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Intimate Partner Aggression Reporting Concordance and Correlates of Agreement Among Men With Alcohol Use Disorders and Their Female Partners

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This study examined relationship aggression reporting concordance among 303 men with alcohol use disorders and their female partners enrolled in couples-based alcohol abuse treatment. Agreement for physical and psychological aggression was generally consistent with, or higher than, concordance rates reported among other populations. Men's antisocial personality disorder characteristics were the strongest predictor of higher concordance for male- and female-perpetrated aggression. Higher alcohol problem severity, poorer relationship adjustment, and higher psychopathic personality features were associated with better concordance in some analyses. Women reported experiencing more physical aggression than men reported perpetrating, and women reported perpetrating more psychological aggression than men reported experiencing. Findings highlight the importance of obtaining aggression reports from both partners and the need for research investigating methods for improving concordance.

Keywords: physical aggression; psychological aggression; concordance; alcohol use disorders; relationship adjustment; antisocial personality disorder characteristics; psychopathic personality features

Intimate partner physical aggression occurs in approximately 8.7 million households in the United States annually (Straus & Gelles, 1990), often resulting in serious physical and psychological health problems, decreased work productivity, and significant health care costs (Centers for Disease Control and Prevention, 2003). Furthermore, psychological aggression occurs in most intimate relationships (Magdol, Moffitt, & Caspi, 1997) and has been found to be associated with negative mental and physical health outcomes among community samples (Basile, Arias, Desai, & Thompson, 2004; Taft et al., in press). Research on intimate partner aggression has advanced considerably in the past two decades, although significant controversy remains surrounding its assessment (Field & Caetano, 2005; Schafer, 1996). One such issue involves interpartner concordance of reports of aggression. This issue has important implications for the validity of research findings because studies differ with respect to use of self- versus partner reports and these sets of reports may differ with respect to accuracy (Margolin, 1987). In the clinical context, threats to the validity of relationship aggression reporting and the accurate identification of abuse perpetration may hinder intervention efforts for both victims and perpetrators.

Physical aggression reporting concordance has been examined among samples of couples seeking marital therapy (Jouriles & O'Leary, 1985; O'Leary, Vivian, & Malone, 1992; Simpson & Christensen, 2005), couples in which the male partner is in treatment for domestic violence perpetration (Browning & Dutton, 1986; Cantos, Neidig, & O'Leary, 1994; Edleson & Brygger, 1986), and representative and nonrepresentative community samples of couples (Capaldi & Owen, 2001; Heyman, Feldbau-Kohn, Ehrensaft, Langhinrichsen-Rohling, & O'Leary, 2001; Kim & Capaldi, 2004; Margolin, 1987; Moffitt et al., 1997; O'Brien, John, Margolin, & Erel, 1994; O'Leary & Arias, 1988; Schafer, Caetano, & Clark, 2002; Szinovacz, 1983; Szinovacz & Egley, 1995). These investigations have generally shown that couples evidence low to moderate levels of agreement for the occurrence or nonoccurrence of physical aggression, with kappa and percentage agreement values averaging .47 (range = .36-.64) and 43% (range = 27%-57%), respectively, for male-perpetrated physical aggression and .39 (range = .25-.62) and 40% (range = 17%-62%), respectively, for female-perpetrated physical aggression. Furthermore, Pearson correlations examining both partners' reports of the frequency of physically aggressive behaviors

average .55 (range = .49-.65) for male perpetrators and .48 (range = .26-.61) for female perpetrators.

Fewer studies have examined concordance between partners' reports of psychological aggression, but existing investigations report similar levels of interpartner agreement as found for physical aggression. In one study of a large community sample, kappa values reflecting the occurrence and nonoccurrence of psychological aggression were .32 and .31 for male and female perpetrators, respectively (Moffitt et al., 1997). Agreement statistics obtained in a marital therapy sample indicated better agreement for severe psychological aggression ($\kappa = .58$ for male-perpetrated aggression, $\kappa = .62$ for female-perpetrated aggression; Simpson & Christensen, 2005). Edleson and Brygger (1986) examined interpartner agreement for the frequency of specific psychologically aggressive behaviors and reported item-level correlations ranging from .05 to .50, with the majority falling below .30. Finally, in an investigation of at-risk men and their female partners, correlations between partners' frequency reports of male- and female-perpetrated overall psychological aggression ranged from .51 to .55 in two longitudinal assessments (Kim & Capaldi, 2004).

Interpartner reporting concordance of relationship aggression has not previously been examined among a clinical sample of men with alcohol use disorders, despite findings indicating that rates of intimate partner physical aggression among these individuals range from 50% to 60% for the year before seeking alcohol use treatment (e.g., O'Farrell, Fals-Stewart, Murphy, & Murphy, 2003; O'Farrell & Murphy, 1995; Stuart et al., 2003). These rates are approximately 4 to 5 times higher than those found in a nationally representative study (Straus & Gelles, 1990). Furthermore, from 75% to more than 90% of men in treatment for alcohol use disorders demonstrate elevated psychological aggression relative to national samples (O'Farrell et al., 2003; O'Farrell, Murphy, Neavins, & Van Hutton, 2000). Given the exceptionally high rates of partner aggression among this population and uncertainty in applying concordance findings obtained in community or community-based marital therapy populations to this unique group, it appears important to examine aggression reporting concordance among these individuals.

Several factors suggest that concordance of aggression reports may be low among couples in which one partner is in treatment for an alcohol use disorder. Memory problems are generally associated with alcohol abuse (e.g., White, 2003), and researchers have suggested that individuals

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who abuse alcohol and/or drugs may have poor memory for incidents of relationship aggression (Armstrong et al., 2001; Medina, Schafer, Shear, & Armstrong, 2004). In addition, studies suggest that both partners may be less likely to hold perpetrators responsible for their aggressive behavior if the perpetrator had been drinking at the time of the event because the behavior may be viewed as unintentional or excusable, leading partners to underreport (LeJeune & Follette, 1994; O'Leary et al., 1992). Indeed, Heckert and Gondolf (2000) found that female partners of men who were in a domestic violence treatment program were less likely to report relationship aggression if the male partner also had been in alcohol use treatment.

Conversely, there is some evidence to suggest the possibility of high aggression reporting concordance between men in treatment for alcohol use disorders and their partners. In clinical samples of men with alcohol problems, high agreement rates between men's self- and women's collateral reports of alcohol use quantity and frequency, as well as alcohol problem severity, have been consistently documented (Babor, Steinberg, Anton, & Del Boca, 2000; Connors & Maisto, 2003). Another study of men in treatment for alcohol use disorders and their partners found that couples tend to agree on aspects of the family environment, such as how well family members work together (McKay, Maisto, Beattie, Longabaugh, & Noel, 1993). These data suggest that couples in which one partner is in treatment for an alcohol use disorder may be good reporters of each other's behavior, even when it is socially undesirable.

Very little research has attempted to move beyond the reporting of relationship aggression concordance rates by examining factors that may influence agreement. As discussed, problematic alcohol use may affect interpartner concordance, possibly due to attributions related to responsibility for abusive behavior among this population and memory problems. However, one study of a nationally representative sample of couples did not find a relationship between alcohol problem severity and partners' physical aggression reporting concordance (Caetano, Schafer, Field, & Nelson, 2002). It is not known if such findings would generalize to a sample of individuals in treatment for alcohol use disorders, who presumably consume alcohol more frequently and have more difficulties related to their alcohol use.

Consistent with research on partners' agreement regarding daily relationship behaviors and interactions (Christensen, Sullaway, & King, 1983; Margolin, Hattem, John, & Yost, 1985), one study of couples seeking marital therapy found lower relationship adjustment ratings among couples who disagreed on the husband's classification as nonviolent, mildly violent, or severely violent

in their relationships (Langhinrichsen-Rohling & Vivian, 1994). Those low in relationship satisfaction are more likely to place blame on their partners for negative relationship experiences (Byrne & Arias, 1997; Fincham, Bradbury, Arias, Byrne, & Karney, 1997), and those who blame their partner for the aggression are less likely to acknowledge their own perpetration (O'Leary & Arias, 1988; O'Leary et al., 1992). Notably, however, a recent study of couples in marital therapy did not find an association between couples' relationship adjustment and concordance of relationship aggression reporting (Simpson & Christensen, 2005).

