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**Comparison and Prediction of Completers and Non-completers of  
a Domestic Violence Program**

**by**

**April Ann Gerlock**

**A dissertation submitted in partial fulfillment of the  
requirements for the degree of**

**Doctor of Philosophy**

**University of Washington**

**1999**

**Program Authorized to Offer Degree: School of Nursing**

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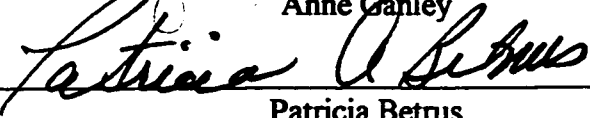
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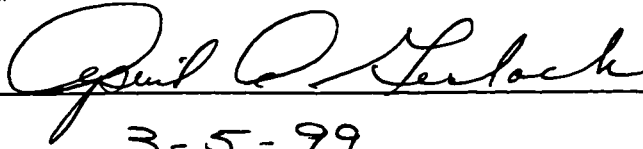
  
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**Abstract**

**COMPARISON AND PREDICTION OF COMPLETERS AND  
NON-COMPLETERS OF A DOMESTIC VIOLENCE  
PROGRAM**

**by April Ann Gerlock**

**Chairperson of the Supervisory Committee: Associate Professor, Patricia Betrus  
Department of Psychosocial and Community Health Nursing**

Sixty-two male batterers and 31 female victim/partners were recruited from an existing batterers' rehabilitation program from June 1997 through December 1997. Forty-eight men were veterans and 14 active duty. All subjects were interviewed at the initial or second contact with the program. In addition, the batterers were given eight research tools and the victims' two tools to complete. Of the 62 men who volunteered for the study, one man transferred to another duty station, 38 dropped out of the program, and 23 made the transition from the rehabilitation to maintenance phase of the program.

Using t-test and Chi-square analysis, comparisons were made between batterers' and victims' reports and completion status on the descriptive variables and research tools. A logistical regression was performed to predict completion/non-completion status. The results of the logistical regression was a Model Chi-square statistic of 31.08 ( $p = .000$ ). The model predicted 88.89% of the non-completers, 78.26% of the completers, and had an over-all predictive ability of 84.75% for the research sample. Completers were found to be more likely young, to be court-monitored, to have lower levels of stress (SOS Inventory) and post-traumatic stress (PCL), and to have higher levels of mutuality (MPDQ) in their relationships than non-completers.

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## Comparison and Prediction of Completers and Non-completers of a Domestic Violence Program

### Introduction

Domestic violence has received considerable attention in the past decade. Focus has shifted from domestic violence (DV) as being primarily a criminal-justice system problem, to a social problem, to more recently a health care problem (Salber, 1995). Women are overwhelmingly the victims of domestic violence perpetrated by men (Douglas, 1991; Wilson & Daly, 1993). Contrary to common beliefs about the risk of stranger violence, women are at greater risk at home with their family member or intimate partner (Gelles & Straus, 1989). In many cases, domestic violence may result in murder. In 1977-78, Dobash and Dobash reported that 70-80% of women murdered were killed by their husbands, other family members, or close male friends. Caputi and Russell (1992) report that women murdered by their husbands outnumber all other categories of female homicides. Thus, a primary threat to the health of young women is being murdered by their mate (Wilson & Daly, 1993; Campbell, 1992).

Battered women are also more likely to be seen for stress related ailments than non-battered women (Campbell & Sheridan, 1989; Noel & Yam, 1992), and more likely to have physical symptoms, higher levels of depression, anxiety, and low self-esteem (McCauley et al., 1995). In homes where there is domestic violence, family members visit physicians eight times more than does the general population (McPherson, 1994). Moreover, an estimated 3.3 million children in the United States between the ages of three and seventeen years are at risk of exposure to parental violence yearly (Carlson, 1984).

In the military, 95% of domestic violence incidents occur at home with victims reporting that 43% of the time children witness the abuse (Wasileski, Callaghan-Chaffee, & Chaffee, 1982).

In the past decade the body of research has grown in the area of health consequences to victims of domestic violence, but has gone mostly unstudied for the perpetrators of domestic violence. Clinical reports indicate that there are medical and mental health consequences to perpetrators as well as victims of domestic violence (Ganley, 1995). Batterers may seek health care for medical problems that are caused or complicated by their battering behaviors. Low self-esteem and depression, rather than a cause of domestic violence, may be a consequence (Goldstein & Rosenbaum, 1985).

There has also been an increasing interest in the prevalence of domestic violence in the active duty military and veteran populations. Miller and Veltkamp (1993) suggest that one-third of all military and post-military personnel may experience various forms of family violence. It has been reported that there is a general trend for more domestic violence in military families as compared to civilian families (Cronin, 1995). Few studies actually address the incidence of domestically violent behaviors in the male veteran population (Kulka et al., 1990; Gondolf & Foster, 1991; Petrik, Rosenberg, & Watson, 1983). Only one study examines rehabilitation effectiveness for male veteran batterers (Petrik et al., 1994). Thus, this study provides an opportunity to add to the knowledge base in better understanding the dynamics of domestic violence in the soldier/veteran clinical population.

It is difficult to determine the exact cost of direct medical and mental health care to

victims of domestic violence, but it has been estimated to be in the range of 1.8 billion dollars a year (Miller, Cohen & Wiersema, 1995). When the indirect costs of loss of work, decreased productivity at work, or the loss of an employee due to injury or death are tabulated, the financial toll mounts. This same question has not been examined for perpetrators of domestic violence. As the demand for dwindling health care dollars increases, health consequences of domestic violence for both the victim as well as the perpetrator must be considered (Ganley, 1995). As importantly, an understanding of how and if domestic violence rehabilitation works is needed to justify spending health care dollars for intervention with domestically violent men.

#### Definitions.

In this study, *domestic violence* refers to a pattern of assaultive and coercive behaviors that an adult male uses against his intimate female partner (Ganley, 1995). These behaviors are both psychologically and physically violent. They take the form of a pattern of multiple tactics and multiple episodes that result in maintaining power and control over an intimate partner. Physical violence includes such physical contact as hitting, punching, pushing, use of weapons, and many others. Psychological violence includes, among others: gestures, threats of violence, glares and other tactics resulting in intimidating or controlling the victim's behavior. *Battering* is the use of both physical and psychological violence.

