The Severity of Recurrent Violence During and Following Couples' Participation in Domestic Violence-Focused Couple Therapy

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ABSTRACT

This study explores the severity of psychological and physical aggression that recurred during and following couples' participation in Domestic Violence-Focused Couple Therapy. The overall recurrence of violence was found to be quite high. Chi Square tests revealed a difference in severity of violence during the time couples (N=41) were participating in the program in that more couples reported minor only violence at post-test than at pre-test and fewer couples reported severe violence at post-test than at pre-test for both psychological and physical aggression. Also, more couple reported no physical aggression at post-test than at pre-test and fewer couples reported severe physical aggression at post-test than at pre-test. It was also found that much of the violence that recurred during and following participation in the program was coded in the same category of severity at pre-test and post-test and at post-test and follow-up and few couples reported an increase in the severity of the violence they experienced. Implications for treating couples experiencing interpersonal violence and suggestions for further research are discussed.

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CHAPTER 1: INTRODUCTION

The Problem and its Setting

Intimate Partner Violence (IPV) is a critical social problem in the United States. According to the Center for Disease Control's National Intimate Partner and Sexual Violence Survey (NISVS) conducted in 2010, intimate partner violence affects 12 million people each year. In addition, the study found that 1 in 4 women and 1 in 7 men have experienced severe physical violence by an intimate partner in their lifetime. This does not include the psychological violence that tends to occur in addition to severe physical violence (Tjaden & Thoennes, 2000). Intimate partner violence has been shown to have both physical and psychological effects on recipients of abuse. Physical symptoms can be the direct result of physical violence, such as cuts and bruises or they can be lasting effects such as frequent headaches, chronic pain, and difficulty sleeping (CDC, 2010). In addition, Afifi et al. (2009) found that both male and female victims of abuse experienced poor mental health outcomes with women experiencing a broader range of disorders including disruptive behavior disorders, substance use disorders, anxiety disorders, and suicidal ideation.

Johnson (2006) makes a distinction between four different types of intimate partner violence. The first, *situational couple violence* occurs when one or both partners are violent but neither partner attempts to exert an overall sense of control over their partner and the relationship. The second type, *violent resistance* is when a partner is violent but does not attempt to control their partner and is in a relationship with a partner who is violent and engages in an overarching attempt to control their partner and the relationship. The third type, *intimate terrorism* occurs when one partner is violent and attempts to exert power and control over their partner and the relationship and the other partner is either not violent or violent without

attempting to have coercive control over their partner. The final type, *mutual violent control* is when both partners are violent and both attempt to exert a sense of power and control over their partner and the relationship.

Situational couple violence is suggested to be the most common type of intimate partner violence, especially in couples seeking therapy (Simpson, Doss, Wheeler, & Christensen, 2007). Johnson and Leone (2005) define situational couple violence as a form of violence that "is not rooted in a general pattern of control but occurs when specific conflict situations escalate to violence" (p. 324). This type of violence is contrasted with Intimate Terrorism, which is "defined by the attempt to dominate one's partner and to exert general control over the relationship" (p. 323).

Furthermore, the occurrence of mutual violence (when both partners are violent toward their partner) in intimate relationships has also received increasing attention in the literature. Whitaker, Haileyesus, Swahn, and Saltman (2007) examined the differences between relationships with reciprocal and nonreciprocal intimate partner violence. They found that 24% of the relationships that had been reported on had at least some violence, and about half of those relationships were reciprocally violent. They also found that when the violence was nonreciprocal (only one person was violent), that women perpetrated the violence in more than 70% of the cases. Reciprocal IPV in this study was associated with greater injury than was nonreciprocal IPV.

One of the ways researchers evaluate the effectiveness of a treatment program for intimate partner violence is to explore the recurrence of violence following treatment. A number of studies have explored recidivism following a male partner's participation in a batterers' intervention program (Gondolf, 1999; Hendricks, Werner, Shipway, Turinetti, 2006; Hanson &

Wallace-Capretta, 2004; Gregory & Erez, 2002; Gondolf, 1997). Almost all of these studies have explored the severity and type of violence that occurred during and/or following batterer intervention treatment (Gondolf, 1999; Hanson & Wallace-Capretta, 2004; Gregory & Erez, 2002; Gondolf, 1997). These studies have measured recidivism in a variety of ways including police report, partner report, self-report, or a combination of the three. The findings from these studies suggest at least a slight reduction in severity and frequency of violence following treatment, particularly for programs that include multiple treatment modalities and services such as individual, group, and in-home counseling for the male batterers and case management for their female partners (Gondolf, 1999). It is important to note that in two of these studies physical abuse decreased while psychological abuse increased (Gondolf, 1997; Gregory & Erez, 2002).

Couples experiencing IPV have traditionally been treated separately as male batterers and female victims, where the batterer attends an intervention program and the victim receives resources and support from a victims' services agency (Stith, McCollum, Amanor-Boadu, & Smith, 2012). Two meta-analytic reviews of past research on batterer intervention programs found the efficacy of these programs was not well supported by the evidence (Babcock et al., 2004; Feder & Wilson, 2005). In more recent years, couple therapy has been utilized as a treatment approach with some couples experiencing IPV in their relationship. Using couple therapy as a treatment modality for IPV is not appropriate for couples engaged in intimate terrorism. Johnson and Leone (2005) state, couples counseling is "a strategy that can be extremely dangerous for women entrapped in intimate terrorism, who risk retaliation if they disclose information about the abuse in front of the abuser" (p. 347). Recent research suggests that couples treatment for IPV may be an appropriate approach for some couples, specifically couples engaging in mutual situational violence (Johnson & Leone, 2005; Stith, McCollum,

Amanor-Boadu, & Smith, 2012). Despite this evidence, the idea that couples therapy can be used to treat couples experiencing violence in their relationship is an incredibly controversial issue, so much so that 68% of states in the U.S. have standards limiting or prohibiting its use during primary treatment for partner violence (Maiuro & Eberle, 2008). Some researchers and clinicians have suggested that using a couple therapy treatment modality when there is violence in the relationship would put the recipient of the abuse at greater risk and would blame them for their role in the violence. While this may be true for couples engaged in intimate terrorism, those who support the use of a couple therapy approach believe that it can be a safe and effective treatment modality for couples that meet certain criteria (Bograd & Mederos, 1999). Johnson and Leone (2005) believe that couples engaging in situational violence might gain "problem solving, anger management, and conflict resolution" skills from couples counseling (p.347).

Due to the controversy surrounding the use of conjoint treatment for couples experiencing intimate partner violence, the research on violence recidivism following this form of treatment is limited. Studies exploring the severity and type of violence that occurs during and following couple's treatment for situational mutual IPV have not been found. The current study examined the severity of both physical and psychological aggression that recurred during and after a conjoint treatment for couples who have experienced violence in their relationship.

Significance

It is important to study this problem for a number of reasons. First, the majority of studies reviewed do not differentiate the type of violence that has occurred (Situational Couple Violence, Intimate Terrorism, etc.) causing the severity of the violence to be misrepresented (Johnson & Leone, 2005). Couples engaging in Intimate Terrorism experience violence that is more likely to cause injury and violence that is less likely to stop (Johnson & Leone, 2005). Data from these

couples would cause the findings to be more severe than if the sample consisted of only couples experiencing situational violence. Second, the research on IPV recidivism focuses on male partners who have recidivated violence against their female partner following participation in a batterers' intervention program. The samples used for these studies came from the court system where the occurrence of Intimate Terrorism tends to be higher than in community samples (DeBoer et al., 2012). These studies also do not take into account the occurrence of mutual violence. Finally, knowing the severity and type of violence that occurs during and following couples treatment may help clinicians improve treatment interventions.