Antisocial personality disorder characteristics and psychopathic personality features are commonly associated with alcohol abuse and relationship aggression (e.g., Murphy, Meyer, & O'Leary, 1993; Reardon, Lang, & Patrick, 2002); however, to date, they have not been examined as correlates of interpartner concordance of reports of relationship aggression. These personality traits have been found to be positively associated with greater identification with masculine gender roles (Klonsky, Jane, Turkheimer, & Oltmanns, 2002; Lengua & Stormshak, 2000), and the desire to display one's masculinity may reduce desire to underreport aggression (e.g., Moffitt et al., 1997), leading to higher aggression reporting concordance. In addition, individuals with antisocial personality disorder characteristics or psychopathic personality features commonly score low on measures of social desirability (e.g., Poythress, Edens, & Lilienfeld, 1998), which has been found to negatively affect the accuracy of self-reports of relationship aggression (Sugarman & Hotaling, 1997). Accordingly, individuals high in antisocial personality disorder characteristics or psychopathic personality features may be more accurate reporters of relationship aggression due to their lack of concern for the way that others perceive their behavior. In contrast, it is also possible that because individuals with these personality characteristics are prone to lying and deceitfulness, they may have lower interpartner concordance in aggression reports.

Several studies have found that women report significantly more relationship aggression than their male partners, regardless of which partner is the victim (Jouriles & O'Leary, 1985; Magdol et al., 1997; Schafer et al., 2002; Szinovacz, 1983). However, a few investigations have found that victims report more aggression than perpetrators, regardless of gender (e.g., Moffitt et al., 1997). This issue remains unresolved and is in need of further inquiry.

The current study examined interpartner agreement of relationship aggression among a sample of men with alcohol use disorders and their female partners entering couples-based alcohol treatment. Specifically, concordance of reports of male- and female-perpetrated physical

and psychological aggression was examined, as were associations between concordance levels and men's alcohol problem severity, couples' relationship adjustment, and men's antisocial and psychopathic personality features. We hypothesized that men's higher alcohol problem severity and couple's poorer relationship adjustment would be associated with lower reporting concordance. Regarding men's antisocial personality disorder characteristics and psychopathic personality features, we proposed two competing hypotheses based on evidence to suggest that these characteristics could be associated with either higher or lower levels of concordance. Finally, consistent with other research in this area (e.g., Schafer et al., 2002), it was expected that women's reports of physical aggression and psychological aggression victimization and perpetration would be higher than men's reports.

METHOD

Participants

Participants were 303 men diagnosed with an alcohol use disorder and their female relationship partners who were enrolled in the Counseling for Alcoholics' Marriages (CALM) program at one of four Massachusetts addiction treatment sites. Men were recruited by project staff at all four sites and through media advertisements (see O'Farrell, Murphy, Stephan, Fals-Stewart, & Murphy, 2004, for further recruitment details). Couples were part of a larger project examining factors predicting outcome after behavioral couples therapy (BCT; O'Farrell, 1993; O'Farrell & Fals-Stewart, 2000; O'Farrell & Murphy, 1995; O'Farrell, Van Hutton, & Murphy, 1999). Inclusion criteria were as follows: (a) both partners were between 21 and 65 years of age; (b) the couple was married or, if unmarried, cohabitating for at least 1 year immediately prior to enrolling in the study; (c) the male partner met *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R*; American Psychiatric Association, 1987) criteria for alcohol abuse or dependence; (d) the male partner agreed to abstain from alcohol during treatment and seriously agreed to consider taking Antabuse if medically cleared; (e) male participants meeting criteria for alcohol abuse could not meet *DSM-III-R* criteria for drug dependence to ensure that alcohol use was their most salient substance problem (however, if a potential participant met criteria for alcohol dependence and drug dependence, the couple remained eligible for the study); (f) neither partner met *DSM-III-R* criteria for a psychotic disorder during the 6 months prior to the assessment; (g) neither partner evidenced any organic impairment that might hinder project completion, as judged by the couple's therapist; (h) if

separated, the couple agreed to reconcile during their participation in the CALM program (thus, all couples were living together at the time of their assessment); (i) the male partner agreed to not participate in other alcohol-related treatment other than self-help support groups (e.g., Alcoholics Anonymous) while enrolled in the CALM program; (j) the female partner did not meet criteria for alcohol or drug abuse or dependence during the 6 months prior to assessment, unless she had a mildly severe substance abuse problem and had already stopped or reduced use to a nonproblematic level when the couple started the program.¹

Study participants were drawn from 347 consecutive eligible couples that signed informed consents to participate in the CALM program between February 1992 and June 1998. Forty-four of these eligible participants were not included because they dropped out after the initial screening interview. On average, dropouts were significantly younger, in shorter relationships, and more likely to be unmarried but cohabitating than couples included in the study. Data presented in the current investigation were obtained from the remaining 303 couples during the baseline assessment, prior to beginning therapy. The majority of these couples were married (268, 88%) and the remaining couples (35, 12%) were cohabitating for at least 1 year. Average annual family income fell within the \$40,001 to \$45,000 range.

Male partners were an average of 43.3 years old ($SD = 10.0$ years), and the majority (278, 92%) had at least completed high school or obtained an equivalent degree. Two hundred eighty-nine (95%) were Caucasian, 8 (3%) were African American, and 6 (2%) were Hispanic. Most male participants (286, 94%) met criteria for current alcohol dependence, 5 (2%) met criteria for current alcohol abuse, 4 (1%) met criteria for alcohol dependence in partial remission, and 8 (3%) met criteria for alcohol dependence in full remission. Fifty-nine men also met criteria for current drug abuse or dependence. Slightly more than half (157, 52%) of the male participants completed inpatient alcohol use disorder treatment prior to enrolling in the CALM program, 126 (41%) were seeking outpatient alcohol use disorder treatment when they entered CALM, and 20 (7%) enrolled in the program through other referral sources (e.g., advertisements, media announcements).

On average, female partners were 41.2 years old ($SD = 9.9$ years), and 95% ($n = 289$) had at least completed high school or obtained an equivalent degree. Similar to the male participants, the majority of the female partners were Caucasian (292, 96%), 5 (2%) were African American, 4 (1%) were Hispanic, 1 (0.3%) was Native American, and 1 (0.3%) described herself as none of the above. Four women (1%) met criteria for alcohol dependence and 6 (2%) met

criteria for drug abuse or dependence. Overall, participants were demographically similar to those in other studies of couples-based treatment for alcohol and drug use disorders (e.g., Fals-Stewart, O'Farrell, & Birchler, 1997). Further sample details are available in O'Farrell et al. (2004) and a description of the CALM program is provided in O'Farrell and Fals-Stewart (in press).

Measures

Intimate partner aggression was measured with the Conflict Tactics Scale (CTS; Straus, 1979). For the present study, the eight-item Physical Assault subscale (sample items: pushed, grabbed, or shoved; beat up) and the six-item Psychological Aggression subscale (sample items: did or said something to spite the partner; threatened to hit or throw something at the partner) were used. For each item, response options were never, once, 3 to 5 times, 6 to 10 times, 11 to 20 times, and more than 20 times, and all responses were based on the 12 months prior to the assessment. Consistent with the suggestion of Straus (1990), items were recoded to reflect the estimated frequency of each behavior (e.g., 3 to 5 times equals a score of 4). Total frequency scores for male- and female-perpetrated aggression were calculated by summing the recoded frequencies for each item. The CTS possesses sound internal consistency reliability (Cronbach's α s > .79) for both male- and female-perpetrated physical and psychological aggression (Straus, 1979). Among the current sample, internal consistency reliability estimates for male reports of aggression were as follows: .65 and .86 for male-perpetrated physical and psychological aggression and .93 and .86 for female-perpetrated physical and psychological aggression, respectively. Reliability estimates for the female reports of aggression were similar; α = .84 and .82 for male-perpetrated physical and psychological aggression and α = .88 and .82 for female-perpetrated physical and psychological aggression, respectively.

Male partner alcohol problem severity was assessed with the Alcohol Dependence Scale (ADS; Skinner & Allen, 1982) and the Michigan Alcoholism Screening Test (MAST; Selzer, 1971). For the ADS, responses to each of the 34 items (e.g., Do you panic because you fear you may not have a drink when you need it?) were summed, with higher scores indicating greater alcohol dependence and more severe alcohol problems. The MAST consists of 25 dichotomous (yes/no) response items reflecting problems associated with alcohol abuse (e.g., Can you stop drinking without a struggle after one or two drinks?). As with the ADS, higher scores indicate more severe alcohol problems. Psychometric investigations of the ADS and the MAST have documented their high reliability (α > .92 for both measures), and both measures have been found to

accurately identify those with and without alcohol use disorders in approximately 88% of cases (Ross, Gavin, & Skinner, 1990; Skinner & Allen, 1982; Teitelbaum & Carey, 2000). Internal consistency reliability estimates were .84 and .91 for the MAST and ADS, respectively, in the current sample.