For this study *batterer* refers to men who are both physically and psychologically assaultive toward their partner in heterosexual relationships.<sup>1</sup> *Victim* refers to the most

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<sup>1</sup> While battering also occurs in relationships with same-sex partners, it is not included in this study.

recent female partner who was victimized by the batterer. *Victim/partner* is used to indicate the changing dynamics in the relationship from one of being the victim, to that of partner. A *partner* status indicates that all forms of violence and control have stopped in the relationship. She is treated with respect and as an equal.

#### Study sample.

A sample of men who are batterers were recruited from a specialized one-year batterers' rehabilitation program. This program is available to eligible veterans and active duty military followed at the combined Madigan Army Medical Center (MAMC) and American Lake Division of the VA Puget Sound Health Care System (VAPSHCS) domestic violence program. Thus both active duty military and veterans were recruited for this study. Men who have completed the intensive rehabilitation phase and who have moved to the once-a-month maintenance phase are considered *rehabilitation completers*. Two groups of *non-completers* exist. Men who either choose to remove themselves from rehabilitation or are removed because of non-compliance with rehabilitation are considered *non-completers*. Those men who leave the program because of deployment or relocation are also *non-completers*, but are not statistically included as non-completers because the potential outcome is not known due to external circumstances.

#### Research purpose.

The main purpose of this research study is to compare rehabilitation completers to non-completers on the study variables and to develop a predictive model for who will complete the domestic violence intensive rehabilitation phase. This data will aid in better understanding the attrition from domestic violence rehabilitation programs. It will

ultimately help in developing criteria to modify the existing program to better reach difficult populations or to identify those for whom treatment is not appropriate.

The following are the specific research questions:

- I. Who will remain in domestic violence rehabilitation and who will leave?
  - A. Are there significant differences between the completers and the non-completers on the study variables?
  - B. Can completion or non-completion of the rehabilitation phase of the domestic violence program be predicted?

## Chapter 2

### Literature Review

Women are overwhelmingly the victims in domestic violence incidents (Douglas, 1991). In an early study by Berk et al. (1983), that analyzed injurious effects in 262 domestic disturbance incidents reported to the police, women were the victims 94% of the time. They challenged the myth of the battered husband syndrome stating that their data showed that it is women who are being battered. They compared their data to that of the National Crime Survey (U.S. Department of Justice, Bureau of Justice Statistics, 1980), which was collected from a nationally representative sample of households. The National Crime Survey data indicated that in heterosexual relationships, when victimization occurs, 95% of the time it is the woman who suffers. More recently, Bourg and Stock (1994) found that even in a city where there was little police education on domestic violence, police identified men as the primary perpetrator 88% of the time, and arrested men as the batterer 92% of the time.

In a review of the evidence on marital violence the authors conclude that women are more likely to be injured than men (Brush, 1990), more likely to seek medical assistance for DV-related injuries (McLeer & Anwar, 1989), and more likely to be the identified victim in national crime statistics on domestic violence (Dobash, Dobash, Wilson, & Daly, 1992). They highlight that women still constitute ninety to ninety-five percent of the victims in domestic violence incidents.

These findings are also consistent with those found in the military population. In a sample of 60 abused spouses seen at a Family Enrichment Clinic, 93% of the victims were

female, while only seven percent were male (Wasileski, Callaghan-Chaffee, Chaffee, 1982).

This data contradicts the frequently quoted work of Straus (1980; 1990; Straus, Gelles, and Steinmetz, 1980) whose results from a national US survey using the Conflict Tactics Scale indicated that violence within marriage is approximately equal for males and females. This work has been criticized, however, as failing to take the context of the violence into account, failing to determine injurious outcomes (Dobash & Dobash, 1988), failing to account for systematic biases in reporting, (Berk, Berk, Loseke, & Rauma 1983), and failing to account for self-defense as the most frequent reason for women's use of violence (Saunders, 1988).

### Characteristics of batterers

#### Demographic characteristics.

Contrary to early hegemonic views that class and race are causally related to domestic violence, research indicates that batterers are a heterogeneous group, and that batterer characteristics may be partially determined by the recruitment source (Hamberger & Hastings, 1991; Dutton, 1995). Based on 270 face-to-face interviews with domestic violence victims nation-wide, batterers are described as both white and non-white. However, white batterers were both more severely domestically violent (i.e. more likely to inflict serious injuries) as well as generally violent (Fagan, Stewart, & Hansen, 1983) when compared to non-white batterers. Berk et al., (1983) also found white males as more likely to inflict serious injury. This is consistent with the findings of Zacker and Bard (1977; Bard & Zacker, 1974) who compared police reports on domestic violence incidents

in Harlem to those in Norwalk. In doing so they were comparing DV assaults in a working class black area to that of a middle-class white neighborhood. Assaultiveness was higher in the middle-class white neighborhood than the working class black neighborhood (44% vs. 30% respectively).

These results are echoed in the military community (Cronin, 1995). In comparing randomly selected reports of intimate partner violence of parents (n = 202) by their adolescent children of both civilian and military families, no significant differences between whites and African Americans for incidents of domestic violence. In comparing military to civilian families, the percentage of domestic violence was higher for white military families than civilian, particularly slapping and hair pulling. No differences occurred between black military and civilian families.

While race does not appear to be a significant factor in determining causality, some believe that age is. Fagan, Stewart, and Hansen (1983) report that 67% of the batterers were in their early thirties or younger, and that the younger men were both more severely domestically violent as well as more generally violent. In examining domestic violence behaviors of 101 VA psychiatric and chemically dependent inpatients, the younger men were found to be more violent toward women than were the older men (Petrik, Rosenberg, & Watson, 1983).

Fagan et al. (1983) also found that batterers with a higher educational attainment and batterers who are unemployed inflict more severe injuries. While looking at the impact of arrest on recidivism, Sherman et al. (1992) had similar and dissimilar findings. They found arrest to actually escalate recidivism for unemployed batterers and batterers who

were high school dropouts. They theorized that the “socially marginal” had little to lose and so were more likely to re-offend. The differences in the findings of these two studies may be explained both by the design of the study as well as the research question. Fagan et al. (1983) were retrospectively looking at prior violent incidents, while Sherman and colleagues (1992) were prospectively looking at the impact of arrest on recidivism.