Rationale

It is widely agreed that studies on the effectiveness of conjoint treatment are needed (Simpson et al., 2007; Stith & McCollum, 2011). Because this study sought to measure the occurrence and characteristics of specific violent behaviors related to IPV during and following treatment, a quantitative methodology was appropriate. The use of a quantitative approach allowed for a comparison of reports from a large number of participants on the same variables of severity and form of abuse that occurred before, during, and after the treatment was administered.

Theoretical Framework

The current study was guided by Family Systems Theory (FST). FST assumes that families are complex systems made up of individual members who continuously influence one another (Smith, Hamon, Ingoldsby, & Miller, 2009). Problems are viewed as arising from the dysfunction of the system, as opposed to lying within one person. Systems theorists believe that "individuals are ultimately responsible for their own behavior but that no behavior can be understood in isolation. One's behaviors, emotions, and interactions make sense only within the

context of their social world or the environment in which they occur" (Smith et al., 2009, p.125). Another assumption of FST is that "circular causality guides behavior" (Smith et al., 2009, p. 126). The focus is not on what a couple argues about, but the process or "repetitive pattern of interaction that is of interest" (Smith et al., 2009, p.126). Functional as well as dysfunctional rules are established in the couple relationship as the result of repeated behavioral responses, this is known as the *redundancy principle*. Some rules are explicit, meaning that they are easily identified and agreed on by members. However, most rules are implicit, meaning they are unspoken and outside of awareness. The implicit rules are the most influential rules in the system (Smith et al., 2009).

A systems theorist would conceptualize intimate partner violence as resulting from the escalation of dysfunctional interaction patterns that have been adopted by the couple system over time. Partners are viewed as both affecting the system and being effected by the system. Therefore, violence is part of the couples overall pattern of interaction while also being the full responsibility of the aggressor. Systems theory does not relieve people of their personal responsibility for their use of violent acts. This way of conceptualizing intimate partner violence fits well with Johnson's typology of *situational couple violence* because it helps us to understand the reciprocal nature of the violence and the escalation of specific arguments over time. In a relationship characterized by frequent situational couple violence, "the relationship may involve areas of conflict that continue to be unresolved and one or more partners who regularly choose to resort to violence in the context of those conflicts" (Johnson & Leone, 2005, p. 324). The couple is a system that is influenced by a number of different forces. This theory assumes that positive change occurs in the system when the couple is able to change their dysfunctional rules. During treatment, the couple receives positive feedback which encourages them to "break out of the

homeostatic balance" (Smith et al., 2009) they were in when they entered treatment. Systems theory was used to help understand the severity of violent behavioral responses couples exhibit during and after participating in a systemic treatment program focused on ending all violence in the couple relationship.

Purpose of the Study

The purpose of this study was to identify if the violence that was occurring in the relationship during and after couple's participation in DVFCT was more severe, less severe or the same severity as the violence that was occurring in the relationship prior to couple's treatment. The study also sought to understand the form of abuse (physical and/or psychological) that occurred before, during, and after couple's treatment.

Research Questions

The following research questions were used to guide the present study:

1. What was the severity of psychological aggression that recurred during and following couples' participation in DVFCT?
2. What was the severity of physical aggression that recurred during and following couples' participation in DVFCT?

CHAPTER 2: LITERATURE REVIEW

The following review of the literature will survey the research on typologies of intimate partner violence, recidivism following participation in batterer intervention treatment, conjoint treatment of intimate partner violence, and the recurrence of violence following couples treatment. The section on the typologies of IPV is divided into an explanation of each type, an explanation of how the type of violence differs depending on the sample, research on mutual violence, and research on treating the typologies differently. The section on recidivism following participation in batterer intervention treatment reviews the research on batterer intervention programs and their effectiveness as measured by rate of recidivism. The section on couples treatment of intimate partner violence includes research on the two opposing perspectives of conjoint treatment and conjoint treatment models and their effectiveness. This section concludes with a DVFCT program description and review of the outcome research. The section on recurrence of IPV following couples treatment reviews the limited research that exists in this area including studies that have measured frequency and prevalence of violence following couples treatment.

Typologies of Intimate Partner Violence

Johnson has identified four distinct typologies of intimate partner violence, which "are defined conceptually in terms of the control motives of the violent member(s) of the couple, motives that are identified operationally by patterns of controlling behavior that indicate an attempt to exercise general control over one's partner" (Johnson, 2006, p. 1003). The four major types of IPV are *intimate terrorism*, *violent resistance*, *situational couple violence*, and *mutual violent control*. Johnson (2006) believes the types of violence have "different causes, different

patterns of development, different consequences, and that they require different forms of intervention" (p. 1003).

Intimate terrorism (IT) is "violence that is embedded in a general pattern of controlling behaviors, indicating that the perpetrator is attempting to exert general control over his partner" (Johnson & Leone, 2005, p. 322). Johnson's (2006) research suggests "intimate terrorism is perpetrated almost exclusively by men" (p. 1003) and is unilateral. Johnson and Leone (2005) found IT to be the most severe type of IPV. In comparison to victims of situational couple violence, they found victims of IT were attacked more often and the violence was less likely to stop. They were also more likely to experience injury and symptoms of post-traumatic stress syndrome, use painkillers more often, and were more likely to miss work (Johnson & Leone, 2005).

Johnson describes *situational couple violence* (SCV) "as involving specific arguments that escalate to violence but showing no relationship-wide evidence of an attempt to exert control over one's partner" (Johnson & Leone, 2005, p. 323). SCV is more likely to be bilateral (perpetrated by both partners) as well as gender symmetric (perpetrated by men and women at equal rates) (Stith et al., 2012; Johnson, 2006). As stated previously, SCV is thought to be the "most prevalent type of relationship violence" in studies of the general population as well as studies of couples seeking therapy (Stith et al. 2012).

Violent resistance is violence that is used "to resist intimate terrorism and may have the primary motive of wanting to protect oneself, or be the result of an expression of anger or resistance to a controlling partner" (Stith et al., 2012, p. 221). Women are more likely to engage in this type of violence (Johnson, 2006).

The final type of IPV Johnson identified is *mutual violent control*. This type of violence occurs when both partners are violent and controlling and are "engaged in a struggle for control of the relationship" (Stith et al., 2012). Johnson (2006) states that *mutual violent control* is also gender symmetric.

In 1995, Johnson proposed an explanation why feminist researchers studying batterers in treatment and victims in shelters found IPV to be mostly perpetrated by males against their female partners while family violence researchers studying large samples of the general population found IPV to be more gender symmetric. Johnson proposed "the dramatic differences in the patterns of violence described by these two research traditions arise because the sampling decisions of the two traditions have given them access to different, largely nonoverlapping populations, experiencing different forms of violence" (Johnson, 1995, p. 289). He suggested that intimate terrorists are more likely to be identified through batterer and shelter programs while couples experiencing situational violence are more likely to be identified in studies of the general population.

It is also important to consider the mutuality of violence that is occurring. Straus (2008) studied dominance and symmetry of physical partner violence using data from 13,601 university students in 32 nations who participated in the International Dating Violence Study (Straus, 2008). He found the most prevalent pattern of dominance was bidirectional (both partners were violent). Similarly, Whitaker et al. (2007) used data from the 2001 National Longitudinal Study of Adolescent Health to explore the prevalence of reciprocal and nonreciprocal intimate partner violence and the relationship between reciprocity and violence frequency and injury. The data set contained information from 11,370 young adults aged 18 to 28 years on partner violence and injury. Whitaker et al. (2007) found that of all the relationships that had been reported on, 24%

had some violence and 49.7% of those relationships were reciprocally violent. They also found that "reciprocal intimate partner violence was associated with greater injury than was nonreciprocal intimate partner violence regardless of the gender of the perpetrator" (p. 941). This differs from Johnson's view that unilateral intimate terrorism is the most injurious form of IPV. However, it does provide support for the need to consider the physical harm that can be caused by different types of abuse.