Relationship adjustment during the 3 months prior to assessment was assessed for both partners using three different indices: the Marital Status Inventory (MSI; Weiss & Cerreto, 1980), the Dyadic Adjustment Scale (DAS; Spanier, 1976), and the Positive Feelings Questionnaire (PFQ; O'Leary, Fincham, & Turkewitz, 1983). The 14 MSI items assess relationship termination behaviors (e.g., I have discussed the question of my divorce or separation with someone other than my spouse or partner) and thoughts (e.g., Thoughts of divorce or separation occur to me very frequently). Higher scores indicate more steps taken toward separation. Previous research has demonstrated that scores on the MSI are highly correlated with measures of marital satisfaction (r s > .59; Weiss & Cerreto, 1980), and the MSI differentiates couples that are seeking marital therapy from those seeking other treatment (Wang & Crane, 2001). The DAS is a 32-item measure that is commonly used to assess perceptions of relationship consensus, cohesion, expression of affection, and satisfaction. The DAS possesses sound convergent validity (e.g., correlations > .85 with other measures of relationship satisfaction and status) and high internal consistency reliability (α = .95; Carey, Spector, Lantinga, & Krauss, 1993; Heyman, Sayers, & Bellack, 1994). Higher scores indicate more positive relationship adjustment. The PFQ assesses positive emotions with regard to physical (e.g., Sitting or lying close to my partner makes me feel . . .) and emotional (e.g., How do you feel about the degree to which your partner understands you?) aspects of the relationship. Responses to each of the 18 items are given on a scale ranging from 1 (*extremely negative*) to 7 (*extremely positive*), and higher scores indicate more positive feelings toward the partner. Previous research has documented the internal consistency reliability of the measure (α = .94; O'Leary et al., 1983) and its ability to distinguish between happy and distressed couples (Heyman et al., 2001). For each of the three relationship adjustment measures, a composite score reflecting the mean of male and female partner scores was computed to reflect overall couple adjustment. These average scores reflect relationship adjustment as a couple-level variable, consistent with study hypotheses. In the current sample, internal consistency reliability estimates range from .80 to .96 across measures and reporter gender.

Male partner antisocial personality disorder characteristics and psychopathic personality features were measured with the Structured Clinical Interview for *DSM-III-R*

(SCID-II; Spitzer, Williams, Gibbon, & First, 1990) Antisocial Personality Disorder (APD) module and the Socialization Scale of the California Personality Inventory (CPI-So; Gough, 1994). Regarding the former measure, the number of positively endorsed SCID-II APD criteria (e.g., failure to conform to social norms with respect to lawful behavior) was summed, excluding the item reflecting irritability as indicated by frequent fights or assaults because this item could have been coded positive based on intimate partner violence. Previous studies have found that the number of items endorsed on the SCID-II APD module, as well as APD ratings based on the SCID-II, are correlated with other continuous measures of antisociality and psychopathy (e.g., Hart & Hare, 1989; $r = .45$). The SCID-II APD module also displays excellent test-retest reliability ($r = .83$; Ross, Swinson, Doumani, & Larkin, 1995). In the present study, the SCID-II APD module yielded an internal consistency reliability estimate of .86. The CPI-So is based on Gough's (1946) role-taking theory of sociopathy/psychopathy and was designed to measure adherence to social norms. The CPI-So consists of 46 items (e.g., I would do almost anything on a dare) and positively endorsed items are summed to arrive at a total score. Higher scores indicate greater socialization (i.e., fewer psychopathic personality features). The CPI-So has demonstrated good internal consistency reliability ($\alpha = .77$; Alterman et al., 2003). Studies have found significant negative correlations in the medium to large range of magnitude ($r > -.46$) between the CPI-So scale and measures of antisocial behavior and psychopathic personality characteristics (Alterman et al., 2003; Hare, 1985; Kadden, Litt, Donovan, & Cooney, 1996). However, recent work suggests that the CPI-So correlates more strongly with the behavioral features of psychopathy than with its interpersonal and affective features, and some researchers have reported correlations of $-.08$ to $-.01$ between the CPI-So and the latter psychopathy factor (e.g., Benning, Patrick, Blonigen, Hicks, & Iacono, 2005; Hare, 2003). The internal consistency reliability estimate was .91 for the CPI-So in the current sample.

RESULTS

Descriptive Statistics

Descriptive statistics for the CTS are presented in Table 1. As previously reported in Murphy, O'Farrell, Fals-Stewart, and Feehan (2001) and O'Farrell et al. (2004), of the 303 couples who completed the study, 181 (59.7%) men had been physically aggressive, with 114 (62.9%) perpetrating minor aggression only, 66 (36.6%) perpetrating minor and severe aggression, and 1 (0.6%)

TABLE 1
Descriptive Statistics for Partner Aggression Perpetration

	M	SD	Range
Men's physical aggression			
CTS frequency scores			
Male self-report	2.20	5.82	0-64
Female collateral report	4.50	12.61	0-129
Men's psychological aggression			
CTS frequency scores			
Male self-report	38.93	33.54	0-150
Female collateral report	42.27	31.88	0-150
Women's physical aggression			
CTS frequency scores			
Female self-report	6.87	18.90	0-200
Male collateral report	7.29	19.84	0-150
Women's psychological aggression			
CTS frequency scores			
Female self-report	39.56	32.67	0-150
Male collateral report	31.42	31.17	0-150

NOTE: CTS = Conflict Tactics Scale.

perpetrating severe aggression only. In addition, 300 (99.0%) men had been psychologically aggressive during the past year according to either partner's report. For 195 (64.4%) couples, either the man or woman reported that the woman had been physically aggressive, including 67 (34.4%) who perpetrated minor aggression only, 125 (64.0%) who perpetrated minor and severe aggression, and 3 (1.6%) who perpetrated severe aggression only. Three hundred (99.0%) couples reported that the woman had been psychologically aggressive during the past year. Clinically significant psychological aggression, as defined by CTS psychological aggression frequency scores at or above the 75th percentile of national norms (see Straus & Sweet, 1992), was reported by 87.8% of the male partners and 83.5% of the female partners perpetrated.

Among all couples, using couples' highest report (i.e., either the male or female partner's report, depending on whichever report was higher), men perpetrated an average of more than five acts of physical aggression and women perpetrated an average of more than 10 acts of physical aggression during the past year. Men and women perpetrated approximately 50 acts of psychological aggression during the past year, on average. Male participants' scores on the MAST ($M = 35.45$, $SD = 10.92$, range = 0-53) and the ADS ($M = 17.73$, $SD = 8.97$, range = 0-46) indicate high levels of alcohol problem severity (Selzer, 1971; Skinner & Allen, 1982). Average couple scores on the DAS ($M = 94.51$, $SD = 19.67$, range = 34-144) were in the "distressed" range according to the commonly employed cutoff of 98 (Heyman et al., 1994). MSI scores

($M = 4.25$, $SD = 2.66$, range = 0–11) similarly indicated that, on average, couples were experiencing significant relationship distress (Whiting & Crane, 2003). According to the DSM-III-R, 15% of male participants met criteria for antisocial personality disorder, with more than four symptoms endorsed on average ($M = 4.21$, $SD = 3.49$, range = 0–17), and CPI-So scores ($M = 22.72$, $SD = 6.09$, range = 5–37) were consistent with other samples of men with alcohol use disorders (Kadden et al., 1996).

Overall Partner Concordance

Partner concordance was initially examined using dichotomous scoring of the occurrence/nonoccurrence of male and female physical and psychological aggression perpetration. We first calculated percentage of occurrence agreement, indicating the percentage of couples that agreed that a form of aggression had been perpetrated by one of the partners. This analysis was conducted only among couples with at least one partner reporting the presence of that form of aggression to avoid inflation of agreement due to relationship aggression nonoccurrence.² That is, in the same manner as is common in the study of partner concordance (e.g., Simpson & Christensen, 2005), and for this analysis only, we did not include couples who agreed that the particular form of aggression had not occurred to provide a more conservative estimate of concordance.