Dooley and Catalano (1984) caution us further about drawing relationships between demographic information and domestic violence. Problems arise when attributing individual behaviors based on aggregate data, such as is the case when explaining domestic violence as a consequence of poverty or unemployment. Dutton (1995) identifies poverty and unemployment as contributing factors to domestic violence, but these alone fail to account for ameliorative variables. Unemployment does not necessarily mean that a person is without financial means. The person may be retired, or as is often the case in the veteran clinical population, on disability. Nor does it account for the support individuals and families receive from their social and spiritual communities.

No singular characteristic is sufficient to predict battering behaviors. However, certain characteristics have been identified, in combinations, as relational to domestic violence including early exposure to violence (Egeland, 1993; Johnston, 1988) sex-role socialization (Finn, 1986; Birns, Cascardi, & Meyer, 1994), self-esteem (Johnston, 1988), and the use of drugs and alcohol (Flanzer, 1993; Gelles, 1993).

#### Substance usage and battering.

One of the strongest arguments made in seeking causality of domestic violence is that alcohol and other drugs are key causal agents of violence (Flanzer, 1993). Flanzer

states that, "alcoholism causes family violence" (1993, p. 171). Gelles (1993) maintains that alcohol and other drugs contribute, but are not the cause of violence.

In his typology of batterers, Saunders (1992) determined that the most violent men were those who were violent both inside and outside the home and who abused alcohol. In a cross-sectional study of four community-based, primary care internal medicine settings, recently battered women were more likely than non-battered women to have a partner abusing drugs or alcohol (McCauley et al, 1995). In examining 262 police reports of domestic violence incidents, Berk and colleagues (1983) found that a history of alcohol problems seemed to affect the severity of the female's injuries. However, whether either party had been drinking at the time had no impact, leading them to conclude that alcohol did not seem to play a major role in the battering incidents. They did not report on current or historical drug usage on either party.

Also, in contradiction to commonly held assumptions by police that alcohol causes domestic violence, Bard and Zacker (1974) found alcohol to be involved in the origin of the dispute in only 14% of police calls to the greater Harlem area. In the Norwalk area, one or the other partner in 34.4% of the time (Zacker & Bard, 1977) used alcohol. The investigators speculated that there might have been selective attrition in officer reporting incidence of alcohol. Once again, they did not look at the presence of non-prescription drug usage.

Research on domestic violence rarely includes information on the use of drugs (Kaufman, Kantor & Straus, 1989). Considerable debate exists regarding the role of drugs and aggressive behaviors (Gelles, 1993). While numerous studies indicate the

presence of alcohol, few incorporate measures of an alcohol usage threshold and none incorporate measures on other substance usage thresholds.

### Learning experiences and battering.

Another argument for causality of domestic violence is the intergenerational transmission of violence theory. This theory has received considerable support and traces some of its earliest influence from Bandura's social learning analysis of aggression (1973, 1983). Although Bandura did not directly discuss domestic violence, a social learning analysis of aggression included the origins of battering behaviors in terms of biological determinants, observational learning, and reinforced performance of the perpetrator within a social context (Ganley, 1989).

Another argument states that exposure to violence is a significant risk factor leading to violence (Egeland, 1993; Johnston, 1988). Kalmuss (1984) explored the relationship between childhood family aggression and severe marital aggression in the next generation in a sample of 2,143 adults. Her results indicated that witnessing hitting between parents is more strongly related to involvement in severe marital aggression than is being hit as a teenager is by one's parents. She also concludes that the witnessing of domestic violence predisposes both men and women to be as likely victims as perpetrators, and that the transmission of violence across generations is role specific and not sex specific. If women are as likely to be perpetrators as victims, and if men are as likely to be victims as perpetrators, her findings fail to account for why women are overwhelmingly the victims in domestic violence incidents.

Rouse (1984) also concludes that exposure to domestic violence in the family of

origin is a predictor for later domestically violent behaviors. She found observation of violence as strongly correlated with the use of abusive conflict tactics in domestic disputes, while neither victimization nor commission of violence against peers was significantly related to later domestically violent behaviors.

Dutton's (1995) work confirms that of Straus, Gelles, and Steinmetz (1980) who found that men who had witnessed parents physically attacking each other were three times more likely to have hit their own wives. Dutton found that batterers had higher rates of witnessing domestic violence and being the victim of family violence than did non-domestically violent men. He hypothesizes that abusive fathers not only model abusive behaviors, but they also contribute to the formation of a personality pattern that is associated with adult abusiveness, anger, depression, and mood cycles. He believes that a cold rejecting father has a strong relationship to a boy child growing up to become an abusive adult. He does not, however, report this to be role-specific as Kalmuss does. He is reporting on the process of becoming an abusive adult man.

These findings are further supported by the work of Hotelling and Sugarman (1986). In a meta-analysis of over 400 empirical reports on husband to wife violence, they found three risk markers to show a strong association with the use of violence toward wives. These included violence toward children, sexual aggression toward wives, and witnessing parental violence as a child or adolescent.

In addition to childhood exposure to domestic and family violence, Dutton (1995) identifies that violence is learned and reinforced in other ways. When men are successful at using violence to reinforce their dominance, and when they escape punishment for doing

so (as in the case of no arrest or conviction), this only further reinforces their continued use of violence. Miller and Veltkamp (1993) speculate that active duty military and veterans may engage in more “quick action” (p. 767) violence because of their military training and reinforced military experiences to do so. This theory, however, has not been tested or compared to non-military personnel.

In Saunders’ (1992) typology of batterers, the most violent men were those who were violent in and out of the relationship, who abused alcohol, and who had been severely abused in their family or origin.

#### Psychological characteristics and battering.

Some researchers look to personality traits and personality disorders as related to domestic violence (O’Leary, 1993; Hamberger & Hastings, 1991; Margolin, 1988), others to typologies of men who batter based on battering styles (Saunders, 1992; Shields, McCall, & Hanneke, 1988). Saunders classified three types of batterers based on data from 165 batterers entering a rehabilitation program. Of those three types, the second most violent batterer was described as the “emotionally volatile” (p. 273) type, and had higher scores on depression, jealousy, and anger. In another study, elevated levels of anger, hostility, and depression were also found in the sample of male batterers seeking rehabilitation (Maiuro, Cahn, Vitaliano, Wagner, & Zegree, 1988). When comparing self-referred to court-referred batterers, Dutton and Starzmoski (1994) identified more pronounced anger and depression in the self-referred group.