Johnson and Leone (2005) suggest the different types of violence be treated differently. Services provided to female victims of violence tend to focus on the power and control aspects of intimate terrorism. A woman who is involved in a relationship that is characterized by situational couple violence might not view her relationship as fitting this description and may be less likely to seek the help she needs. Johnson and Leone believe couples counseling for a couple engaged in intimate terrorism could put the victim at greater risk if she shared information about the abuse making couples treatment potentially dangerous and inappropriate for this type of violence. However, Johnson and Leone (2005) state, "for couples involved in situational couples violence, …[couples] counseling might provide useful skills in problem solving, anger management, and conflict resolution" (p. 347). Yet, couples treatment for IPV is controversial.

Recidivism Following Batterers' Intervention

We have some understanding of recidivism following batterer intervention. Batterer intervention programs are the current standard treatment for intimate partner violence. Reviewed individually, studies examining the outcome of these programs suggest at least a slight decrease in severity and/or frequency of abuse (Gondolf, 1997; Gregory & Erez, 2002). Gondolf (1997) examined the pattern of reassault by batterers from four different "well-established" batterer intervention programs. The sample consisted of eight hundred forty male batterers and their

female partners. Batterers were interviewed at intake and batterers and their partners were interviewed by phone every 3 months for 15 months after intake. According to partner reports, 32% of the men physically reassaulted a female partner during the follow-up period. Of those men who reassualted their partner during follow-up, half reassaulted in the first 3 months after intake. Gondolf (1997) states "the 'well-established' batterer programs appear to contribute to a short-term cessation of assault in the majority of batterers. However, a small portion of the men are unaffected by or unresponsive to the intervention" (p. 373). Gregory and Erez (2002) conducted in-depth interviews with 33 women whose partners had participated in a batterer's intervention program in order to understand the effect these programs have on battered women. According to the results, "the majority of the respondents (81%) reported a decrease in the frequency in which violent incidents (including verbal abuse/ threats) occurred while their abuser participated in the treatment" (p. 214). In addition, 55% of respondents reported that physical abuse was completely eliminated while only 16% reported that verbal abuse was completely eliminated.

While these findings are encouraging, when reviewed together these programs appear to have a small effect on the recurrence of violence (Babcock et al. 2004; Feder & Wilson, 2005). Babcock et al. (2004) conducted a meta-analysis of 22 studies examining the effectiveness of treatment for partner violent males. Re-assault in these studies was assessed by partner report and/or police report. They found that "treated batterers have a 40% chance of being successfully nonviolent, and without treatment, men have a 35% chance of maintaining nonviolence. Thus, there is a 5% increase in success rate attributable to treatment" which is considered to be a small effect size (p.1044). The studies reviewed in these meta-analyses of batterers' intervention

programs did not explore the severity of the violence that occurred when the male batterers re-assaulted their partners.

Feder and Wilson (2005) conducted a meta-analysis using more rigorous inclusion criteria than Babcock et al. Ten studies that measured recidivism rates following court-mandated batterer intervention were analyzed. Three of these studies had been included in Babcock et al.'s prior analysis. Recidivism was again measured by partner report and/or police report. The mean effect size for experimental studies using police reports was a 7% reduction in recidivism. The mean effect size for experimental studies using partner reported outcomes was zero.

Studies examining recidivism following batterers' intervention treatment measure recidivism in a variety of ways, including police report, self-report, partner report or a combination of reports, which makes it difficult to compare results across studies due to differences in response rates (Sartin, Hansen, & Huss, 2006). Studies that use police reports as their measure of recidivism fail to account for abuse that is not reported to the police (Stith et al., 2012). Using only self-reports is problematic because batterers tend to underestimate their use of violence (Sartin, Hansen, & Huss, 2006). Finally, while partner reports are somewhat biased, they are thought to be the most accurate measure of recidivism.

Couples Treatment of Intimate Partner Violence

Stith and McCollum (2011) reviewed two opposing perspectives of using conjoint treatment when partner violence has occurred. The feminist perspective assumes conjoint treatment is never appropriate for couples that have experienced violence in their relationship (Avis, 1992). In contrast, the systemic perspective of IPV is that conjoint treatment can be appropriate for a particular group of couples, specifically those couples engaging in low-level situational violence (Johnson & Leone, 2005).

The feminist perspective provides several important cautions why couples treatment may not be an acceptable treatment modality in cases of IPV (Avis, 1992). First, treating a couple engaging in IPV conjointly may imply that the victim is partially to blame and that the abuser is not responsible for their use of violence (Goldner, Penn, Sheinberg, & Walker, 1990). Second, there is concern that the therapist would take a neutral stance regarding the violence and would not conceptualize the violence in terms of power and control (Avis 1992). Finally, there is concern that the victim would not feel he/she could be completely open and honest in therapy for fear of upsetting their partner and putting themselves in greater danger (Jory, Anderson, & Greer, 1997).

While the feminist perspective provides important cautions against treating couples engaged in IPV (Avis, 1992), the systemic perspective provides equally important suggestions why conjoint treatment may be a beneficial treatment modality for some couples. First, many couples want to be treated together to work on their relationship. In many cases they want the violence to end, not the relationship (Istar, 1996). Second, not all partner violence is the same. As stated earlier, Johnson (2006) defined different types of intimate partner violence and suggested that situational couple violence may be more appropriately treated by conjoint therapy. Therefore, "a one-size-fits-all approach to intervention (gender-specific, pro-feminist) may not meet the needs for all couples" (Stith & McCollum, 2011, p.315). Third, treating one partner in the couple without treating the other can negatively impact the partner not involved in treatment as well as the relationship. Skills and techniques learned in treatment may be misused against the victim (Rosen, Matheson, Stith, McCollum, & Locke, 2003). Fourth, IPV has been linked to low relationship satisfaction, which can be improved in couple therapy (Stith, Green, Smith, & Ward, 2008). Fifth, as stated earlier, many couples engage in mutual violence (Straus, 2008; Whitaker,

2007). If both partners are engaging in violence, they should both be involved in treatment to end the violence. Sixth, conjoint treatment may give the victim the strength she needs to remove her from an abusive relationship by providing validation of her experience (Stith & McCollum, 2011). Finally, the evidence supporting the efficacy of male batterer intervention programs is not strong (Babcock et al., 2004; Feder & Wilson, 2005).

Despite the controversy, there is evidence to suggest that couples treatment can be helpful. Several treatment models have at least some evidence for their efficacy. Behavioral couples treatment (BCT) appears to be the most promising conjoint treatment for IPV. BCT is a behavioral model that has been used to treat co-occurring substance abuse and intimate partner violence. It typically consists of 15 to 20 couple sessions conducted over 5 to 6 months. BCT is a skills-based approach that utilizes the substance-abusing patient's partner as a source of support (O'Farrell & Fals-Stewart, 2000). O'Farrell et al. (2004) examined partner violence before and after 20 to 22 sessions of BCT for 303 male alcoholic participants and their female partners. In the year prior to treatment, 60% of male alcoholic participants were violent toward their female partner. In the first year following BCT, violence decreased to 24% overall and 12% for patients whose alcoholism was remitted following BCT. The prevalence rate of violence for the nonalcoholic comparison group was also 12%. Schumm et al. (2009) conducted a similar study of 103 female alcoholic patients and their male partners before and after 20 to 22 sessions of BCT. Prior to treatment, 68% of female alcoholic patients had been violent toward their partner. In the year following BCT, the prevalence rate of violence decreased to 31% overall and 22% for patients whose alcoholism was remitted following BCT. The prevalence rate of violence in the nonalcoholic comparison group was 15%. BCT is currently the model for conjoint treatment of intimate partner violence with the most empirical support.