Next, using the entire sample (including those who agreed on the nonoccurrence of aggression), we calculated kappa (Cohen, 1960) and Yule's Y (Spitznagel & Helzer, 1985), estimates of concordance that are less influenced by chance (Bartko, 1991). Incorrect kappa estimates may still arise when the prevalence of a type of behavior is at an extreme (i.e., the base rates are skewed), but this is corrected to a degree by Yule's Y (Hoffmann & Ninonuevo, 1994). Percentage of occurrence agreement, kappa, and Yule's Y are commonly reported in studies of partner concordance (e.g., Simpson & Christensen, 2005) and are reported here for the purpose of comparison with such studies. A separate measure of concordance, d' (d-prime), also was calculated as a measure of concordance that it is less influenced by skewed base rates than any other measure of agreement (Helberg & Brown, 1995). This measure is derived from signal detection theory and receiver operating characteristic (ROC) analysis and represents the relationship between a distribution of noise and a distribution of signal + noise. In other words, d' represents the difference in couples' tendency to indicate that a form of aggression occurred when it did not occur, compared to their tendency to indicate that the same form of aggression occurred when it actually did occur (i.e., when each partner agreed that it occurred). D-prime was

TABLE 2
Partner Concordance on
the Occurrence/Nonoccurrence of
Aggression Perpetration

	Percentage of Occurrence Agreement	Kappa	Yule's Y	d'
Male CTS physical aggression	54.9	.47	.49	0.66
Male CTS psychological aggression	97.6	.45	.79	4.08
Female CTS physical aggression	64.6	.54	.55	0.99
Female CTS psychological aggression	95.2	.28	.67	3.57

NOTE: CTS = Conflict Tactics Scale. Percentage of occurrence agreement is calculated only for couples in which at least one partner reported a specific form of aggression (male CTS physical aggression, $n = 181$; male CTS psychological aggression, $n = 300$; female CTS physical aggression, $n = 195$; female CTS psychological aggression, $n = 300$).

calculated by subtracting couples' standardized "false alarm" rate (i.e., the average of the probability that the male partner reported aggression when the female partner did not and the probability that the female partner reported aggression when the male partner did not) from their standardized "hit" rate (i.e., probability of both partners reporting that aggression occurred). Finally, we calculated partner concordance of the frequency of each form of relationship aggression using Pearson correlations. To correct for positive skewness, we applied a log-transformation to the relationship aggression frequency summary scores prior to calculating these correlations.

Kappa and Yule's Y provide estimates of concordance on a scale ranging from -1 to +1, with a score of 0 indicating agreement at the level of chance. Landis and Koch's (1977) standard of interpretation for kappa was applied to the current results.³ Yule's Y does not have a similar standard of interpretation (Bartko, 1991), but in the same manner as other authors (e.g., Hoffman & Ninonuevo, 1994), Yule's Y was interpreted according to the established guidelines for kappa. Although d' does not possess clearly defined boundaries (e.g., -1 to +1), its lower boundary for our purposes is 0 (indicating performance at the level of chance) and it is easily interpreted as an effect size according to Cohen's (1988) guidelines for effect size d .⁴ Correlation coefficients were similarly interpreted according to Cohen's guidelines for effect size r .⁵

As indicated in Table 2, across most measures of concordance, partners agreed slightly more regarding the occurrence/nonoccurrence of female-perpetrated physical aggression than male-perpetrated physical aggression.

Approximately 65% of couples agreed regarding whether female-perpetrated physical aggression had occurred during the past year, and approximately 55% of couples agreed regarding whether past-year male-perpetrated physical aggression had occurred. For both male- and female-perpetrated physical aggression, the kappa and Yule's Y coefficients fell within the moderate range (Landis & Koch, 1977), and the d' estimates indicated medium to large effect sizes. In contrast to measures of concordance for physical aggression, partners agreed slightly more regarding male-perpetrated psychological aggression than female-perpetrated psychological aggression. Percentage of occurrence agreement estimates revealed that nearly all couples agreed regarding the occurrence of psychological aggression perpetrated by each partner. These highly skewed base rates caused notable variability across measures of concordance, depending on how well each measure corrected for skewed base rates. Concordance for men's psychological aggression fell within the moderate range as measured by kappa and in the substantial range as measured by Yule's Y. Similarly, concordance for women's psychological aggression fell within the fair range as measured by kappa and in the substantial range as measured by Yule's Y. Concordance for both partners' psychological aggression perpetration indicated a large effect size, as measured by d' .

Correlational analyses indicated that partner concordance regarding the frequency of each type of behavior fell within the large range. Use of the Z-based Pearson-Filon (ZPF) procedure (Raghunathan, Rosenthal, & Rubin, 1996) indicated that partner concordance regarding female-perpetrated physical aggression ($r = .63, p < .001$) was significantly higher ($ZPF = 3.698, p < .001$) than that of male-perpetrated physical aggression ($r = .48, p < .001$). Partner concordance for reports of male-perpetrated psychological aggression ($r = .47, p < .001$) did not differ significantly ($ZPF = 0.156, ns$) from concordance for female-perpetrated psychological aggression ($r = .46, p < .001$).⁶

Correlates of Concordance

Bivariate correlations were computed to examine associations between the correlates of interest and an index of concordance consisting of the proportion of CTS behaviors endorsed by both partners out of those items reported by either partner. This proportional index of concordance was preferable to other measures because it accounted for level of aggression (e.g., as opposed to simple difference scores in which interpartner differences would be higher as the result of higher aggression reporting). Furthermore, using a dichotomous index of concordance (agreed or disagreed) would fail to distinguish couples that disagreed on

a single behavior from those who disagreed on multiple behaviors. This proportional index of concordance ranged from 0 (no agreement) to 1 (perfect agreement) for male-perpetrated physical aggression ($M = .34, SD = .38$), male-perpetrated psychological aggression ($M = .75, SD = .25$), female-perpetrated physical aggression ($M = .34, SD = .34$), and female-perpetrated psychological aggression ($M = .66, SD = .29$).

A series of multiple regression analyses, with each independent variable simultaneously entered into each equation, were then used to examine associations between the correlates and the CTS proportion scores. Four separate regressions were computed, corresponding to male-perpetrated physical and psychological aggression and female-perpetrated physical and psychological aggression. Consistent with previous research examining correlates of relationship aggression reporting concordance (Caetano et al., 2002), couples that did not endorse any items on the CTS Physical Assault scale were excluded from analyses involving physical aggression, and the same approach was taken for analyses involving psychological aggression. This approach was taken to reduce inflation of concordance rates by couples that agreed regarding aggression because there was none in their relationship (because this is presumably easier to agree on) to arrive at a more conservative estimate of agreement.

Bivariate associations between the correlates and the CTS proportion scores for male-perpetrated aggression, as well as results from the multiple regression analyses examining associations between these predictor and outcome variables, are presented in Table 3. Counter to expectations, measures reflecting higher alcohol problem severity and poorer relationship adjustment were correlated with higher concordance of reports of psychological aggression perpetration at the bivariate level. In addition, higher levels of antisocial personality disorder characteristics and psychopathic personality features were correlated with higher concordance of both male-perpetrated physical aggression and psychological aggression. The number of positively endorsed indicators on the Structured Clinical Interview for the *DSM-III-R* Antisocial Personality Disorders module (SCID APD) evidenced the largest bivariate association with each CTS proportion score outcome, and this correlate was the only significant predictor when accounting for the other predictors in the regression analyses. Counter to expectations, measures reflecting higher alcohol problem severity and poorer relationship adjustment also were correlated with higher concordance for reports of psychological aggression perpetration at the bivariate level.