The role of self-esteem and battering has also been examined by a number of researchers. In addition to looking at the impact of observing or experiencing violence as

a child, Johnston (1988) investigated the relationship between spouse abuse and attitudes towards women and self-esteem by comparing abusive men with non-abusive men. While many of the abusive as well as non-abusive men had low self-esteem scores, there was a significant negative between self-esteem and battering. Low levels of self-esteem were correlated with high levels of battering. In addition, there was a strong relationship between self-esteem and spouse abuse for the men who were exposed to violence as children. Low self-esteem, in this study, is considered to be a consequence of exposure to violence in childhood and one of a combination of factors that is predictive of domestic violence.

Significant differences were also found in comparing the self-esteem of 20 domestically violent husbands with nonviolent husbands. The violent husbands had significantly lower scores on the self-esteem measure (Goldstein & Rosenbaum, 1985).

The relationship between self-esteem and battering is not so delineated in other studies. In a random sample of homeowners in a Midwestern city, self-esteem was only slightly related to level of battering (Rouse, 1984). Neidig (1986) reports that attitudinal variables do not seem to distinguish abusive males from non-abusive controls. Although he and his colleagues did find two statistically significant differences between the abusive sample and the non-abusive controls on the self-esteem measure and one item on the Generalized Expectations of Others Questionnaire (Neidig, Friedman, & Collins, 1986). In these studies on self-esteem and abuse, definitions of abuse varied widely from a serious physical injury to their female partner in the past year (Neidig, Friedman, & Collins, 1986), to slapped their wife any time during their entire relationship (Goldstein & Rosenbaum,

1985). Comparisons are difficult to make with such varied definitions of battering. Results may also be unreliable when identification of battering is based solely on self-identification and self-report as in the case of the study by Goldstein and Rosenbaum (1985).

Dutton (1995) examined psychological trauma. The Trauma Symptom Checklist (Briere & Runtz, 1989) was one of several instruments given to 140 men in treatment for domestic violence. This checklist was used to assess the level of emotional sequelae as a result of exposure to violence in the individual's family of origin. Dutton found a correlation among the childhood trauma, frequency and severity of battering, and his hypothesized borderline personality organization (BPO).

#### Relationship and battering.

As one might expect, both batterers and victims report greater marital discord than do partners in relationships where there is no violence. In a study by Neidig (1986, Neidig, Friedman, & Collins, 1986), batterers evidenced more dysfunctional marital relationships as measured by the Dyadic Adjustment Scale (DAS) (Spanier, 1976). In addition, they had particular deficits in their ability to reach agreement on important issues (Consensus) and the extent to which they engage in satisfying mutual activities (Cohesion). Similarly, in a study by Goldstein and Rosenbaum (1985), the abusive and nonviolent but maritally discordant groups scored significantly lower than the satisfactorily married group on the Short Marital Adjustment Test. Dutton (1995) found the batterers, the generally assaultive, and the maritally conflicted groups to score similarly on the DAS, but all the groups differed significantly from the happily married group in

their level of marital adjustment. In couples' ratings of marital adjustment, comparisons were made among physically abusive, verbally abusive, withdrawn /non-abusive, and non-distressed/non-abusive groups. The non-distressed group showed an overall marital satisfaction. The physically abusive and withdrawn groups showed the lowest levels of marital adjustment (Margolin, 1988). Perceived emotional, sexual, and intellectual intimacy was highest for the nondistressed couples and lowest for the physically abusive and withdrawn couples. Once again, the low level of marital satisfaction is more likely to be viewed as a consequence of domestic violence rather than a cause.

Waldo (1986) looked at relationship variables before and after rehabilitation of a group of batterers. There were significant gains on several of the scales such as improved communication, improved understanding on the non-conflict listening scale, improvement on the conflict listening task, and the conflict speaking task of the Communication Quality Scale and the Verbal Interaction Task. But there were non-significant trends towards improvement in the quality of their marital relationship and in their ability to express personal problems to their spouse.

Rather than mutually determined, domestic violence was viewed as individually determined in a survey of Army medical personnel (Hamlin, Donnewwerth, & Georgaulakis, 1991). One trait that may be considered in the individual determination of DV is male dominance. Male dominance in an intimate relationship is considered to be a predictor of battering. In measuring power motivation, Dutton (1995) administered The Thematic Apperception Test of n-power (McClelland, 1975; Winter, 1973) to wife assaulters, generally violent men, maritally conflicted men, and happily married men.

There was a significant difference between the wife assaulters and the happily married men when the stimulus materials were male-female scenes. Dutton states that this suggests that domestically violent men have a stronger need to dominate in a male-female context than do men who are happily married.

In examining police reports on domestic violence calls, Berk et al., (1983) concluded that male dominance increases violence. In a relationship where the man is dominant, the woman is more likely to be seriously battered.

Clinical observations also identify dominance and control as key characterizations of batterers. Ganley (1981) describes batterers as desiring to be in charge of external situations. Their drive to maintain this dominance of others (primarily their female partner) results in their use of aggression and violent tactics. Gondolf (1985) describes the men enrolled in RAVEN (Rape and Violence End Now) as “fighting for control” (p. 51). He describes these men as overly socialized into a traditional male role predicated on control, which includes “a privilege of being in authority” (p. 51).

Perilla, Bakeman, and Norris (1994) compared levels of mutuality for 30 self-identified battered Latina immigrants to 30 non-battered Latina women. Mutuality was measured by the Mutual Psychological Development Questionnaire (MPDQ) (Genero, Miller, & Surrey, 1990), that measures different aspects of the relationship, such as empathy, communication, understanding, and mutual respect. The battered women experienced higher levels of stress, had lower self-esteem, and perceived less mutuality in their primary relationships than the comparison women. After controlling for the effects of intoxication, the level of mutuality accounted for an additional 31% of the variance.

While traditional attitudes towards gender roles were unrelated to battering, the man's drinking habits and the woman's perceptions of the level of mutuality between the couple appeared to be important predictors of abuse in Latino households. The authors recommend that future studies should examine levels of mutuality from the male batterer's perspective.

Taking a cross-cultural perspective, Levinson (1989) examined kinship variables in 90 different societies and the level of domestic violence. He concluded that "wife beating is likely to be frequent ...when men control the wealth, have the final say in household decision making, and are able to prevent their wives from escaping from the marriage through divorce" (p. 73). Adler (1981) found that domestic violence occurs more frequently in marriages where the husband dominates the domestic decision-making. Bowker (1983) reported that battering decreases in frequency when decision making becomes more egalitarian.

