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Domestic Violence and Post-Traumatic Stress Disorder Severity for Participants of a Domestic Violence Rehabilitation Program

Gerlock, April A

Domestic violence has been a long-standing problem for our nation's active duty and military veterans. The purpose of this article is to describe participants of a domestic violence program, the program design to help lessen attrition, and the completers and noncompleters of the program. There was a significant relationship between post-traumatic stress disorder (PTSD) and domestic violence severity for the sample. PTSD severity was also related to reports of domestic violence in the family of origin. Completers and noncompleters were compared on demographic and violence variables and on nine research measures. Completers were more likely younger than 35 years old, employed, had higher self-ratings of relationship mutuality, lower levels of stress and post-traumatic stress, and were regularly court monitored. The results of a logistic regression significantly predicted completers and noncompleters based on age, relationship mutuality, PTSD, and court-monitored status (model $[\chi]^2$ statistic of 31.08, $p = 0.0000$).

Introduction

The cluster of domestic violence (DV) homicides and related suicides in the summer of 2002 at Fort Bragg, North Carolina, renewed the national interest and concern over the impact of war zone exposure and "high operations tempo" on marital stability. Although marital discord is identified as a factor in each case, barriers to seeking assistance such as fear over jeopardizing career and lack of TriCare reimbursement for private counseling are cited as preventing service members from getting adequate and early intervention.¹

The incidence of DV is identified as higher in military than in civilian families.^{2,3} The unique stresses of military life such as frequent moves, deployments with prolonged separation from family, financial stress, combat training, and exposure to violence have all been identified as placing military personnel at increased risk for domestically violent behaviors.^{2,4-6} Additionally, family life has historically been molded to the needs of the military, placing the military goals first and family issues as a lesser priority.⁷

The exposure to combat and development of post-traumatic stress disorder (PTSD) symptoms places an additional risk to military veterans for becoming domestically violent. Veterans with PTSD are identified as more likely to display a pattern of relationship difficulties and DV than veterans without PTSD.^{8,10} Combat veterans with PTSD have a greater incidence of aggression and violence than those without PTSD.¹¹ Analysis of data from the National Comorbidity Survey (a probability sample of men nationwide) revealed that 21% of current spouse or partner abuse was indirectly attributable to combat exposure and was mediated by the development of PTSD.¹²

Given the stresses of military life, the possibility of combat exposure, and development of PTSD, in addition to the barriers in seeking assistance, military personnel and veterans are at risk of becoming domestically violent, with the violence potentially ending in the death of a family member. A better understanding of the factors related to DV for active duty military and veterans, as well their response to specialized DV intervention is needed. This article describes a DV rehabilitation program for military personnel and veterans. Factors related to DV for a sample of men in the program and their program completion/noncompletion is described.

Methods

In 1995, the Department of the Army and Department of Veterans Affairs (VA) entered into the first Sharing Agreement ever to combine resources in the delivery of a state certified rehabilitation program for DV perpetrators. The Madigan Army Medical Center and American Lake VA Medical Center provided personnel to jointly offer DV rehabilitation to active duty military and military veterans. From a convenience sample of men attending the program, 62 DV perpetrators were recruited during a 6-month period from June 1997 to December 1997. The purpose of the study was to describe the program participants and to track rehabilitation program completion or noncompletion. All participation was voluntary.

The Rehabilitation Program

The rehabilitation program was a Washington State DV-certified program and, as such, met all of the requirements mandated by the law (Washington Administrative Code 388-60). To meet program eligibility, veterans had to first meet VA eligibility criteria. There were no out-of-pocket costs to attend the program. Veterans and active duty military identified at least one incident of physical assault (or credible threat of assault) against an intimate partner, and identified themselves as having a problem. The men's cognitive and mental health states were stable and they were able to participate in a cognitive-behaviorally oriented program. State standards mandate a minimum of 1-year accountability to the program, but it often took longer to meet the behavioral criteria for completion.

The program consisted of four phases: assessment, orientation, rehabilitation, and maintenance (for a detailed description of each phase, see Gerlock¹³). Initial DV assessments were completed by specifically trained Madigan Army Medical Center Family Advocacy Program and American Lake VA Medical Center staff for active duty and veterans, respectively. The weekly orientation class met for 4 weeks, followed by rehabilitation lasting for a minimum of 26 weekly meetings, and finally, the maintenance phase consisting of a minimum of 6 months of monthly meetings. Each phase required successful completion of transition criteria. Criteria to transition into the maintenance phase was the most stringent and required stopping all physical violence, stopping their pattern of psychological abuse, remaining drug and alcohol free, and halting all blaming of the victim. To verify these criteria, interviews were conducted with the victim or a community contact.