A similar pattern of results was found for associations between the correlates and CTS proportion scores for female-perpetrated aggression (see Table 4). As with

TABLE 3
Associations Between Correlates
and Interpartner Concordance for
Male-Perpetrated Aggression

<i>CTS Physical Assault Proportion Scores</i>				
<i>Variable</i>	<i>Zero-Order r</i>	β	T	<i>Partial r</i>
MAST	.10	.04	.41	.03
ADS	.11	-.03	-.30	-.02
MSI	.13	.07	.78	.06
DAS	-.15	-.06	-.64	-.05
PFQ	-.12	-.00	-.02	-.00
SCID APD	.31***	.27	3.13	.24**
CPI-So	-.17*	-.02	-.18	-.01
$R^2 = .11, F(7, 167) = 2.81, p < .01$				
<i>CTS Psychological Aggression Proportion Scores</i>				
<i>Variable</i>	<i>Zero-Order r</i>	β	T	<i>Partial r</i>
MAST	.13*	-.02	-.24	-.01
ADS	.19**	.10	1.32	.08
MSI	.17**	.08	1.11	.07
DAS	-.23***	-.14	-1.92	-.11
PFQ	-.16**	.01	.14	.01
SCID APD	.29***	.22	3.32	.20**
CPI-So	-.18**	.01	.14	.01
$R^2 = .12, F(7, 279) = 5.63, p < .00$				

NOTE: CTS = Conflict Tactics Scale; MAST = Michigan Alcoholism Screening Test; ADS = Alcohol Dependence Scale; MSI = Marital Status Inventory; DAS = Dyadic Adjustment Scale; PFQ = Positive Feelings Questionnaire; SCID APD = number of positively endorsed indicators on the Structured Clinical Interview for the *DSM-III-R* Antisocial Personality Disorders module; CPI-So = California Personality Inventory Socialization Scale. Physical assault analyses are based on the 181 couples in which at least one partner reported male-to-female physical assault. Psychological aggression analyses are based on the 300 couples in which at least one partner reported male-to-female psychological aggression.

* $p < .05$. ** $p < .01$. *** $p < .001$

analyses for male-perpetrated aggression, male partners' SCID APD symptom scores were positively associated with concordance for both female-perpetrated physical and psychological aggression, and this measure was the only correlate associated with both outcomes when controlling for the other predictors. Although CPI-So scores were not associated with either outcome at the bivariate level, this correlate evidenced a small but significant positive partial association with CTS Psychological Aggression proportion scores in regression analyses, suggestive of a suppression effect (Tzelgov & Henik, 1991). Consistent with results for male relationship aggression perpetration, and counter to expectations, measures reflecting higher alcohol problem severity and poorer relationship adjustment were correlated with higher female-perpetrated psychological aggression concordance at the bivariate level. Furthermore,

TABLE 4
Associations Between Correlates
and Interpartner Concordance for
Female-Perpetrated Aggression

<i>CTS Physical Assault Proportion Scores</i>				
<i>Variable</i>	<i>Zero-Order r</i>	β	T	<i>Partial r</i>
MAST	.01	-.02	-.17	-.01
ADS	.03	.01	.10	.01
MSI	.20**	.16	1.91	.12
DAS	-.13	-.07	-.73	-.05
PFQ	-.13	.02	.17	.01
SCID APD	.19*	.22	2.52	.19*
CPI-So	.00	.14	1.52	.11
$R^2 = .08, F(7, 179) = 2.13, p < .04$				
<i>CTS Psychological Aggression Proportion Scores</i>				
<i>Variable</i>	<i>Zero-Order r</i>	β	T	<i>Partial r</i>
MAST	.17**	.12	1.57	.09
ADS	.14*	.01	.14	.01
MSI	.21***	.09	1.28	.08
DAS	-.19**	-.06	-.86	-.05
PFQ	-.22***	-.11	-1.42	-.08
SCID APD	.25***	.23	3.45	.20**
CPI-So	-.07	.14	1.97	.12*
$R^2 = .12, F(7, 281) = 5.65, p < .00$				

NOTE: CTS = Conflict Tactics Scale; MAST = Michigan Alcoholism Screening Test; ADS = Alcohol Dependence Scale; MSI = Marital Status Inventory; DAS = Dyadic Adjustment Scale; PFQ = Positive Feelings Questionnaire; SCID APD = number of positively endorsed indicators on the Structured Clinical Interview for the *DSM-III-R* Antisocial Personality Disorders module; CPI-So = California Personality Inventory Socialization Scale. Physical assault analyses are based on the 195 couples in which at least one partner reported female-to-male physical assault. Psychological aggression analyses are based on the 300 couples in which at least one partner reported female-to-male psychological aggression.

* $p < .05$. ** $p < .01$. *** $p < .001$.

couples' MSI scores also were positively correlated with female-perpetrated physical aggression concordance.

Direction of Concordance

To examine whether men and women's reports of victimization would be higher than their reports of perpetration, we computed difference scores for each couple by subtracting partners' reports of victimization from self-reports of perpetration. Thus, a positive score indicates that participants reported perpetrating more aggression than their partners reported experiencing, whereas a negative score indicates that participants reported higher levels of victimization than the levels of perpetration that their partners reported. Consistent with expectations, one-sample *t* tests indicated that women reported experiencing

significantly more male-perpetrated physical aggression than men reported perpetrating, $t(293) = -3.35, p < .001, r = .19$, and women reported perpetrating significantly more psychological aggression than men reported experiencing, $t(295) = 3.67, p < .001, r = .21$. Contrary to expectations, men and women did not differ significantly on their reports of female-perpetrated physical aggression, $t(292) = -.59, ns, r = .03$. Also counter to hypotheses, men and women did not significantly differ on their reports of male-perpetrated psychological aggression, $t(294) = -1.76, ns, r = .07$. Notably, the effect sizes for these tests all fall within the small range (Cohen, 1988).

DISCUSSION

This study examined concordance of reports of intimate partner physical and psychological aggression among men with alcohol use disorders and their female partners enrolled in couples-based treatment for alcohol abuse. Concordance rates, particularly as measured by percentage of occurrence agreement and kappa, were generally higher in this sample than those reported in studies of couples in marital therapy (e.g., Jouriles & O'Leary, 1985) and community sample investigations (e.g., Moffitt et al., 1997). These findings suggest that self- and partner reports of relationship aggression perpetration and victimization among men in treatment for alcohol use disorders may evidence slightly higher accuracy than other relevant populations. Given the elevated rates of physical aggression and psychological aggression commonly reported among clinical samples of individuals with alcohol use disorders (e.g., O'Farrell & Murphy, 1995), these findings have important implications for the accuracy of clinical assessments and the validity of research findings using self- and partner reports in this population.

Several factors may explain findings of comparable to high concordance rates among this sample as compared with other populations. Couples with a partner in treatment for alcohol abuse may be especially aware of each other's behavior, as previous research among such populations has found high interpartner agreement on alcohol consumption quantity, frequency, and related problems (Connors & Maisto, 2003) and aspects of the family environment (McKay et al., 1993). Furthermore, couples in the present study may have been more willing to disclose their difficulties accurately than other treatment-seeking couples due to the dual focus of the treatment (alcohol abuse and relationship problems). The seemingly counterintuitive finding that for both male- and female-perpetrated psychological aggression, men's alcohol problem severity was associated with higher interpartner agreement is consistent with the notion that couples with more severe problems

may be more motivated to report relationship aggression accurately in this help-seeking context.

A number of other correlates were associated with relationship aggression reporting concordance, although many of the associations were small and only occurred at the bivariate level. For both men and women, across physical and psychological aggression, men's elevated antisocial personality disorder characteristics were the strongest unique predictor of higher interpartner concordance. Men who possess higher levels of antisocial personality characteristics may have more accepting attitudes toward violence (Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2003) and may identify more strongly with masculine gender roles (e.g., Klonsky et al., 2002), which could lead them to report existing aggression more accurately because they do not feel compelled to conceal it. High levels of social desirability are negatively associated with aggression self-reports on the CTS (e.g. Sugarman & Hotaling, 1997), and men with antisocial personality disorder characteristics may be less likely to deny or minimize abusive behaviors because they do not perceive them as socially undesirable, leading to more accurate aggression reports and higher concordance. It is also possible that those with antisocial personality disorder characteristics may be prone to distort aggression reports in contexts where there are perceived benefits (e.g., if they are in legal trouble for partner abuse). Collectively, results suggest that individuals with antisocial personality disorder characteristics may not be inherently unreliable reporters of partner aggression, particularly in treatment-seeking contexts. Such conclusions, and all of those drawn from studies of aggression reporting concordance, are tempered by the fact that we do not know the true level of aggression within a relationship.

Men's psychopathic personality features also were positively associated with concordance of male-perpetrated aggression at the bivariate level, although these effects were reduced to nonsignificance when accounting for the other correlates. Furthermore, when controlling for these correlates, men's psychopathic personality features predicted concordance for female-perpetrated psychological aggression in the opposite direction, such that more psychopathic personality features were associated with less concordance. Although this association was small and caution must be taken when interpreting suppression situations, some research regarding emotional processing in psychopathy (e.g., Patrick, 1994) suggests the possibility that elevated psychopathic personality features, independent of antisocial behavior, are related to an increased difficulty recognizing and processing emotional stimuli, perhaps affecting recognition of psychological aggression.