#### Police/judicial response and battering.

Sherman and Berk (1984) created an extraordinary impact on public policy on domestic violence. As a result of their study on police intervention in domestic violence incidents, police departments started implementing a policy of probable cause as grounds to arrest. They conducted a randomized design where police were instructed to arrest, separate the couple, or conduct mediation. The recidivism rate of the arrested men was significantly lower than for either the separation or mediated interventions at the six-month follow-up. Recidivism rates were based on both police and victim report. However, they did not take into account whether couples had separated or divorced when

conducting their follow-up. They also did not measure other non-physical forms of battering.

Attempts to replicate this study were met with mixed results, however. In a study conducted by Dunford, Herizinga, & Elliott (1990), arrest neither increased nor decreased subsequent violence as compared to separation and/or mediation. In another randomized design, Sherman and colleagues (Sherman et al., 1992) examined this question again for a certain subcategory of DV offenders. The initial effect of the arrest was suppression in recidivism. However, seven to nine months after the initial event, the arrest group had a higher rate of domestic violence than the non-arrest group. Arrest appeared to escalate violence for those that were unemployed and/or high school dropouts. They concluded that arrest does not work for those who have little to lose. Once again, they did not report on judicial consequences, so we are without information on all other factors that could affect outcome, such as jail time, prosecution, judicial response, mandated rehabilitation, or victim services.

Jaffe et al. (1986) looked at the impact of police charges and the incidence of battering. They examined both police records and conducted interviews with wives of the men who had been arrested for domestic violence. When the police charged the man with domestic violence, there was a significant decrease in post-charge violence (as measured by the number of new contacts or wife's report of his violence) in the ensuing year. Compared to the preceding year, violent acts had decreased by two-thirds.

The prospect of being arrested for domestic violence, even in states where there is a mandatory arrest for probable cause law, may be slim. In reviewing all domestic

violence reports over a one-year period, Bourg and Stock (1994) found that less than one third of the police responses on a domestic violence call ended in arrest. Even with serious felony level offenses, only 37.4% resulted in arrest.

Taking it to the next level, judicial response, Ford and Regoli (1992) looked at four different judicial policies. The policies included no prosecution, pretrial diversion, prosecution, and rehabilitation. They found that just going through with the initial hearing decreased future acts of violence. Interestingly, they also found that dropping the charges at the victim's request resulted in the lowest percent of new reports of violence in a six-month follow-up period.

The probability of a case even going to court, however, is slim. Dutton (1987) devised an equation where he looked at the probability of detection (6.5 %), with the evidence for probable cause for arrest (21.2 % of the time) and found that, weighted across averages, the rate of arrest is about 7.3 %. By reviewing several empirical studies, he determined that the probability of the case then going to court was about 67 %, with only an eight- percent chance of conviction.

Studies that look only at arrest fail to take into account the effects of a combined, coordinated community response that includes victim advocacy, prosecution, harsher penalties, and court-mandated rehabilitation (Tolman & Edleson, 1995; Gerlock, 1997). To investigate possible pro-arrest sanctions, Steinman (1989) conducted a study that compared cases before and after implementation of a coordinated community effort. Police actions that were not followed up with other sanctions led to an increase in violence. However, arrest, in coordination with other judicial efforts became a significant

deterrent. This deterrent effect was also noted by Syers and Edleson (1992) when they looked at police visits combined with the arrest of the perpetrator, and followed by court-mandated treatment. This combination was found to be significantly more likely than other combinations of judicial actions to end repeat incidents of domestic violence.

#### Health consequences and battering.

The health consequences of domestic violence to victims are tremendous. Victims of domestic violence seek assistance for injuries, medical problems, obstetrical or gynecologic manifestations, and psychiatric presentations (for a review see Warshaw, 1995). In the past decade the body of research has grown in the area of health consequences to victims of domestic violence, but has been mostly unstudied for the perpetrators of domestic violence. Clinical reports indicate that there are medical and mental health consequences to perpetrators as well as victims of domestic violence (Ganley, 1995). Batterers may seek health care for medical problems that are caused or complicated by their battering behaviors. Men who are domestically violent may also experience more stress than non-domestically violent men (Straus, Gelles, & Steinmetz, 1980). Low self-esteem, rather than a cause of domestic violence, may be a consequence (Goldstein & Rosenbaum, 1985).

One study exists that examines the health consequences of domestic violence for both perpetrator and victims, and compares them to maritally satisfied community controls. Cascardi, Langhinrichsen, and Vivian (1992) compared 93 couples seeking therapy at a marital therapy clinic to 16 maritally satisfied matched control couples. Using both husband and wife reports of the other's behaviors, and by using self-reports on the

Modified CTS, the prevalence of domestic violence in the marital therapy group was assessed. They were then classified as mildly or severely aggressive. The over-all findings on husband-to-wife violence indicated that 61% of the couples reported at least one act of H → W aggression in the past year. The over-all rate of wife-to-husband violence in the past year was reported to be 62%. The authors concluded that the rates of H → W aggression were nearly equal to the rates of W → H aggression, and of the “aggressive couples” (p. 1181), 86% reported reciprocal aggression. However, when they looked at the injurious outcomes of the aggression, the women were significantly more likely to sustain severe injuries than the husbands. Although the husbands’ injuries were less, some sustained injuries as well. Two percent of the husbands, who experienced mild aggression from their female partner, reported sustaining broken bones, broken teeth, and/or injury to sensory organs. This study examines the physical consequences of the results of the domestic violence perpetrated by either partner, rather than the consequences of personal physical injury as a result of the perpetrator’s violence. Thus, the husbands were injured by their wives during the domestic violence incident. The study did not measure self-inflicted injuries as a result of domestic violence. No mention is made of whether self-defense was determined as reason for the women's violence.

The researchers then compared the “aggressive couples” to the discord only and community control spouses, and found that both husbands and wives reported significantly more depressive symptoms ( $p < .09$  and  $p < .02$ , respectively) than the community controls. Contrary to their hypothesis, they did not find that either the wives or the husbands of the aggressive group were more ill or more likely to be taking medication

than those who were in the discord or the community control groups. The authors suggest that when domestic violence occurs, the risk factor for health consequences and distress of both the victim and perpetrator must be considered.