There is some evidence to support the use of other couples treatment programs for IPV including Couples Abuse Prevention Program (CAPP), Circles of Peace (CP), and Domestic Violence-Focused Couples Treatment (DVFCT). Couples Abuse Prevention Program (CAPP) is a cognitive-behavioral couple treatment that focuses on improving the couple relationship and reducing risk factors for IPV (LaTaillade, Epstein, & Werlinich, 2006). The treatment includes 10 weekly conjoint sessions conducted over 3 to 4 ½ months (LaTaillade et al., 2006) Research on CAPP shows similar outcomes to treatment as usual (TU) with an increase in relational satisfaction and decrease in psychological aggression. There was no difference in frequency of physical aggression between the CAPP group and TU group, most likely due to the fact that the frequency was already quite low (LaTaillade et al., 2006). Circles of Peace (CP) is "the first court-referred domestic violence treatment program to use a restorative justice circle approach to reduce violent behavior in families in the United States" (Mills, Maley, & Shy, 2009, p. 129). CP typically consists of 26 to 52 weekly meetings between partners who have been abusive (the "applicants"), family members ("participants"), a trained facilitator, and community volunteers (Mills, et al., 2009). A study was conducted that measured the effectiveness of the Circles of Peace program using subsequent arrest reports as the measure of recidivism. The article describing that study is currently under review and has not yet been published.

DVFCT, the program on which this project is based, was developed with NIMH funds. It began in 1997 at Virginia Tech. The 18-week manualized program uses solution-focused brief therapy as its main theoretical framework. DVFCT is conducted by co-therapists in either a multi-couple group (MC) or with a single couple (SC). The goal of the program is to eliminate all forms of violence, promote self-responsibility, and, if the couple chooses to remain together, enrich the couple relationship (Stith, McCollum, & Rosen, 2011). The first 6 weeks of the

program are gender-specific and therapist-directed. This phase focuses on learning safety skills and developing a vision of a healthy relationship to guide therapy. Co-occurring substance abuse issues are also addressed during this beginning phase of treatment as needed. The last 12 weeks of the program are conducted conjointly and address the couples' specific relationship issues that have been contributing to the conflict.

This model has focused on safety in a number of ways. Prior to participation in the program, couples are thoroughly screened to determine their appropriateness for conjoint treatment. If it is determined that the program would not be a safe option, other referral sources are provided. During the 12-week conjoint phase of treatment, pre- and post-session meetings are used to confidentially screen for indication of increased risk and additional occurrences of violence (Stith et al., 2011). In addition, the use of co-therapists allows for the couple or group to be split up if needed to maintain safety. Finally, a written post-session safety assessment is utilized as an additional safety measure.

The outcome research on DVFCT indicates that the program is effective in reducing the occurrence of violence for some couples. Stith et al. (2004) used a quasi-experimental design to measure the outcomes of the treatment program. The participants for this study were recruited from all over the Washington, DC, metropolitan area. The sample consisted of forty-two couples that were randomly assigned to either the individual or multi-couple group. Nine couples that met the criteria for inclusion in the study but were unable to participate due to scheduling conflicts were chosen by program researchers to be the comparison group. The age range of the male participants was 22 to 74, while the age range of the female participants was 18 to 68. Caucasians made up the majority (63%) of the participants; 25% were African American; 13% considered themselves to be "Other" (Hispanic, Asian, Native American, or Mixed Race). The

majority of the couples (75%) were married when they started the program. Recidivism was measured using the Revised Conflict Tactics Scale. Male violence recidivism rate in the multi-couple group was 25% at the 6-month follow-up, which was significantly less than the comparison group recidivism rate of 66% and the single couple recidivism rate of 43%. This means that the men in the single couple group were not significantly less likely to recidivate than men in the comparison group (Stith et al., 2004). At the two-year follow-up, 19 of the 30 female partners who completed treatment were contacted. Only two of the 19 couples reported experiencing a violent incident since the end of treatment, indicating a 13% recidivism rate. In addition, four of the nine female partners from the comparison group were contacted, and half reported a subsequent violent incident, indicating a 50% recidivism rate.

Stith et al. (2011) also reported on the outcome of DVFCT in their book describing the treatment program. More couples were treated bringing the total to fifty-five couples that completed the program and the 6-month follow-up. The comparison group again consisted of nine couples that did not receive treatment. The Revised Conflict Tactics Scale was used to measure the recurrence of physical and psychological violence. The results "indicate that for both men and women, completing the 18-week program, either in the SC or MC, led to significant reduction in physical violence toward their partner, as measured by partner reports" (Stith et al., 2012, p. 231). The men in the multi-couple group experienced a multitude of additional benefits not seen in the single-couple format. These men reported that "martial conflict decreased, relationship satisfaction increased, constructive communication increased, destructive communication decreased, and the use of the pursue-distance patterns decreased"

(Stith et al., 2011, p. 172). They also reported, "decreased anger, decreased anxiety, increased differentiation, and increased partner differentiation" (p. 172). Women did not seem to benefit more from one condition than the other (Stith et al., 2012). Stith et al. (2011) report "women in both modalities reported increases in marital satisfaction, constructive communication, and respondent differentiation. However, only women in the multicouple group were reported by their partners to be less psychologically abusive, and only these women reported significant reductions in marital conflict and partner differentiation" (p. 172). In addition, "only women in the single-couple condition reported reduction in partner pursues-respondent distance" (Stith et al., 2011, p. 172). The severity of the violence that recurred following the DVFCT program has not yet been explored and so it appears that more research is needed to understand the difference in severity of recurrent violence before, during, and after this program.

We know that couple treatment appears to reduce the frequency of violence. What we do not know is when violence recurs during or following couples treatment what form of abuse does it take and is it as severe, less severe, or more severe than it was prior to treatment? That is the question this study sought to answer. Having more information about the severity of recurrent violence may provide clinicians and researchers with a better understanding of how severe the violence is that couples experience during and following treatment, which will help to inform future interventions and further research.

Recurrence of IPV Following Couples Treatment

Studies examining the recurrence of violence during and following conjoint treatment for IPV have focused on the prevalence and/or frequency with which physical and psychological violence recurred (Stith, Rosen, McCollum, & Thomsen, 2004; Taft et al., 2010; Schumm et al.,

2009; Simpson, Atkins, Gattis, & Christensen, 2008). Schumm et al. (2009) measured prevalence and frequency of verbal aggression, overall violence, and severe violence before and after behavioral couple therapy for female alcoholic patients and their male partners. Results of this study showed a significant reduction in prevalence of violence. However, the researchers did not identify the type of violence (intimate terrorism, situational couple violence, etc.) that was occurring in these couple relationships. Simpson et al. (2008) measured prevalence and frequency of physical and psychological aggression before, during, and after couples therapy for couples engaging in mild to moderate physical aggression. However, the treatment used was non-aggression-focused behavioral couples therapy. The author was unable to find a study measuring the severity and form of abuse that recurs during and after conjoint treatment for couples engaged in situational mutual violence.

Summary

In summary, the literature suggests there are different types of violence that should be treated differently. The evidence for the effectiveness of batterer intervention programs is not strong. The use of different measures for recidivism makes these studies difficult to compare. Couples treatment may be an appropriate treatment modality for couples experiencing situational mutual violence. Couples treatment of IPV is controversial. However, there is evidence to suggest couple treatment can be helpful. Research on the severity of recurrent violence following couples treatment is extremely limited. The current study sought to fill this gap in the literature by identifying the severity and type of violence that recurs during and following couple's participation in DVFCT.

CHAPTER 3: METHODS

Design of the Study

This study is a secondary analysis of quantitative data taken from a study conducted by faculty at Virginia Tech's marriage and family therapy program, which began in 1997. The data were originally collected as part of the development and testing of a manualized solution-focused conjoint treatment program for couples experiencing violence in their relationships called Domestic Violence-Focused Couples Therapy (Stith et al., 2011).