Victim contact was maintained during all phases of the program. Washington State law mandates that all victims be notified when a batterer seeks and leaves DV rehabilitation. They were provided with information on victim's services, limitations of DV rehabilitation, and how to contact program staff. Victims were also invited to meet with DV program staff individually and attend a weekly victims support group. No information about the victim was shared with the batterer (including contact and participation) without the victim's written permission to do so.

A high level of organization, commitment, and collaboration was needed for the combined staff to deliver batterers' rehabilitation efficiently while staying in compliance with state standards and working with military directives. The program received referrals from the Army and Air Force bases and U.S. Coast Guard in the Puget Sound region of Washington State. The program staff had to work directly with the unit Commanding Officers to make special arrangements to delay deployments and participation in field training exercises. For the men receiving a deferred sentence (treatment in lieu of possible jail time), the time commitment of the program was less than losing them to a jail sentence. However, in some cases, long deployments or being transferred to another duty station were unavoidable and the men were lost from treatment.

To remain in good standing with the program, the men could miss no more than four consecutive sessions during the rehabilitation phase, and all missed sessions were to be made up. However, long absences of up to 4 weeks often resulted in the men lapsing back into justifying their violence and blaming the victim. When military duties necessitated that the soldier, sailor, or airman be absent for a field training exercise, the men were allowed to complete assigned reading and written homework¹⁴ to remain in good standing with the program. As long as their absence was no more than 4 weeks and written assignments were received, they were maintained as active with the program.

Other arrangements were made to allow flexibility while maintaining the standards set for the program by law. The men were allowed to make up a missed session in any of the rehabilitation or maintenance classes that were meeting in the week before, during, or after their absence.

Participants

Sixty-two men participated in the study. Forty-eight (77%) were veterans and 14 (23%) were active duty military. The men were Caucasian (55%, $n = 34$), African American (29%, $n = 18$), Latino (6%, $n = 4$), Asian American (5%, $n = 3$), Native American (3%, $n = 2$), and mixed racial identity (2%, $R = 1$). Their ages ranged from 20 to 62 years, with a mean age of 38.81 years. Three men (African American, Asian American, and Caucasian) declined to participate in the study, thus the sample represents 95% of all men entering DV rehabilitation during the 6-month period specified. The men attended an average of 21.2 weekly sessions.

Research Measures

A personal demographic and battering history interview was conducted. This interview instrument was modified and expanded from the standard clinical assessment previously used by the program. Information gathered from batterers included demographics, battering history, exposure to violence from family/community history, substance use and abuse, criminal history, and court-ordered status.

The following nine research instruments were given to the batterers. Split-half reliability testing was conducted on each tool for overall scores, subscales (where indicated), and by Caucasian and African-American groups. For instrument parametric properties, see Gerlock.¹³

The Symptoms of Stress (SOS) Inventory¹⁵ quantified self-perception of affective, behavioral, cognitive, and physiological components of health and illness on a 5-point scale for the previous week. Physiological subscales included peripheral manifestations, cardiorespiratory, neurological, and gastrointestinal distress, and muscle tension. Psychological subscales included habitual patterns, depression, anxiety, anger, and cognitive disorganization. Reliability testing for the research sample resulted in a Guttman split-half for the SOS overall range from 0.78 to 0.93. The Caucasian group SOS subscales ranged from 0.57 to 0.90 and for African Americans, the range was 0.83 to 0.96. Because of the colinearity among the psychological subscales, summing and taking the mean of each subscale created a new variable called "mean psychological."

The Self-Esteem Rating Scale (SERS) is a 40-item instrument developed to provide a clinical measure of problematic and nonproblematic areas of self-esteem.^{16,17} For the research sample, the Guttman split-half reliability overall for the SERS was 0.95, was 0.96 for Caucasians, and was 0.92 for African Americans.

The brief Michigan Alcoholism Screening Test is a widely used and standardized instrument. The 10 best questions to identify alcoholism are highly correlated with the longer 25-question version.¹⁸ Reliability for the research sample overall was a Guttman split-half of 0.90, and was 0.92 for Caucasians and 0.90 for African Americans.

The Drug Abuse Screening Test¹⁹ is also a widely used and standardized research instrument. A shortened version was developed using the 20 items with high item-total scale correlations.²⁰ The Guttman split-half reliability overall for the research sample was 0.91 and was 0.85 for Caucasians and 0.97 for African Americans.