### Batterers' Rehabilitation Programs

Batterer's rehabilitation programs have been evolving over the past 20 years and have been in existence in the United States since mid to late 70's (Pirog-Good & Stets-Kealey, 1985). Approaches to domestic violence intervention include couples counseling (Deschner, 1984; Neidig & Friedman, 1984), grass-roots programs that emerged as a result of the batter women's movement (Adams & McCormick, 1982), anger control (Deschner, 1984), community based interventions of police response and arrest (Sherman & Berk, 1984), programs that offer a combination of skills training and sex role re-socialization (Edleson, 1984), and intervention models shaped by both social learning theory and feminist theory (Pence & Paymar, 1986; Ganley, 1981).

The majority of the published articles describing batterers' treatment utilize some variation of cognitive-behavioral or social learning approach (Tolman & Edleson, 1995). Purely cognitive-behavioral approaches have been criticized as failing to incorporate a gendered analysis of battering (Gondolf & Russell, 1986; Tolman & Saunders, 1988). In the past ten years, many programs have incorporated both social learning theory and profeminist content (Ganley, 1989; Tolman & Edleson, 1995).

Early batterer programs adapted assumptions about anger and aggression in designing anger control rehabilitation strategies (Gondolf & Russell, 1986). The goal of treatment in the traditional anger management approach is to help individuals towards self-

control techniques for regulation of the emotion of anger and associated behaviors. The anger response is conceptualized as having physiological arousal translated into possible responses. In men, the behavioral response is most likely aggression because it is socially sanctioned and seen as normative in the United States (Greenblat, 1985).

Anger management strategies include identification of the external provocation or trigger, awareness of the emotional and physiological state, and self-regulatory activities to de-escalate the emotional and physiological response (Novaco, 1975). Identifying the persons and situations that trigger anger are necessary components of this treatment. Self-regulatory activities may include relaxation techniques as in “stress inoculation” (Novaco, 1977), cognitive mediation in the form of self-talk, time outs, and anger logs (Ganley, 1981).

The traditional anger control programs, however, fail to account for the continued patterns of psychological abuse in the context of intermittent physical violence. While these rehabilitation approaches are often effective in decreasing the frequency of physical violence, battered women complain that continued threats of physical violence reminds them that the violence is never in the past and that the pattern of coercion continues (Barnett & LaViolette, 1993).

In the past ten years a model for domestic violence intervention has emerged that draws on the assumptions of feminist theory. This model differs from previous ones by situating domestic violence in a societal context that has historically sanctioned violence towards women. A feminist analysis of domestic violence requires the acknowledgment of the differences between victim and perpetrator, the gender-specific nature of battering,

and views domestic violence as an issue of power and control of the female partner (Ganley, 1989). Pro-feminist rehabilitation models place women's safety first and target the pattern of behaviors that are instrumental to gain control over a female partner. This dynamic of control and dominance is central to an understanding of male battering (Ganley, 1989; Pence & Paymar, 1993).

Drawing on the assumptions of feminist theory, programs such as the “Duluth Model” (a curriculum-based program developed by the Duluth Domestic Abuse Intervention Project, and referred to as Education Groups for Men Who Batter: The Duluth Model; Pence & Paymar, 1993) have as a goal stopping both physical and psychological violence. This model conceptualizes violence as stemming from the abuse of power and control in intimate relationships. In pro-feminist intervention logs are also used, but instead of anger logs, these logs are designed to examine all the controlling and abusive behaviors of the batterer in light of beliefs that facilitate his behaviors.

Feminists argue that battering is not an anger control problem. Rather, it is a pattern of behaviors that result in the perpetrator gaining control over a partner (Ganley, 1989). In the pro-feminist model, anger is secondary. Anger is a means to intensify abuse, express frustration at losing control, or to retaliate against a woman's resistance to the battering (Gondolf, 1985). Paymar (1993) views anger as an emotion men use when things are not going their way.

Gondolf and Russell (1986) identify shortcomings of anger control from a feminist analysis. A strategy in anger management is to identify a trigger to an angry response. By doing so, it implies that the victim provoked the anger and precipitates the abuse. Anger

control fails to account for the premeditated controlling behaviors associated with battering. The externalization for their battering further diffuses the responsibility of the abuse and prolongs the batterer's denial. Gondolf and Russell (1986) further assert that anger control too frequently lets the community off the hook "...[by implying] a problem of psychologically deficient men who lose their temper and impulsively abuse rather than of inadequate protection services, reduced opportunities, and second class citizenry for women" (p. 4). Pro-feminist rehabilitation models also address the importance of community involvement in the form of arrest, probation monitoring, and mandating rehabilitation for perpetrators as well as advocacy services for victims.

Another therapeutic approach to batterers' interventions is working with couples' groups and couples' treatment. While most of the articles focus on groups for batterers, there has been some research on conjoint couples counseling and multi-couple group interventions. Once-again the approach is largely cognitive-behavioral. While the goal of stopping all forms of domestic violence is the same as other cognitive-behavioral batterers' groups, the theoretical underpinnings differ.

Neidig and Friedman, (1984) introduced a program for "abusive couples" (Neidig, 1986, p. 275) called the Domestic Conflict Containment Program (DCCP). Batterers' intervention programs---anger management, profeminist, or otherwise, have focused on the male batterer as the source of the DV problem, and as the person in the intimate dyad that needs to change. The philosophy behind the couples intervention approach is that the DV problem lies within the context of an ongoing relationship, and so each person's behavior is contingent on the behavior of the other person (Neidig & Friedman, 1984).

The role of victim or perpetrator may shift depending on the outcome of the interaction. A woman returning to a domestically violent relationship, in part, supports this philosophical belief. However, research into why women return to domestically violent relationships indicates that financial dependence and the fear of never being able to escape their abuser are the two primary reasons women return, rather than a desire to be in an abusive relationship (Browne, 1987; Barnett & LaViolette, 1993; Gondolf & Fisher, 1988; Gondolf, 1988).

The DCCP group approach is a skills-building format for abusive couples. A large segment of the ten-part program is focused on anger control strategies. Other group content includes sex role stereotyping, communication, understanding violence, stress and violence, and understanding conflict (Neidig & Friedman, 1984).

Measuring success of the couples-based approaches raises both questions and concerns. In a study by Lindquist et al. (1983) of an individual couples-based approach, the reported recidivism rate for physical abuse was 100%. At a six-month follow-up, all eight couples in the study reported subsequent violence. Of the 50 couples that Taylor (1984) worked with, 35% reported new violence at the six-month follow-up. He does not state how this information was obtained, or who reported.