For male- and female-perpetrated psychological aggression, all of the relationship adjustment measures were

significantly associated with concordance at the bivariate level, in the opposite direction as hypothesized. More specifically, couples reporting taking the most steps toward relationship termination, experiencing lower relationship adjustment, and having fewer positive feelings toward each other were more likely to agree on psychological aggression in their relationship. Relationship termination behaviors also were positively associated with concordance of reports of female-perpetrated physical aggression. As discussed above for alcohol problem severity, it is possible that couples experiencing more severe relationship problems were more motivated to report relationship aggression accurately to express their need for treatment effectively. Furthermore, couples with more severe problems may be more cognizant of problems in their relationship, leading them to track and report instances of aggression better than couples who are more satisfied with their relationship. However, it is important to note that measures of relationship adjustment, as well as alcohol problems, were not significant predictors of concordance in any of the regression analyses, suggesting the possibility that these constructs may only be related to concordance because of their associations with antisocial personality disorder characteristics.⁷ It is important also to note that the regression analyses made use of a conservative estimate of concordance by excluding couples who agreed that no aggression was present, which may have reduced the potential associations of reporting concordance with relationship adjustment and alcohol problems.

Consistent with expectations, women reported experiencing more physical aggression than men reported perpetrating, and women reported perpetrating more psychological aggression than men reported experiencing. Counter to hypotheses, women and men did not significantly differ in their reports of female-perpetrated physical aggression and male-perpetrated psychological aggression. It is possible that men underreported their partner's aggression because of the social undesirability of being a victim of a woman's aggression (Caetano et al., 2002; Szinovacz & Egley, 1995). Furthermore, men may have a higher tendency to perceive their partner's aggression as nonproblematic (Ehrensaft & Vivian, 1996) and may be particularly likely to minimize psychological aggression (Tolman, 1989). Men also may be more likely to underreport their own physical aggression perpetration to avoid negative evaluation because male-perpetrated relationship violence may be perceived more negatively than female-perpetrated relationship violence (e.g., Simon et al., 2001).

Although concordance rates were slightly higher relative to most other studies in this area, it is important to note that concordance was far from perfect. For example, 45% of couples did not agree regarding whether male-perpetrated

physical aggression had occurred and 35% of couples did not agree regarding whether female-perpetrated physical aggression occurred, despite findings of effect sizes for concordance that would typically be interpreted as medium to large. These findings demonstrating differential reporting based on gender suggest that reliance on either partner's report of perpetration or victimization is suboptimal. Clearly, it is important to obtain both partners' reports of relationship aggression, and combining couples' reports of aggression may help researchers and clinicians obtain more accurate estimates of relationship aggression than relying on a single report.

One limitation of the present investigation was the use of an earlier version of the CTS. Future concordance studies should employ the more comprehensive CTS2 (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) and other measures of relationship aggression that have been developed to enhance the precision of abuse reporting. Simpson and Christensen (2005), in the only published study to date that has examined relationship aggression reporting concordance using the CTS2, reported concordance levels among a sample in marital therapy that were comparable to or somewhat higher than those found in the current study, and their concordance rates were consistently higher than those reported in earlier studies. Fals-Stewart, Birchler, and Kelley (2003) have reported high concordance ($r_s > .72$ and $r_s > .68$ for male- and female-perpetrated aggression, respectively) of reports of physical aggression among men in treatment for relationship aggression perpetration and their partners using the Timeline Followback Spousal Violence interview, which makes use of anchored time points and diary methods to minimize disagreement due to recall difficulties. Future studies also should employ more contemporary measures of psychopathic personality features and measures that rely less heavily on self-report, such as the Revised Psychopathy Checklist (Hare, 2003). Furthermore, diagnostic measures of antisocial personality disorder characteristics with measured interrater reliability should be used in future studies.

Other limitations of this study bear note. Female partners' alcohol problem severity, antisocial personality disorder characteristics, and psychopathic personality features were not assessed. Although couples had sought treatment partially because of male partners' alcohol problems, it is plausible that female partners' alcohol use and personality characteristics could affect concordance as well. In addition, given the nature of the study sample, it is possible that findings may not generalize to minority populations or unmarried, lower-income couples. The treatment-seeking nature of this sample also precludes generalization of these results to community and other non-help-seeking populations. Finally, it is possible that the representativeness of the current sample may have been affected by the inclusion/exclusion criteria used.

Despite these limitations, findings suggest that inter-partner agreement on relationship aggression reporting was somewhat higher among this clinical sample of men in treatment for alcohol use disorders and their partners than in most previous studies of other clinical and non-clinical populations. The present study also elucidates correlates of relationship aggression reporting concordance, the most robust of which was antisocial personality disorder characteristics. Additional inquiries in this area are needed to more fully explicate the role of antisocial personality disorder characteristics and other potential correlates in the assessment of partner aggression. Given the importance of this issue for both researchers and clinicians, it is hoped that future research will continue to investigate relationship aggression reporting concordance and explore ways in which concordance may be enhanced.

NOTES

1. No specific data are available regarding the number of potential participants who were excluded on the basis of each of these criteria.

2. Percentage of agreement values for all couples, regardless of whether aggression was reported, were 73.2% for male-perpetrated physical aggression, 97.6% for male-perpetrated psychological aggression, 77.1% for female-perpetrated physical aggression, and 95.3% for female-perpetrated psychological aggression.

3. Landis and Koch's (1977) suggestions for the interpretation of kappa are as follows: < 0.0 = poor, 0.0–0.2 = slight, 0.2–0.4 = fair, 0.4–0.6 = moderate, 0.6–0.8 = substantial, 0.8–1.0 = perfect.

4. Cohen's (1988) suggestions for effect size *d* interpretation are as follows: 0.20–0.49 = small, 0.50–0.79 = medium, ≥ 0.80 = large.

5. Cohen's (1988) suggestions for effect size *r* interpretation are as follows: .10–.29 = small, .30–.49 = medium, $\geq .50$ = large.

6. We conducted the same series of analyses to examine partner concordance separately for minor and severe physical aggression. Overall, the pattern of results was the same and concordance was consistently slightly lower for reports of severe aggression, as also was found by Simpson and Christensen (2005).

7. In supplementary analyses, all measured correlates were significantly associated with the number of positively endorsed indicators on the Structured Clinical Interview for the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)* Antisocial Personality Disorders module (SCID APD; all *ps* < .01): Michigan Alcoholism Screening Test (MAST; *r* = .30); Alcohol Dependence Scale (ADS; *r* = .36); Marital Status Inventory (MSI; *r* = .20); Dyadic Adjustment Scale (DAS; *r* = -.21); Positive Feelings Questionnaire (PFQ; *r* = -.19); California Personality Inventory Socialization Scale (CPI-So; *r* = -.48).

REFERENCES

Alterman, A. I., McDermott, P. A., Mulvaney, F. D., Cacciola, J. S., Rutherford, M. J., Searles, J. S., et al. (2003). Comparison of embedded and isolated administration of the California Personality Inventory's Socialization Subscale. *Psychological Assessment, 15*, 64-70.

- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd Rev. ed.). Washington, DC: Author.
- Armstrong, T. G., Heideman, G., Corcoran, K. J., Fisher, B., Medina, K. L., & Schafer, J. (2001). Disagreement about the occurrence of male-to-female intimate partner violence: A qualitative study. *Family and Community Health, 24*, 55-75.
- Babor, T. F., Steinberg, K., Anton, R., & Del Boca, F. (2000). Talk is cheap: Measuring drinking outcomes in clinical trials. *Journal of Studies on Alcohol, 12*, 5-13.
- Bartko, J. J. (1991). Measurement and reliability: Statistical thinking considerations. *Schizophrenia Bulletin, 17*, 483-489.
- Basile, K. C., Arias, I., Desai, S., & Thompson, M. P. (2004). The differential association of intimate partner physical, sexual, psychological, and stalking violence and posttraumatic stress symptoms in a nationally representative sample of women. *Journal of Traumatic Stress, 17*, 413-421.
- Benning, S. D., Patrick, C. J., Blonigen, D. M., Hicks, B. M., & Iacono, W. G. (2005). Estimating facets of psychopathy from normal personality traits: A step toward community epidemiological investigations. *Assessment, 12*, 3-18.
- Browning, J., & Dutton, D. (1986). Assessment of wife assault with the Conflict Tactics Scale: Using couple data to quantify the differential reporting effect. *Journal of Marriage and the Family, 48*, 375-379.
- Byrne, C. A., & Arias, I. (1997). Marital satisfaction and marital violence: Moderating effects of attributional processes. *Journal of Family Psychology, 11*, 188-195.
- Caetano, R., Schafer, J., Field, C., & Nelson, S. M. (2002). Agreement on reports of intimate partner violence among White, Black, and Hispanic couples in the United States. *Journal of Interpersonal Violence, 17*, 1308-1322.
- Cantos, A. L., Neidig, P. H., & O'Leary, K. D. (1994). Injuries of women and men in a treatment program for domestic violence. *Journal of Family Violence, 9*, 113-124.
- Capaldi, D. M., & Owen, L. D. (2001). Physical aggression in a community sample of at-risk young couples: Gender comparisons for high frequency, injury, and fear. *Journal of Family Psychology, 15*, 425-440.
- Carey, M. P., Spector, I. P., Lantinga, L. J., & Krauss, D. J. (1993). Reliability of the Dyadic Adjustment Scale. *Psychological Assessment, 5*, 238-240.
- Centers for Disease Control and Prevention. (2003). *Costs of intimate partner violence against women in the United States*. Atlanta, GA: Author.
- Christensen, A., Sullaway, M., & King, C. E. (1983). Systematic error in behavioral reports of dyadic interaction: Egocentric bias and content effects. *Behavioral Assessment, 5*, 129-140.
- Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement, 10*, 37-46.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences*. Hillsdale, NJ: Lawrence Erlbaum.
- Connors, G. J., & Maisto, S. A. (2003). Drinking reports from collateral individuals. *Addiction, 98*, 21-29.
- Edleson, J. L., & Brygger, M. P. (1986). Gender differences in reporting of battering incidences. *Family Relations, 35*, 377-382.
- Ehrensaft, M. K., & Vivian, D. (1996). Spouses' reasons for not reporting existing marital aggression as a marital problem. *Journal of Family Psychology, 10*, 443-453.
- Fals-Stewart, W., Birchler, G. R., & Kelley, M. L. (2003). The Timeline Followback Spousal Violence Interview to assess physical aggression between intimate partners: Reliability and validity. *Journal of Family Violence, 18*, 131-142.
- Fals-Stewart, W., O'Farrell, T. J., & Birchler, G. R. (1997). Behavioral couples therapy for male substance abusing patients: A cost outcomes analysis. *Journal of Consulting and Clinical Psychology, 65*, 789-802.
- Field, C. A., & Caetano, R. (2005). Intimate partner violence in the U.S. general population. *Journal of Interpersonal Violence, 20*, 463-469.
- Fincham, F. D., Bradbury, T. N., Arias, I., Byrne, C. A., & Karney, B. R. (1997). Marital violence, marital distress, and attributions. *Journal of Family Psychology, 11*, 367-372.

- Gough, H. G. (1946). A sociological theory of psychopathy. *American Journal of Sociology*, 53, 359-366.
- Gough, H. G. (1994). Theory, development, and interpretation of the CPI Socialization scale. *Psychological Reports*, 75, 651-700.
- Hare, R. D. (1985). Comparison of procedures for the assessment of psychopathy. *Journal of Consulting and Clinical Psychology*, 53, 7-16.
- Hare, R. D. (2003). *Manual for the Revised Psychopathy Checklist* (2nd ed.). Toronto, Ontario, Canada: Multi-Health Systems.
- Hart, S. D., & Hare, R. D. (1989). Discriminant validity of the Psychopathy Checklist in a forensic psychiatric population. *Psychological Assessment*, 1, 211-218.
- Heckert, D. A., & Gondolf, E. W. (2000). Predictors of underreporting of male violence by batterer program participants and their partners. *Journal of Family Violence*, 15, 423-443.
- Helberg, C. P., & Brown, R. L. (1995, June). *Concordance in fourfold tables: A simulation study of statistics indices of agreement*. Paper presented at the meeting of the International Applied Statistics in Industry Conference, Dallas, TX.
- Heyman, R. E., Feldbau-Kohn, S. R., Ehrensaft, M. K., Langhinrichsen-Rohling, J., & O'Leary, K. D. (2001). Can questionnaire reports correctly classify relationship distress and partner physical abuse? *Journal of Family Psychology*, 15, 334-346.
- Heyman, R. E., Sayers, S. L., & Bellack, A. S. (1994). Global marital satisfaction versus marital adjustment: An empirical comparison of three measures. *Journal of Family Psychology*, 8, 432-446.
- Hoffmann, N. G., & Ninonuevo, F. G. (1994). Concurrent validation of substance abusers self-reports against collateral information: Percentage agreement versus kappa versus Yule's Y. *Alcoholism: Clinical and Experimental Research*, 18, 231-237.
- Holtzworth-Munroe, A., Meehan, J. C., Herron, K., Rehman, U., & Stuart, G. L. (2003). Do subtypes of martially violent men continue to differ over time? *Journal of Clinical Psychology*, 71, 728-740.
- Jouriles, E. N., & O'Leary, K. D. (1985). Interspousal reliability of reports of marital violence. *Journal of Consulting and Clinical Psychology*, 53, 419-421.
- Kadden, R. M., Litt, M. D., Donovan, D., & Cooney, N. L. (1996). Psychometric properties of the California Psychological Inventory Socialization Scale in treatment-seeking alcoholics. *Psychology of Addictive Behaviors*, 10, 131-146.
- Kim, H. K., & Capaldi, D. M. (2004). The association of antisocial behavior and depressive symptoms between partners and risk for physical aggression in romantic relationships. *Journal of Family Psychology*, 18, 82-96.
- Klonsky, E. D., Jane, J. S., Turkheimer, E., & Oltmanns, T. F. (2002). Gender role and personality disorders. *Journal of Personality Disorders*, 16, 464-476.
- Landis J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. *Biometrics*, 33, 159-174.
- Langhinrichsen-Rohling, J., & Vivian, D. (1994). The correlates of spouses' incongruent reports of marital aggression. *Journal of Family Violence*, 9, 265-283.
- LeJeune, C., & Follette, V. (1994). Taking responsibility: Sex differences in reporting dating violence. *Journal of Interpersonal Violence*, 9, 133-140.
- Lengua, L. J., & Stormshak, E. A. (2000). Gender, gender roles, and personality: Gender differences in the prediction of coping and psychological symptoms. *Sex Roles*, 43, 787-820.
- Magdol, L., Moffitt, T. E., & Caspi, A. (1997). Gender differences in partner violence in a birth cohort of 21-year-olds: Bridging the gap between clinical and epidemiological approaches. *Journal of Consulting and Clinical Psychology*, 65, 68-78.
- Margolin, G. (1987). The multiple forms of aggressiveness between marital partners: How do we identify them? *Journal of Marital and Family Therapy*, 13, 77-84.
- Margolin, G., Hattem, D., John, R. S., & Yost, K. (1985). Perceptual agreement between spouses and outside observers when coding themselves and a stranger dyad. *Behavioral Assessment*, 7, 235-247.
- McKay, J. R., Maisto, S. A., Beattie, M. C., Longabaugh, R., & Noel, N. E. (1993). Differences between alcoholics and spouses in their perceptions of family functioning. *Journal of Substance Abuse Treatment*, 10, 17-21.
- Medina, K. L., Schafer, J., Shear, P. K., & Armstrong, T. G. (2004). Memory ability is associated with disagreement about the most recent conflict in polysubstance abusing couples. *Journal of Family Violence*, 19, 387-398.
- Moffitt, T. E., Caspi, A., Krueger, R. F., Magdol, L., Margolin, G., Silva, P. A., et al. (1997). Do partners agree about abuse in their relationship? A psychometric evaluation of interpartner aggression. *Psychological Assessment*, 9, 47-56.
- Murphy, C. M., Meyer, S. L., & O'Leary, K. D. (1993). Family of origin violence and MCMI-II psychopathology among partner assaultive men. *Violence and Victims*, 8, 165-176.
- Murphy, C. M., O'Farrell, T. J., Fals-Stewart, W., & Feehan, M. (2001). Correlates of intimate partner violence among male alcoholic patients. *Journal of Consulting and Clinical Psychology*, 69, 528-540.
- O'Brien, M. O., John, R. S., Margolin, G., & Erel, O. (1994). Reliability and diagnostic efficacy of parents' reports regarding children's exposure to marital aggression. *Violence and Victims*, 9, 45-62.
- O'Farrell, T. J. (1993). A behavioral marital therapy couples group program for alcoholics and their wives. In T. J. O'Farrell (Ed.), *Treating alcohol problems: Marital and family interventions* (pp. 170-209). New York: Guilford.
- O'Farrell, T. J., & Fals-Stewart, W. (2000). Behavioral couples therapy for alcoholism and drug abuse. *Journal of Substance Abuse Treatment*, 18, 51-54.
- O'Farrell, T. J., & Fals-Stewart, W. (in press). *Behavioral couples therapy for alcoholism and drug abuse*. New York: Guilford.
- O'Farrell, T. J., Fals-Stewart, W., Murphy, M., & Murphy, C. M. (2003). Partner violence before and after individually based alcoholism treatment for male alcoholic patients. *Journal of Consulting and Clinical Psychology*, 71, 92-102.
- O'Farrell, T. J., & Murphy, C. M. (1995). Marital violence before and after alcoholism treatment. *Journal of Consulting and Clinical Psychology*, 63, 256-262.
- O'Farrell, T. J., Murphy, C. M., Neavins, T. M., & Van Hutton, V. (2000). Verbal aggression among male alcoholic patients and their wives in the year before and two years after alcoholism treatment. *Journal of Family Violence*, 15, 295-310.
- O'Farrell, T. J., Murphy, C. M., Stephan, S. H., Fals-Stewart, W., & Murphy, M. (2004). Partner violence before and after couples-based alcoholism treatment for male alcoholic patients: The role of treatment involvement and abstinence. *Journal of Consulting and Clinical Psychology*, 72, 202-217.
- O'Farrell, T. J., Van Hutton, V., & Murphy, C. M. (1999). Domestic violence after alcoholism treatment: A two year longitudinal study. *Journal of Studies on Alcohol*, 60, 317-321.
- O'Leary, K. D., & Arias, I. (1988). Assessing agreement of reports of spouse abuse. In G. T. Hotaling, D. Finkelhor, J. T. Kirkpatrick, & M. A. Straus (Eds.), *Family abuse and its consequences: New directions in research* (pp. 218-227). Newbury Park, CA: Sage.
- O'Leary, K. D., Fincham, F., & Turkewitz, H. (1983). Assessment of positive feelings toward spouse. *Journal of Consulting and Clinical Psychology*, 51, 937-939.
- O'Leary, K. D., Vivian, D., & Malone, J. (1992). Assessment of physical aggression against women in marriage: The need for multimodal assessment. *Behavioral Assessment*, 14, 5-14.
- Patrick, C. J. (1994). Emotion and psychopathy: Startling new insights. *Psychophysiology*, 31, 319-330.
- Poythress, N. G., Edens, J. F., & Lilienfeld, S. O. (1998). Criterion-related validity of the Psychopathic Personality Inventory in a prison sample. *Psychological Assessment*, 10, 426-430.
- Ragunathan, T. E., Rosenthal, R., & Rubin, D. B. (1996). Comparing correlated but nonoverlapping correlations. *Psychological Methods*, 1, 178-183.
- Reardon, M. L., Lang, A. R., & Patrick, C. J. (2002). An evaluation of relations among antisocial behavior, psychopathic traits, and alcohol problems in incarcerated men. *Alcoholism: Clinical and Experimental Research*, 26, 1188-1197.
- Ross, H. E., Gavin, D. R., & Skinner, H. A. (1990). Diagnostic validity of the MAST and the Alcohol Dependence Scale in the assessment of DSM-III alcohol disorders. *Journal of Studies on Alcohol*, 51, 506-513.