The PTSD Checklist (PCL) is a self-administered rating scale for assessing FfSD²¹ that consists of 17 items that correspond to the Diagnostic and Statistical Manual of Mental Disorders (Ed 4) symptoms of PTSD.²² Subjects rate how much they have been bothered by each symptom in the past month on a 5-point scale. Guttman split-half reliability overall for the research

sample was 0.95 and was 0.93 for Caucasians and 0.95 for African Americans.

The Conflict Tactics Scale (CTS) has been used primarily to measure the use of abuse and nonabuse tactics in couple relationships. The authors have modified it for other measures of family violence as well.²³ In this study, a modified instrument was used asking batterers to rate only their witnessing of conflict tactics used by their father and mother when they were children. Reliability scores on the Guttman split-half on the father subscale overall was 0.90 and was on the mother subscale 0.93 for the research sample. For Caucasians, the reliability score on the father subscale was 0.90 and was 0.93 on the mother subscale. For African Americans, the father subscale reliability score was 0.91 and the mother subscale was 0.92.

The Abusive Behavior Inventory (ABI) was developed to assess a wide range and intensity of physical and psychologically abusive behaviors.²⁴ The ABI allows for matched-pair analysis between male and female ratings of the batterer's abuse. It is a 30-item instrument using a 5-point Likert-type scale to measure frequency of abuse. For the batterer's sample, Guttman splithalf reliabilities ranged from 0.72 overall, to 0.80 for Caucasians, and 0.78 for African Americans.

The Mutuality Psychological Development Questionnaire (MPDQ), form A, measures perceived mutuality in close adult relationships.²⁵ By including two relationship perspectives (self and other), the respondent provides a rating from his own perspective as well as his partner's. The shortened forms include 22 items with ratings ranging from "never" to "all the time" on a 6-point scale. Batterer's ratings of themselves resulted in Guttman split-half reliabilities for the overall sample of 0.90, 0.94 for Caucasians, and 0.86 for African Americans. Batterer's ratings of their partners resulted in reliabilities overall of 0.85, 0.88 for Caucasians and 0.71 for African Americans.

A slight modification was made to the MPDQ, form B, with the author's permission (N. Genero, personal communication). This instrument asked the batterer to rate himself on the same questions as the "self"-subscale. The only change made was the prefacing of the statement with "It is important to me, when I talk about things. . .". This form asked the batterer to rate the importance of these aspects of mutuality. This revised form had a correlation with the original of 0.73 ($p = 0.000$). Overall reliability for the sample was 0.87 and was 0.92 for Caucasians and 0.77 for African Americans.

Results

Sixty-two men participated in the study. Of those who started the program, one (2%) man was transferred to another duty station and was dropped from the comparison (completer versus noncompleter) portion of the study. Twenty-three (37%) men made the transition from the rehabilitation phase to the maintenance phase and 38 (61%) dropped out of the program. It took the men 7 to 15 months to make the transition into maintenance. Completers attended an average of 36 weekly sessions, whereas noncompleters attended an average of 13 weekly sessions.

The Relationship of PTSD to DV

Fifty-six men in the sample identified PTSD symptoms as measured by the PCL. Seventeen (30%) identified military-only trauma as the source of their PTSD symptoms, 22 (39%) identified civilian-only trauma as the source of their PTSD symptoms, and 17 (30%) identified a combination of both civilian and military trauma as the source of their PTSD symptoms.

Of interest was whether there was a relationship between the severity of PTSD (PCL) and DV severity (ABI). Indeed, PTSD severity was significantly correlated with frequency and severity of DV (Pearson $r = 0.47$, $p = 0.000$; two-tailed, $n = 62$) in this sample.

Although the men did not specify the nature of the civilian trauma, their reports of severity and frequency of DV in their family of origin as one possible source of civilian trauma was measured. Their PTSD severity also significantly correlated to their

reports of DV in their family of origin (CTS; Pearson $r = 0.28$, $p = 0.05$; two-tailed, $n = 59$).

Comparisons between Completers and Noncompleters

Comparisons are made between completers and noncompleters on the following variables: demographic, general violence, and research instruments. Of the demographic variables, employment and age significantly distinguished completers from noncompleters. The violence variables that were significantly different between the two groups were court-mandated status and court monitoring. And lastly, of the research instruments, PTSD (PCL), relationship mutuality (MPDQ forms A and B for self and partner), and symptoms of stress (SOS for stress overall and subscales of neurological, habitual patterns, depression, anxiety/fear, anger, and cognitive disorganization) were all significantly different.