Neidig and Deschner report more success in their multi-couple group approach (Neidig et al., 1985; Deschner, 1984). Neidig and colleagues found a 13% recidivism rate of physical violence at the four-month follow-up. They did not state who reported at the time of follow-up. Deschner reported a 15% recidivism rate at the eight-month follow-up. Of the 15 couples who completed the 10-session program, eight were violence free. Five

couples later reported incidents of grabbing or slapping, however, he considered them to be violence free because these were "minor" incidents.

In the most recent study examining a couples-based approach (Rynerson & Fishel, 1993), neither physical nor psychological violence was even measured as an outcome of success. Furthermore, over 50% of the female partners dropped out of the program for "unknown reasons". Obviously these studies failed to capture both the dynamics of battering as well the potential dangerousness of such an approach to the female partners. Whatever the philosophical belief, women are still the ones to be seriously injured or killed in a domestic violence dispute. The success of a program needs to be measured in terms of its impact on women's safety.

#### Attrition in DV rehabilitation programs.

The issue of attrition in batterers' intervention programs is of critical importance to victims. In a study by Lund, Larsen, and Schultz (as cited in Hamberger & Hastings, 1989), the authors noted an increased potential for violence when men drop out of domestic violence rehabilitation. Hamberger and Hastings (1988) found that rehabilitation dropouts had higher rates of repeated violence up to one year following (based on police reports). Large numbers of men contact rehabilitation programs and may even attend a few of the sessions, but fail to complete rehabilitation (Harrell, 1991). It is not uncommon for one-third to one-half of the men to dropout after the first session of a program (Feazell, Mayers & Deschner, 1984). Attrition rates as high as three-fourths of the participants dropping out between assessment and completion of the program, have been reported (Grusznski & Carrillo, 1988). Few studies have included measurement on mediating variables that may aide in

predicting who will stay in rehabilitation and who will dropout, thus providing valuable information to better tailor interventions.

In a national survey of batterers' intervention programs, Pirog-Good and Stets (1986) found that programs with the greatest potential for program completion were those that were short in length (thus providing less opportunity for dropouts), those that utilized referrals from the legal system, and those that provided the service for a reduced or no fee. They also found that white clients were more likely to dropout as well as blue collar and unemployed participants. In looking at marital status and education, these were determined to have no effect. Reporting aggregate data impairs the usefulness of this data.

In a prospective design, Gruznski and Carrillo (1988) reported on the characteristics of rehabilitation program completers and dropouts. The batterers' intervention consisted of a 32-session program. Fifty-nine of their participants completed all phases of the program, 40 completed the intake only, and 76 participated in some of the program. In addition to demographic information, they compared the three groups on the following measures: the Modified Conflict Tactics Scale (CTS); the Fundamental Interpersonal Relations Oriented-Behaviors Scale (FIRO-B); and the Attitudes Towards Women Scale (ATW). They performed a discriminant function analysis and found seven variables to significantly distinguish completers from dropouts. These variables included the use of indirect threats, history of abuse victimization, witnessing domestic violence in their family of origin, educational attainment, employment status, FIRO-B control expressed sub-scale, and the number of children in their family. This combination of variables correctly classified 64.4% of those completed the program, 55% of those who completed only the assessment, and only 25% of those who

completed some part of the program. The predicted group membership was more successful for the completers than for those who dropped out.

Hamberger and Hastings (1989) also conducted a comparison of completers and dropouts and a prediction of program completion based on demographic and personality variables. The intervention program consisted of three intake-orientation sessions, 12 group cognitive-behavioral intervention sessions, and one post-intervention evaluation session. Their success in predicting completers and dropouts was better than Grunznski and Carrillo. Their sample included 88 completers and 68 dropouts. They defined dropouts as anyone who attended at least one assessment and then dropped out during any time in the program. Their dropouts tended to be younger and had lower employment levels. They also had higher pre-treatment levels of police contact for drug and alcohol-related offenses, as well as miscellaneous offenses, but not for violent offenses. On the personality variables, the dropouts had higher levels of borderline and schizodal tendencies. The completers, on the other hand, had lower levels of psychopathology.

In this same study a discriminant function analysis was then conducted to predict who would complete and who would dropout. Hamberger and Hastings successfully predicted 71% of the dropouts on the following variables: they were not court or probation mandated, blacks were marginally over-represented as dropouts, partial support for younger participants, less well educated, and less well employed, higher average annual crime rates, and higher levels on the Millon Clinical Multiaxial Inventory (MCMI) alcohol scale. The best predictors from the combined overall discriminant function analysis were voluntary status, race, employment, MCMI-alcohol scale, and the average annual pre-treatment miscellaneous criminal offenses.

These successfully predicted 76% of the completers and 71% of the dropouts.

The final study done on attrition was one by Saunders and Parker (1989). The intervention program was a 12-week, cognitive-behavioral oriented group. One hundred and fifty-six men entered the program, 97% of them court referred. They looked at attrition that occurred during the four to six week assessment phase, between assessment and entering treatment, and during the treatment phase.

In this study the authors performed a multiple regression analysis on the demographic variables including age, education, income, minority status, and employment status. In addition they looked at levels of violence by administering a modified CTS. Lastly they added the referral source (court mandate) to uncover any suppression effects. Variables, other than the referral source, accounted for only six percent of the variance in explaining completion of the assessment phase. Men who reported more frequent violence and lower rates of life-threatening violence were more likely to complete the assessment. The older participant and those with lower incomes were also more likely to complete the assessment phase. The referral source had a small non-significant relationship with completing assessment.

Predicting dropout at any phase in the program was better than the prediction from the assessment phase, and accounted for 15% of the variance. Men who completed any phase reported more frequent, but less severe abuse. When referral source was added it had a slightly positive relationship with completion of any phase.

The independent variables' ability to predict program completion remained low. Age was the strongest single predictor. The level of violence had the same relationship as the previous two comparisons. Minority status maintained a relatively high relationship with

program dropout.

The authors then looked at three different two-way interaction terms to determine their relationship to completion. They looked at referral source and age, referral source and severe violence, and referral source and education. Completion rate was highest for the voluntary clients with more than a high school education, and lowest for voluntary clients with 1 - 12 years of education. Completion rates were also highest for the voluntary clients who reported no severe violence and lowest for voluntary clients who reported severe violence. Completion rates were about the same for the involuntary clients with severe violence and 40% lower for the involuntary client (than the voluntary client) was with no severe violence. In looking at the interaction of referral source and age they found that completion rates were higher for involuntary, 25 years and younger clients than for the voluntary 25 years and younger clients. Thus they summarized that the voluntary clients older than 25 with more than a high school education were seven times more likely to complete assessment and treatment than voluntary, young clients with no college education.