- Ross, H. E., Swinson, R., Doumani, S., & Larkin, E. J. (1995). Diagnosing comorbidity in substance abusers: A comparison of the test-retest reliability of two interviews. *American Journal of Drug and Alcohol Abuse, 21*, 167-185.
- Schafer, J. (1996). Measuring spousal violence with the Conflict Tactics Scale: Notes of reliability and validity issues. *Journal of Interpersonal Violence, 11*, 572-585.
- Schafer, J., Caetano, R., & Clark, C. L. (2002). Agreement about violence in U.S. couples. *Journal of Interpersonal Violence, 17*, 457-470.
- Selzer, M. L. (1971). The Michigan Alcohol Screening Test: The quest for a new diagnostic instrument. *American Journal of Psychiatry, 127*, 1653-1658.
- Skinner, H. A., & Allen, B. A. (1982). Alcohol dependence syndrome: Measurement and validation. *Journal of Abnormal Psychology, 91*, 199-209.
- Simon, T. R., Anderson, M., Thompson, M. P., Crosby, A. E., Shelley, G., & Sacks, J. J. (2001). Attitudinal acceptance of intimate partner violence among U.S. adults. *Violence and Victims, 16*, 115-126.
- Simpson, L. E., & Christensen, A. (2005). Spousal agreement regarding relationship aggression on the Conflict Tactics Scale-2. *Psychological Assessment, 17*, 423-432.
- Spanier, G. (1976). Measuring dyadic adjustment: new scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family, 38*, 15-30.
- Spitzer, R. L., Williams, J. B. W., Gibbon, M., & First, M. B. (1990). *Structured Clinical Interview for DSM-III-R personality disorders (SCID-II)*. Washington, DC: American Psychiatric Press.
- Spitznagel, E. L., & Helzer, J. E. (1985). A proposed solution to the base rate problem in the kappa statistics. *Archives of General Psychiatry, 42*, 725-728.
- Straus, M. (1979). Measuring intrafamily conflict and violence: The Conflict Tactics (CT) Scales. *Journal of Marriage and the Family, 41*, 75-88.
- Straus, M. A. (1990). Measuring intrafamily conflict and violence: The Conflict Tactics Scales. In M. A. Straus & R. J. Gelles (Eds.), *Physical violence in American families* (pp. 29-48). New Brunswick, NJ: Transaction Publishers.
- Straus, M. A., & Gelles, R. J. (1990). How violent are American families? Estimates from the National Family Violence Resurvey and other studies. In M. A. Straus & R. J. Gelles (Eds.), *Physical violence in American families* (pp. 95-112). New Brunswick, NJ: Transaction Publishers.
- Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The Revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17*, 283-316.
- Straus, M. A., & Sweet, S. (1992). Verbal/symbolic aggression in couples: Incidence rates and relationships to personal characteristics. *Journal of Marriage & the Family, 54*, 346-357.
- Stuart, G. L., Ramsey, S. E., Moore, T. M., Kahler, C. W., Farrell, L. E., Recupero, P. R., et al. (2003). Reductions in marital violence following treatment for alcohol dependence. *Journal of Interpersonal Violence, 18*, 1113-1131.
- Sugarman, D. B., & Hotaling, G. T. (1997). Intimate violence and social desirability: A meta-analytic review. *Journal of Interpersonal Violence, 12*, 275-290.
- Szinovacz, M. E. (1983). Using couple data as a methodological tool: The case of marital violence. *Journal of Marriage and the Family, 45*, 633-644.
- Szinovacz, M. E., & Egley, L. C. (1995). Comparing one-partner and couple data on sensitive marital behaviors: The case of marital violence. *Journal of Marriage and the Family, 57*, 995-1010.
- Taft, C. T., O'Farrell, T. J., Torres, S. E., Panuzio, J., Monson, C. M., Murphy, M., et al. (in press). Examining the correlates of psychological aggression among a community sample of couples. *Journal of Family Psychology*.
- Teitelbaum, L. M., & Carey, K. B. (2000). Temporal stability of alcohol screening measures in a psychiatric setting. *Psychology of Addictive Behaviors, 14*, 401-404.
- Tolman, R. M. (1989). The development of a measure of psychological maltreatment of women by their male partners. *Violence and Victims, 4*, 159-177.
- Tzelgov, J., & Henik, A. (1991). Suppression situations in psychological research: Definitions, implications, and applications. *Psychological Bulletin, 109*, 524-536.
- Wang, L., & Crane, D. R. (2001). The relationship between marital satisfaction, marital stability, nuclear family triangulation, and childhood depression. *American Journal of Family Therapy, 29*, 337-347.
- Weiss, R. L., & Cerreto, M. C. (1980). The Marital Status Inventory: Development of a measure of dissolution potential. *American Journal of Family Therapy, 8*, 80-85.
- White, A. M. (2003). What happened? Alcohol, memory, blackouts, and the brain. *Alcohol Research and Health, 27*, 186-196.
- Whiting, J. B., & Crane, D. R. (2003). Distress and divorce: Establishing cutoff scores for the Marital Status Inventory. *Contemporary Family Therapy: An International Journal, 25*, 195-205.
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