Participants and Selection Process

The original data set included 83 heterosexual couples that were experiencing conflict in their relationships and were living in the Washington D.C. metro area. Couples were randomly assigned to either the multi-couple or single-couple treatment with 55 of these couples completing the program and the 6-month follow-up assessment. Participants were recruited through a number of referral sources throughout the community including probation officers, domestic violence agencies, private therapists, and lawyers. Other participants responded to newspaper advertisements offering free couples counseling for couples experiencing conflict in their relationships.

In order to be included in the study, participants had to be at least 18 years of age, be experiencing male-only or mutual violence in their relationship, have the desire to remain in the relationship, be willing to participate in couples therapy, and be able to speak English. Exclusion criteria were employed to ensure the safety of participants. Couples were excluded from the study if the female partner required medical attention following previous violent incidents and if the female partner felt afraid of her partner or felt that she could not speak freely in front on her partner. Couples were also excluded if they had a current untreated substance use problem, if

they refused to remove firearms from their home or car, and if they refused to sign a no-violence contract (Stith et al., 2011). Given that the current study focused on the recurrence of violence, only couples who reported experiencing violence during and/or following treatment were included in this study.

Procedures

Once referred to the larger study, participants who were interested called the Center for Family Services and were screened by a graduate assistant. If the caller fit the criteria for inclusion and wished to participate in the program, they were scheduled for an initial appointment. The initial appointment was conducted separately with each partner in order to assess risk as accurately as possible without endangering either partner. Participants were first asked to signed an informed consent form explaining the purpose of the study, the potential risks and benefits of participating, the participant's right to withdraw at any time, and the confidentiality of participant information. Participants then provided demographic information and completed several written quantitative measures including the Conflict Tactics Scale, Revised (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996).

Once they had completed the written assessments, a trained therapist intern conducted an assessment interview with each participant in order to gain more information about the individual, the couple, and the degree of violence in their relationship. Once it was determined that both partners were ready to begin treatment, the couple was randomly assigned to a treatment group. The first six couples were assigned to the individual treatment format, with each couple meeting with two co-therapists. The next 4 to 6 couples were assigned to the multi-couple group format, with several couples meeting with two co-therapists. Once the first multi-couple group was filled, the next group of couples was assigned to the individual format. This

process continued until all participants had been assigned to a treatment group. The comparison group was made up of nine eligible couples that were unable to participate in the program due to scheduling conflicts. The quantitative measures administered in the initial interview were also administered at the end of treatment and 6 months after treatment ended.

The selection criteria for this study were that both partners of the couple had to have completed the 18-week program and both partners had to have responded to all questions on the psychological aggression and physical aggression subscales of the CTS-2 at pre-test, post-test, and the 6-month follow-up. There were 41 couples that met the criteria and were included this study.

This study received approval from the IRB (see Appendix A).

Instruments

This study used participants' responses to the Conflict Tactics Scale, Revised (CTS-2; Straus et al., 1996). The CTS-2 is a 39-item measure including the following subscales: psychological aggression, physical assault, negotiation, injury, and sexual coercion. Partner reports on the subscales of psychological aggression and physical assault were used to measure the recurrence of violence during and following treatment. Partner reports were used to avoid the social desirability bias that can sometimes influence an individual's self-report of their own use of psychological aggression and physical assault. The subscales of negotiation, injury, and sexual coercion were not used because there was not enough recurrence of these variables reported to include them in the current analysis.

Psychological Aggression. Psychological aggression was measured by using the psychological aggression subscale of the CTS-2. This scale is further divided into minor and severe subscales (Straus et al., 1996). The Minor Psychological Aggression subscale is a 4-item

measure that assesses the use of insults and swearing, shouting and yelling, stomping out of the room during a disagreement, and saying something to spite one's partner. The Severe Psychological Aggression subscale also consists of 4-items that assesses the use of calling one's partner fat or ugly, destroying property, accusing one's partner of being a lousy lover, and threatening to hit or throw something at one's partner (Straus et al., 1996).

Physical Assault. Physical assault was measured by using the physical assault subscale of the CTS-2. This scale is also divided into a minor subscale and a severe subscale (Straus et al., 1996). The Minor Physical Assault subscale is a 5-item measure that assesses the use of throwing something at one's partner that could hurt, twisting a partner's arm or hair, pushing and shoving, grabbing, and slapping. The Severe Physical Assault subscale is a 7-item measure that assesses the use of a knife or gun, punching or hitting, choking, slamming one's partner against a wall, beating up one's partner, burning or scalding, and kicking (Straus et al., 1996).

At pretest, participants were asked to indicate how often their partner had committed each act in the past year (0 = never, 1 = 1 time, 2 = 2 times, 3 = 3-5 times, 4 = 6-10 times, 5 = 11-20 times, 6 = 20 or more times, 7 = not in the past year, but it has happened before). For the post-test and 6-month follow-up, participants were asked to indicate how many times their partner had committed each act since the last time they completed the instrument. The CTS-2 has been found to have adequate internal consistency reliability with the psychological aggression subscale and physical assault subscale ranging from .79 to .86 (Straus et al., 1996) as well as good construct and discriminant validity (Straus et al., 1996). Table 1 below shows the reliabilities for the subscales used in the current study. There were some moderate reliabilities.

Table 1

Reliabilities of Conflict Tactics Scale-Revised Subscales

Subscale	Male*	Female
Minor Psychological Aggression	0.668	0.808
Severe Psychological Aggression	0.711	0.569
Minor Physical Assault	0.823	0.812
Severe Physical Assault	0.617	0.701

*Partner reports of male behavior

Analyses

Partner reports on the psychological aggression and physical assault subscales of the Conflict Tactics Scale, Revised (CTS-2) were used to identify those couples who experienced any recurrence of violence, as reported by either partner, at post-test and/or follow-up. Recurrence was defined as either partner reporting at least one act of psychological or physical aggression. If both partners reported a recurrence of violence, the more severe of the two partners' responses were used as the severity level for the couple in order to account for more severe acts of violence in the relationship. The violence reported at pre-test, post-test, and follow-up was then coded as none, minor only, or severe. This way of coding for the severity of violence was developed by Straus and Douglas (2004) as a way to avoid the muddling of minor and severe forms of violence that can occur when participants experience items on both the minor and severe subscales of the same form of abuse. Psychological aggression was coded first. "None" meant that neither partner reported experiencing any psychological aggression. "Minor Only" meant that one or both partners reported experiencing only violence on the "Minor Psychological Aggression Subscale" of the CTS-2. "Severe" meant that one or both partners

reported experiencing at least one act of violence on the "Severe Psychological Aggression Subscale" of the CTS-2. Physical assault was then coded. "None" meant that neither partner reported experiencing any physical assault. "Minor Only" meant that one or both partners reported experiencing only violence on the "Minor Physical Assault Subscale" of the CTS-2. "Severe" meant that one or both partners reported experiencing at least one act of violence on the "Severe Physical Assault Subscale" of the CTS-2.

