_ No\_\_\_

If yes, with who (Check all that apply):

\_\_\_ A friend. At what ages? \_\_\_\_\_

\_\_\_ A stranger. At what ages? \_\_\_\_\_

\_\_\_ A family member. (What role did this person have? \_\_\_\_\_)  
(do not write the name). At what ages? \_\_\_\_\_

\_\_\_ A teacher, doctor, or other professional (What role did this person have?  
\_\_\_\_\_) (do not write the person's name). At what ages? \_\_\_\_\_

\_\_\_ A babysitter or nanny. At what ages? \_\_\_\_\_

\_\_\_ Someone else not mentioned above. (What role did this person have?  
\_\_\_\_\_) (do not write the person's name).  
At what ages? \_\_\_\_\_

Did anyone ever use physical force on any of these occasions?

Yes\_\_\_ No\_\_\_

If yes, what role did this person have? \_\_\_\_\_ (do not write the person's  
name).

About how many times did anyone five or more years older have oral, anal, or vaginal  
intercourse with you before age 17, or insert a finger or object in your anus or vagina?  
\_\_\_ times

Overall, how many people (five or more years older than you) did this?

\_\_\_ people (the number of people, not names)

11) To the best of your knowledge, before age 17, were you ever

Sexually abused? Yes\_\_\_ No\_\_\_

Physically abused? Yes\_\_\_ No\_\_\_

## Appendix F

### The Revised Adult Attachment Scale



### The Revised Adult Attachment Scale (Collins, 1996)

Please read each of the following statements and rate the extent to which it describes your feelings about romantic relationships. Please think about all your relationships (past and present) and respond in terms of how you generally feel in these relationships. If you have never been involved in a romantic relationship, answer in terms of how you think you would feel.

Please use the scale below by placing a number between 1 and 5 in the space provided to the right of each statement.

1-----2-----3-----4-----5
<div style="display: flex; justify-content: space-between;"> <span><b>Not at all</b></span> <span><b>Very characteristic</b></span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>characteristic of me</b></span> <span><b>of me</b></span> </div>

- 1) I find it relatively easy to get close to people. \_\_\_\_\_
- 2) I find it difficult to allow myself to depend on others. \_\_\_\_\_
- 3) I often worry that romantic partners don't really love me. \_\_\_\_\_
- 4) I find that others are reluctant to get as close as I would like. \_\_\_\_\_
- 5) I am comfortable depending on others. \_\_\_\_\_
- 6) I don't worry about people getting too close to me. \_\_\_\_\_
- 7) I find that people are never there when you need them. \_\_\_\_\_
- 8) I am somewhat uncomfortable being close to others. \_\_\_\_\_
- 9) I often worry that romantic partners won't want to stay with me. \_\_\_\_\_
- 10) When I show my feelings for others, I'm afraid they will not feel the same about me. \_\_\_\_\_
- 11) I often wonder whether romantic partners really care about me. \_\_\_\_\_
- 12) I am comfortable developing close relationships with others. \_\_\_\_\_
- 13) I am uncomfortable when anyone gets too emotionally close to me. \_\_\_\_\_
- 14) I know that people will be there when I need them. \_\_\_\_\_
- 15) I want to get close to people, but I worry about being hurt. \_\_\_\_\_
- 16) I find it difficult to trust others completely. \_\_\_\_\_
- 17) Romantic partners often want me to be emotionally closer than I feel comfortable being. \_\_\_\_\_
- 18) I am not sure that I can always depend on people to be there when I need them. \_\_\_\_\_