Program completers that made the transition from rehabilitation to maintenance were more likely to be younger than 35 years old, employed, had higher self-ratings of relationship mutuality, lower levels of stress, and post-traumatic stress, and were being monitored regularly by probation services or directly by the courts. On the other hand, noncompleters were generally older than 35 years old, unemployed or disabled, had lower self-ratings of relationship mutuality, higher levels of stress, and post-traumatic stress, and were not being monitored by probation services or the courts (Table I).

The completers and noncompleters did not significantly differ in their active duty military or veteran status, their ethnicity, their income levels (most [87%], $n = 54$, had incomes less than \$30,000/year), or their level of education. They did not differ in marital status or living situation. Although most of the men (63%, $n = 39$) also identified having had a substance abuse problem and treatment, there were no significant differences between the groups in substance use variables. In addition, the groups did not significantly differ on the remaining research instruments, including their reports of abusive behaviors (ABI), self-esteem (SERS), and their witnessing of DV when they were growing up (modified CTS). The anticipated differences in the drinking and substance use instruments (brief Michigan Alcoholism Screening Test and Drug Abuse Screening Test) were also found to not differ significantly.

Predicting Completion versus Noncompletion

Differences between completers and noncompleters are evident on several variables. A logistic regression analysis was conducted to determine the suitability of these variables in predicting completion or noncompletion of DV rehabilitation for the study sample. Two men were missing data on the MPDQ scale and were dropped for the logistic regression part of the analysis. Correlate tables were computed for all the statistically significant variables to determine which variables would enter the regression analysis. Those variables entering the final analysis were based on existing research, had significant differences when comparing completion vs. noncompletion, and had low colinearity.

The results of the logistic regression were a model $[\chi^2]$ statistic of 31.08 ($p = 0.0,000$). The significant variables entering the regression analysis were age at $p = 0.03$, MPDQ at $p = 0.03$, PCL at $p = 0.02$, and court monitoring at $p = 0.73$. Only courtmonitored status failed to reach significance at the 0.05 level. This is likely because of the small number of batterers who were not being monitored. This model predicted 88.89% of noncompleters, 78.26% of completers, and had an overall predictive ability of 84.75% for the research sample.

Discussion

Attrition from batterers' rehabilitation programs has been a long-standing problem and can have dire consequences for victims. Program dropouts are reported to have higher rates of repeated violence for up to 1 year than do program completers.^{26,27} It is understandable that batterers are more likely to complete programs that are short in length.²⁸ However, shorter programs may not be sufficient in changing the full spectrum of abusive behaviors in the long run. Adequate time for

accountability to a batterers' rehabilitation program is needed to ultimately change the attitudes and beliefs that support the abusive behaviors.²⁹ In states where accountability to a DV rehabilitation program is mandated for a minimum of 1 year, the shorter programs are not an option.

Longer programs pose a particular challenge for batterers whose job or work requirements necessitate travel for extended periods of time. This is especially so for the military. Although modifications made to the program may have helped maintain active duty military in the program, attrition overall remained a problem, with nearly two-thirds dropping out.

A link between PTSD and DV is also evident in this sample of batterers, as levels of PTSD symptoms correlated with frequency and severity of abuse. In examining the link between PTSD from childhood and adult DV, Dutton³⁰ reports that PTSD symptoms may be a mediating variable between childhood abuse and adult perpetration of DV. The exact nature of the traumatizing event(s) was not assessed for this sample. However, we do know there was a correlation between child witnessing of DV, PTSD (from civilian or military trauma), and frequency and severity of DV. What is troubling is the relationship between the batterers' levels of PTSD, their abuse, and dropping out of rehabilitation. Further research is needed to determine if this relationship exists in other samples of batterers, and if so, a better understanding of the nature of the relationship.

This research is limited by a number of factors. The batterers were a small convenience sample recruited during a limited time frame. Generalizability is limited because of the research method and sampling procedure. Nevertheless, findings are consistent with previous research on batterers' rehabilitation attrition³¹ and with the limited available research in the area of PTSD and DV. Further research is needed to better understand the DV risk factors for the nation's active duty military and military veterans, as well as improvements in the delivery of DV rehabilitation for this frequently mobile at risk group of men.

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Guarantor; April A. Gerlock, PhD ARNP

Contributor: April A. Gerlock, PhD ARNP

Post-Traumatic Stress Disorder Outpatient Clinic, Department of Veterans Affairs, Puget Sound Health Care System, American Lake Division, Tacoma, WA 98493-5000.

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