Each couple was then coded as to whether the severity of the violence remained the same, increased, or decreased from pre-test to post-test and from post-test to follow-up for both psychological aggression and physical assault (using the more severe of the partners' responses). If the severity of violence was coded in the severe category at both pre-test and post-test or at both post-test and follow-up, the minor-only category at both pre-test and post-test or both post-test and follow-up, or the no violence category at both pre-test and post-test or both post-test and follow-up, it was recorded that the severity of violence remained the same. The percentage of couples that experienced severity of violence that remained at the same level of severity from pre-test to post-test and post-test to follow-up was then determined. This percentage was broken down into the percentage of couples that experienced severity of violence that was coded in the severe category at both pre-test and post-test and at both post-test and follow-up, the percentage of couples that experienced severity of violence that was coded in the minor-only category at both pre-test and post-test and at both post-test and follow-up, and the percentage of couples that experienced severity of violence that was coded in the no violence category at both pre-test and post-test and at both post-test and follow-up. If the severity of violence was coded in the no violence then severe category, no violence then minor category, or minor then severe category, it was recorded that the severity of violence increased. The percentage of couples that experienced

an increase in severity of violence from pre-test to post-test and from post-test to follow-up was then determined. This percentage was broken down into the percentage of couples that experienced severity of violence that was coded in the no violence category at pre-test and the severe category at post-test, the percentage of couples that experienced severity of violence that was coded in the no violence category at post-test and the severe category at follow-up, the percentage of couples that experienced severity of violence that was coded in the no violence category at pre-test and the minor-only category at post-test, the percentage of couples that experienced severity of violence that was coded in the no violence category at no violence at post-test and minor-only violence at follow-up, the percentage of couples that experienced severity of violence that was coded in the minor-only category at pre-test and the severe category at post-test, and the percentage of couples that experienced severity of violence that was coded in the minor-only category at post-test and severe category at follow-up. If the severity of violence was coded in the severe then minor category, severe then no violence category, or minor then no violence category, it was recorded that the severity of violence decreased. The percentage of couples that experienced a decrease in severity of violence from pre-test to post-test and from post-test to follow-up was then determined. This percentage was broken down into the percentage of couples that experienced severity of violence that was coded in the severe category at pre-test and the minor-only category at post-test, the percentage of couples that reported severity of violence that was coded in the severe category at post-test and the minor-only category at follow-up, the percentage of couples that experienced severity of violence that was coded in the severe category at pre-test and the no violence category at post-test, the percentage of couples that experienced severity of violence that was coded in the severe category at post-test and the no violence category at follow-up, the percentage of couples that experienced severity of

violence that was coded in the minor-only category at pre-test and the no violence category at post-test, and the percentage of couples that experienced severity of violence that was coded in the minor-only category at post-test and the no violence category at follow-up. In order to provide a bigger picture of the findings, a 95% confidence interval was calculated for each percentage.

CHAPTER 4: RESULTS

In this chapter, the results of the study are presented. First, a description of the 41 couples included in the analyses is given. Next, the results for psychological aggression are presented followed by the results for physical aggression. Within each form of violence the following are reported: the overall proportion of recurrence of violence at post-test and follow-up and the change in severity couples experienced from pre-test to post-test and from post-test to follow-up shown in percentages and including the 95% confidence interval for each proportion.

Demographics

Of the 41 couples included in this study, demographic information was available for 37 of them (90.24%). The length of relationship for couples ranged from 1 to 45 years with an average relationship length of 8.8 years. There were 3 participants out of the 37 (8.1%) that did not report the length of their relationship. The age of female participants ranged from 18 to 68 with an average age of 35.54 years. The female participants reported their race as follows: 83.8% Caucasian, 8.1% Hispanic, 2.7% Black, 2.7% Other, and 2.7% Mixed Race. Among the female participants 54.1% worked full-time, 21.6% work part-time, 13.5% stay at home with kids, 8.1% were unemployed, and 2.7% did not provide their employment status.

The age of male participants ranged from 24-74 with an average age of 37.59 years. The male participants reported their race as follows: 75.7% Caucasian, 10.8% Hispanic, 8.1% Black, 2.7% Other, and 2.7% Mixed Race. Among the male participants 89.2% worked full-time, 8.1% were unemployed, and 2.7% were students.

Psychological Aggression

First, I examined the overall recurrence of psychological aggression at post-test and follow-up. At post-test, the proportion of couples that reported experiencing at least one act of psychological aggression since pre-test was 97.56%. At follow-up, the proportion of couples that reported experiencing at least one act of psychological aggression since post-test was also 97.56%. I then calculated the proportions of couples that experienced psychological aggression that remained the same, increased, and decreased from pre-test to post-test and from post-test to follow-up. I further broke these proportions down into the different proportions of couples that experienced severity of psychological aggression that was coded in one category of severity at pre-test and then was coded in the same or a different category of severity at post-test (See Table 2) and the different proportions of couples that experienced severity of psychological aggression that was coded in one category of severity at post-test and the same or a different category of severity at follow-up (See Table 3). I also calculated the 95% confidence interval for each proportion.

Table 2

Change in Severity of Psychological Aggression from Pre-test to Post-test

Change in Severity	N	Percentage	95% Confidence Interval
No Change			
Severe-Severe*	29	70.73%	56.8% - 84.66%
Minor-Minor	2	4.88%	0.0% - 11.47%
None-None	0	-	-
Total	**31**	**75.61%**	**62.47% - 88.75%**
Increased			
None-Minor	0	-	-
None-Severe	0	-	-
Minor-Severe	0	-	-
Total	**0**	**-**	**-**
Decreased			
Minor-None	0	-	-
Severe-Minor	9	21.95%	9.28% - 34.62%
Severe-None	1	2.44%	0.0% - 7.16%
Total	**10**	**24.39%**	**11.25% - 37.53%**

*The first label indicates severity of psychological aggression at pre-test and the second label indicates severity of psychological violence at post-test.

As can be seen in Table 2, 75.61% of couples (N=31) reported severity of psychological aggression that remained in the same category of severity from pre-test to post-test. The majority of these couples (N=29), reported severity of psychological aggression that was coded in the severe category at pre-test and remained in the severe category at post-test. It is also important to note that none of the couples reported severity of psychological aggression that increased from pre-test to post-test. In addition, of the 24.39% of couples that reported psychological aggression that decreased from pre-test to post-test, the majority of them (N=9) reported experiencing psychological aggression that was coded in the severe category at pre-test and the minor category at post-test.

Table 3

Change in Severity of Psychological Aggression from Post-test to Follow-up

Change in Severity	N	Percentage	95% Confidence Interval
No Change			
Severe-Severe	23	56.10%	40.91% - 71.29%
Minor-Minor	7	17.07%	5.55% - 28.59%
None-None	0	-	-
Total	**30**	**73.17%**	**59.61% - 86.73%**
Increased			
None-Minor	1	2.44%	0.0% - 7.16%
None-Severe	0	-	-
Minor-Severe	3	7.32%	0.0% - 15.29%
Total	**4**	**9.76%**	**0.68% - 18.84%**
Decreased			
Minor-None	1	2.44%	0.0% - 7.16%
Severe-Minor	6	14.63%	3.81% - 25.45%
Severe-None	0	-	-
Total	**7**	**17.07%**	**5.55% - 28.59%**

As can be seen in Table 3, 73.17% of couples (N=30) reported experiencing severity of psychological aggression that remained in the same category of severity from post-test to follow-up. This included 56.10% of couples (N=23) that experienced severity of psychological aggression that was coded in the severe category at post-test and remained in the severe category at follow-up and 17.07% of couples (N=7) that reported experiencing severity of psychological aggression that was coded in the minor category at post-test and remained in the minor category at follow-up. There were few couples that reported an increase in the severity of psychological aggression they experienced from post-test to follow-up accounted for 9.76% of couples (N=4); 7.32% of couples (N=3) experiencing severity of psychological aggression that was coded in the minor category at post-test and the severe category at follow-up and 2.44% of couples (N=1)

experiencing psychological aggression that was coded in the no violence category at post-test and the minor category at follow-up. In addition, 17.07% of couples (N=7) experienced an increase in severity of psychological aggression from post-test to follow-up; 14.63% of couples (N=6) experienced severity of psychological aggression that was coded in the severe category at post-test and the minor category at follow-up and 2.44% of couples (N=1) experienced psychological aggression that was coded in the minor category at post-test and the no violence category at follow-up.

Table 4

Number and Percentage of Couples in Each Category of Severity of Psychological Aggression at Pre-test, Post-test, and Follow-up

	Pre-test		Post-test		Follow-up	
Severity	N	Percentage	N	Percentage	N	Percentage
Severe	39	95.12%	29	70.73%	26	63.41%
Minor	2	4.88%	11	26.83%	14	34.15%
No Violence	0	-	1	2.44%	1	2.44%

Summary of Psychological Aggression

When psychological aggression recurred, much of it remained in the same category of severity. The severity of psychological aggression remained quite high at both post-test and follow-up despite treatment. There was no increase in severity of psychological aggression reported from pre-test to post-test and very little increase in severity of psychological aggression reported from post-test to follow-up. There was some decrease in severity of psychological aggression that recurred. Overall, it appears that psychological aggression continued during and following treatment with much of it remaining severe.

Physical Aggression

I first examined the overall recurrence of physical aggression at post-test and follow-up. At post-test, the proportion of couples that reported experiencing at least one act of physical aggression since pre-test was 75.61%. At follow-up, the proportion of couples that reported experiencing at least one act of physical aggression since post-test was 56.10%. I then calculated the proportions of couples that experienced physical aggression that remained the same, increased, and decreased from pre-test to post-test and from post-test to follow-up. I further broke these proportions down into the different proportions of couples that experienced severity of physical aggression that was coded in one category of severity at pre-test and then was coded in the same or a different category of severity at post-test (See Table 3) and the proportions of couples that experienced severity of physical aggression that was coded in one category of severity at post-test and the same or a different category of severity at follow-up (See Table 4). I also calculated the 95% confidence interval for each proportion.

Table 5

Change in Severity of Physical Aggression from Pre-test to Post-test

Change in Severity	N	Percentage	95% Confidence Interval
No Change			
Severe-Severe	20	48.78%	33.48% - 64.08%
Minor-Minor	3	7.32%	0.0% - 15.29%
None-None	1	2.44%	0.0% - 7.16%
Total	**24**	**58.54%**	**43.46% - 73.62%**
Increased			
None-Minor	0	-	-
None-Severe	0	-	-
Minor-Severe	1	2.44%	0.0% - 7.16%
Total	**1**	**2.44%**	**0.0% - 7.16%**
Decreased			
Minor-None	1	2.44%	0.0% - 7.16%
Severe-Minor	7	17.07%	5.55% - 28.59%
Severe-None	8	19.51%	7.38% - 31.64%
Total	**16**	**39.02%**	**24.09% - 53.95%**

As can be seen in Table 5, 58.54% of couples (N=24) reported experiencing severity of physical aggression that remained in the same category of severity at pre-test and post-test; 48.78% of couples (N=20) experienced severity of physical aggression that was coded in the severe category at pre-test and remained in the severe category at post-test, 7.32% of couples (N=3) experienced severity of physical aggression that was coded in the minor category at pre-test and remained in the minor category at post-test, and 2.44% of couples (N=1) reported experiencing severity of physical aggression that was coded in the no violence category at pre-test and remained in the no violence category at post-test. Only 2.44% of couples (N=1) reported an increase in the severity of physical aggression from pre-test to post-test; they reported severity of violence that was coded in the minor category at pre-test and the severe category at post-test. It is also important to note that 39.02% of couples reported experiencing severity of physical

aggression that decreased from pre-test to post-test; 2.44% of couples (N=1) reported severity of physical aggression that was coded in the minor category at pre-test and the no violence category at post-test, 17.07% of couples (N=7) experienced severity of physical aggression that was coded in the severe category at pre-test and the minor category at post-test, and 19.51% of couples (N=8) reported experiencing severity of physical aggression that was coded in the severe category at pre-test and the no violence category at post-test.

Table 6

Change in Severity of Physical Aggression from Post-test to Follow-up

Change in Severity	N	Percentage	95% Confidence Interval
No Change			
Severe-Severe	16	39.02%	24.09% - 53.95%
Minor-Minor	4	9.76%	0.68% - 18.84%
None-None	8	19.51%	7.38% - 31.64%
Total	**28**	**68.29%**	**54.05% - 82.53%**
Increased			
None-Minor	2	4.88%	0.0% - 11.47%
None-Severe	0	-	-
Minor-Severe	0	-	-
Total	**2**	**4.88%**	**0.0% - 11.47%**
Decreased			
Minor-None	6	14.63%	3.81% - 25.45%
Severe-Minor	1	2.44%	0.0% - 7.16%
Severe-None	4	9.76%	0.68% - 18.84%
Total	**11**	**26.83%**	**13.27% - 40.39%**

As can be seen in Table 6, 68.29% of couples (N=28) experienced severity of physical aggression that remained in the same category of severity from post-test to follow-up; 39.05% of couples (N=16) reported experiencing severity of physical aggression that was coded in the severe category at both post-test and follow-up, 9.76% of couples (N=4) reported experiencing severity of physical aggression that was coded in the minor category at both post-test and follow-

up, and 19.51% of couples (N=8) reported experiencing severity of physical aggression that was coded in the no violence category at both post-test and follow-up. Also, only 4.88% of couples (N=2) reported experiencing an increase in the severity of physical aggression in their relationship from post-test to follow-up; both couples reported severity of physical aggression that was coded in the no violence category at post-test and the minor category at follow-up. It is also important to note that 26.83% of couples (N=11) reported experiencing severity of physical aggression that decreased from post-test to follow-up; 14.63% of couples (N=6) experienced severity of physical aggression that was coded in the minor category at post-test and the no violence category at follow-up, 2.44% of couples (N=1) experienced severity of physical aggression that was coded in the severe category at post-test and the minor category at follow-up, and 9.76% of couples (N=4) experienced severity of physical aggression that was coded in the severe category at post-test and the no violence category at follow-up.

Table 7

Number and Percentage of Couples in Each Category of Severity of Physical Aggression at Pre-test, Post-test, and Follow-up

	Pre-test		Post-test		Follow-up	
Severity	N	Percentage	N	Percentage	N	Percentage
Severe	35	85.37%	21	51.22%	16	39.03%
Minor	5	12.19%	10	24.39%	7	17.07%
No Violence	1	2.44%	10	24.39%	18	43.90%

Summary of Physical Assault

When physical aggression recurred during and following treatment much of it was coded in the same category of severity. The severity of physical aggression also remained fairly high at post-test and follow-up despite treatment. There was very little increase and some decrease in

severity of physical aggression from pre-test to post-test and from post-test to follow-up. Overall, much of the physical aggression that recurred during and following treatment remained at the same level of severity.

Summary

In summary, when psychological and physical aggression recurred during and following treatment much of it remained at the same level of severity. The severity of psychological aggression remained quite high despite treatment. There was no increase in severity of psychological aggression during treatment and only a small increase in severity of psychological aggression during the follow-up period. There was a small increase in severity of physical aggression during and following treatment. There was some decrease in severity of both psychological aggression and physical aggression during and following treatment. Overall, a fairly large number of couples reported experiencing psychological and physical aggression that remained in the same category of severity during and following treatment.

CHAPTER 5: DISCUSSION

Summary of Findings

Almost all (97.56%) of the 41 couples in this study reported experiencing at least one act of psychological aggression during treatment and during the six months after they completed the program. Overall, the severity of psychologically aggressive acts remained quite high during and following treatment. The study also found the recurrence of physical assault during and following the program to be quite high. About two-thirds (75.61%) of couples in this study reported experiencing at least one act of physical assault during the time they were participating in treatment. At follow-up, just over half (56.10%) of couples reported experiencing at least one act of physical assault during the six months following completion of the program. It is important to keep in mind that a recurrence in this study was defined as the occurrence of at least one act of aggression. Also, this study did not measure frequency of violent acts. It measured the severity of violent acts that recurred during and following treatment.

Another important finding is that much of the severity of violence was coded in the same category of severity for both psychological and physical aggression from pre-test to post-test and from post-test to follow-up. From pre-test to post-test, 75.61% of couples reported psychological aggression that was coded in the same category of severity (4.88% minor, 70.73% severe) and 58.54% of couples reported physical aggression that was coded in the same category of severity (7.32% minor, 48.78% severe). From post-test test to follow-up, 73.17% of couples reported psychological aggression that that was coded in the same category of severity (17.07% minor, 56.10% severe) and 68.29% of couples reported physical aggression that that was coded in the same category of severity (9.76% minor, 39.02% severe). This means that's despite treatment,

the severity of the psychological and physical aggression that recurred remained at the same level of severity.

One encouraging finding of this study was that very few couples reported an increase in the severity of violence in their relationship. From pre-test to post-test 2.44% of couples (N=1) reported experiencing an increase in severity of physical assault. From post-test to follow-up 9.76% of couples (N=4) reported experiencing an increase in the severity of psychological aggression and 4.88% of couples (N=2) reported experiencing an increase in severity of physical aggression.

These findings should be reviewed in the context of previous research exploring the outcomes of the Domestic Violence Focused Couples Therapy program (Stith et al., 2004; Stith et al., 2012). Overall, prior outcome research on the DVFCT program shows that violence in the couple relationship decreased. Male violence recidivism was measured for the multi-couple and single couple formats as well as the comparison group. At the 6-month follow-up, recidivism rates for each group was as follows: 25% for the multi-couple group, 43% for the single-couple group, and 66% for the comparison group. This means men in the multi-couple group were significantly less violent during the follow-up period than were men in the comparison group. Also, men in the single-couple format were not significantly less likely to recidivate than men in the comparison group. The previous study measured recidivism at the 2-year follow-up by contacting 19 out of the 30 female partners in the treatment group and asking them about recurrent violent incidents in their relationship. Only 2 of the 19 female partners reported experiencing a violent incident since the end of treatment indicating a 13% recidivism rate. Also at the 2-year follow-up, 4 of the 9 female partners in the comparison group were contacted. Half reported a violent incident since the end of treatment indicating a 50% recidivism rate.

Stith et al. (2011) reported on the outcomes of the program after more couples had been treated. There were fifty-five couples that completed the program and 6-month follow-up. Results indicated that for both men and women completing the program contributed to a "significant reduction in physical violence toward their partner, as measured by partner reports" (Stith et al., 2012, p. 231).

It is difficult if not impossible to compare these findings to the present study for several reasons. First, the present study measured the change in severity as opposed to the change in frequency. Second, the present study measured violence perpetrated by both male and female partners as opposed to the first outcome study, which only measured the recidivism of male violence. Third, unlike previous research, the present study did not differentiate between couples in the single-couple group and the multi-couple group. The only comparison that can be made is to state that previous outcome research found an overall decrease in frequency of recurrent violence while the present study found some change toward less severe violence during treatment.

The only other research we have to compare these findings to is data from studies of Batterer's Intervention Programs. A study by Gregory and Erez (2002) found a significant decrease in violence during the time that the "abuser" was participating in treatment. The researchers conducted in-depth interviews with 33 women whose male partners had participated in a batterer's intervention program. There was an 81% decrease in the frequency in which violent acts occurred. Once again, it is difficult to compare these findings to the findings of the present study because the study by Gregory and Erez measured the frequency of violent acts and the present study measured severity alone. In addition, their study used only the female partners'

reports as opposed to both partners' reports and measured male-only violence as opposed to bilateral violence.

A study by Gondolf (1997) examined the pattern of re-assault of batterers from four well established batterer's intervention programs. Eight hundred forty male batterers and their female partners were interviewed for the study. The study found that of the batterers who physically re-assaulted their partner during the 15-month follow-up period after intake, about half of them re-assaulted in the first 3 months following the completion of treatment. This is partially consistent with the finding from the current study in that just over half (56.10%) of couples reported experiencing at least one recurrence of physical assault during the six-month follow-up period. The differences are that the Goldolf study interviewed couples in which only the male partner participated in treatment as opposed to both partners participating in treatment, measured male-only violence as opposed to bilateral violence, and he found that half of the batterers had re-assaulted their partner during the first three months after treatment as opposed to the first six-months after treatment in the present study.

These findings indicate that partner violence, particularly psychological aggression, is difficult to change. This suggests that treatment interventions should be developed that specifically target psychological aggression. Also, when reviewing these findings it is important to consider the exclusion criteria for the original study. It is possible that couples who were excluded from the study due to the female partner seeking medical treatment following an incident with her partner and/or couples in which the female partner was afraid of speaking freely about the abuse in front of her partner, if included, may have experienced more recurrence of physical aggression and physical aggression that was more severe than was found in the current study.

Limitations of the Study

There are several limitations of this study. First, the sample size of 41 couples is relatively small and cannot be generalized to all couples experiencing interpersonal violence. In addition, the couples included in this study completed the 18-week treatment program and 6-month follow-up measures. There may be differences between these couples and couples who did not complete the program. For example, couples that completed the program may have been more likely to view the program as benefitting their relationship and therefore more likely to use the tools they learned during treatment to decrease the severity of violence in their relationship during and following the program. Finally, there were some moderate reliabilities among the CTS-2 subscales used in this study. The data might have been more accurate with a more reliable scale.

Future Research

Further research is needed to understand the change and lack of change in the severity of interpersonal violence. It would be interesting to know what helps couples decrease the severity of violence in their relationship. It would also be good to know how couples are able to keep the violence in their relationship from increasing. Additional research should be done to understand what keeps the severity of violence at the same level. Also, a study of the change in severity of violence during treatment in comparison to the period immediately following treatment is needed. It would also be beneficial to know what resources couples could use following treatment that would help them to continue reducing the severity of violence on their relationship once they are no longer in the program.

Clinical Implications

There are a number of important implications for clinicians working with this population to consider. Because this study found that between pre-test and post-test 97.56% of couples reported experiencing at least one act of psychological aggression and 75.61% of couples reported experiencing at least one act of physical aggression, clinicians need to be aware of the fact that violence can continue during the course of treatment. They should remain vigilant about assessing for the recurrence of violence in the relationship. The study also found the overall recurrence of both psychological and physical aggression to be quite high. Therefore, it is important that clinicians understand that interpersonal violence is difficult to stop, particularly psychological aggression. They should implement treatment interventions that specifically focus on psychological aggression, because the findings suggest that treating psychological aggression is equally as important as treating physical aggression. The study found that much of the violence remained at the same level of severity. Clinicians should explore with couples how the severity of violence in their relationship is maintained as well as what contributes to it increasing and decreasing.

Conclusion

The present study has shown that it is useful to examine the severity of psychological and physical aggression that recurs during and after couples participate in a treatment program focused on ending interpersonal violence. The study found the overall recurrence of psychological and physical aggression at post-test and follow-up to be quite high. The study also found that much of the violence remained at the same level of severity during and following treatment. This information may be helpful to clinicians working with couples that report experiencing violence in their relationship. It would be important to explore with couples how

the severity of violence in their relationship is maintained and what causes the severity to increase or decrease. It is also important that clinicians continue to assess for the presence of both physical and psychological aggression throughout the course of treatment.

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Appendix A

Office of Research Compliance
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MEMORANDUM

DATE: January 7, 2013

TO: Eric E McCollum, Jillian Amanda Drank

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires May 31, 2014)

PROTOCOL TITLE: Systemic Treatment of Batterers in Intact Relationships

IRB NUMBER: **05-453**

Effective January 7, 2013, the Virginia Tech Institution Review Board (IRB) Chair, David M Moore, approved the Amendment request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

http://www.irb.vt.edu/pages/responsibilities.htm

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:

Approved As:	**Expedited, under 45 CFR 46.110 category(ies) 6,7**
Protocol Approval Date:	**September 19, 2012**
Protocol Expiration Date:	**September 18, 2013**
Continuing Review Due Date*:	**September 4, 2013**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.