In a second study, Saunders and Parker (1989) looked at the overall number of sessions completed. Their sample size was 104 completers and 29 dropouts. They also looked at the referral source categorized as deferred prosecution, probation or parole, or voluntary through other agencies. The authors conducted a bivariate analysis and compared the three types of referrals and those who completed and those who did not.

Saunders and Parker found that the completers were significantly more likely to be employed, older, and have higher incomes. They found no difference on the referral source between program completers and dropouts. Completers were significantly more likely to

report anger in work and friendship situations and less marital agreement. The strongest bivariate and multivariate predictor of attendance was the lack of agreement in the relationship. Of the mandated referrals, completers were more likely to be young and non-college educated. Voluntary clients who were older than 25, who had some college education, and who did not report severe violence, were more likely to complete the program.

In the above study it is evident that they found subgroups of batterers who were more likely to complete based on the combination of variables including education, age, and mandated or voluntary status. Mandated treatment improved program completion for the young non-college educated, but not so for the older than 25 age group with some education. They appeared to be more internally motivated to complete the intervention program.

In the four studies cited there is some conflicting information. While Pirog-Good and Stets (1986) found completion to be better when clients are referred from the criminal justice system, Saunders and Parker (1989) found this only to be true for the younger less educated clients. Hamberger and Hastings (1989) also found the voluntary clients as more likely to dropout. The younger, less educated, and those with lower levels of employment were also found to be more likely to dropout. Minority status and completion or dropout had varied results. Only the studies by Saunders and Parker and Grunznski and Carrillo looked at levels of violence. Their results were non-conclusive. Only Hamberger and Hastings looked at the issue of substance by including the MCMI alcohol scale, and only they found a relationship to personality variables. In the studies conducted thus far, only age, educational level, employment level, and court-mandated status maintains a common thread through all. And in each study they did a better job of predicting completion than predicting dropout. Some

variable or combination of variables seems to be missing in better predicting dropout from batterers' rehabilitation programs. In the veteran/soldier population, the issue of substance usage is critical.

#### Characteristics of veteran/active duty batterers

Little research exists on domestic violence in the veteran or military population. Only one study has been conducted examining the effectiveness of specialized batterer's rehabilitation for veterans who batter (Petrik et al., 1994). In two recent studies examining veterans' response to anger management intervention, domestically violent veterans were either excluded (Gerlock, 1994) or were not dealt with as a separate group (Novaco, May conference, 1993).

However, evidence exists that indicates the seriousness of this problem for the veteran population. Vietnam Theater veterans with posttraumatic stress disorder (PTSD) report statistically higher rates of domestic violence than their non-PTSD counterparts (Kulka et al., 1990). Sixty-four percent of the combined PTSD/non-PTSD (N = 373) sample reported committing acts of physical violence towards their partner in the past year. Further evidence addressing the presence of domestic violence in the "treatment-seeking" veteran population exists as well. In a sample of 218 patients in a VA alcohol rehabilitation program, more than 33 percent reported assaulting their wives or partners at least once in the previous year, and 20 percent reported committing severe assaults (Gondolf & Foster, 1991). In the same study, on further examination of a subsample of veterans' clinical records, clinicians had identified domestic violence for only 20 percent of the subsample. In addition, a recent national VA survey was initiated in response to a

congressional inquiry about what the VA is doing to address this problem (Memorandum, August 2, 1995). Of those medical centers that responded to the VA FORUM survey, six identified having formal domestic violence programs, the remainder indicated that domestic violence was seen frequently, and managed through other means including anger management, couples counseling, individual counseling, and drug and alcohol counseling. Other responses from mental health treatment providers indicated that two-thirds of couples presenting with marital problems also report some form of domestic violence in the past year. A survey conducted at the Memphis, TN, VA, revealed that 50% of their outpatient psychiatric population reported that physical violence had occurred. Of those reporting physical violence, only half (25%) had reported this to their therapist. Although few in number, these studies indicate that domestic violence is a problem for the veteran population and is probably under-reported.

In a recent study conducted at the Minneapolis Veterans Affairs Medical Center (Murdoch & Nichol, 1995), 487 female veterans responded to an anonymous questionnaire. Twenty-four percent of respondents under the age of 50 reported domestic violence in the past year. Of those who reported domestic violence in the past year, 78% reported that at least one assault was life threatening. They were also twice as likely to report a history of anxiety and depression and more lifetime surgical procedures than those who had not indicated any domestic violence. These women reported poorer health habits, more emergency department visits, more hospitalization within the past year, and greater enrollment in the Mental Health Clinic.

Active duty military life is believed to produce unique stresses that place personnel

at increased risk for domestically violent behaviors. These stresses include frequent moves, deployment with prolonged separation from family members, financial stress, separation from extended family, combat training and exposure to violence (Waldo, 1986; Miller & Veltkamp, 1993; Cronin, 1995). The incidence of domestic violence is cited as being higher in military than civilian families (Cronin, 1995; Griffin & Morgan, 1988). As with other populations, domestic violence is believed to be underreported. This underreporting is attributed to circumstances that, once again, are believed to be unique to the military culture. Nichols (1982) states that domestic violence is less likely to be reported because of the multiple consequences for the soldier, including being chaptered out of the military. In addition, historically family life has been molded to the needs of the military, placing the military goals first and family issues as a lesser priority (McNelis, 1985).

In a study of 60 abused spouses seen at a Family Enrichment Clinic for spouse abuse, the vast majority of victims were female (93%). Twenty-five percent of the batterers did not graduate from high school, and the overwhelming majority was of enlisted ranks with only 2% of the batterers identified as officers. In addition, 42% of the batterers had consumed alcohol within three hours of the incident (Wasileski, Callaghan-Chaffee, & Chaffee, 1982). Of the victims, 51% sought medical treatment following a battering incident, and 86% of the victims reported multiple methods to inflict harm. The overrepresentation of enlisted is believed to be a systematic bias in reporting of incidents, with reporting of DV incidents more likely to be suppressed in officer families.

Cronin (1995) reports that domestic violence is greater in military than civilian

families. By randomly sampling students and obtaining confidential reports of witnessed violence between their parents, the results are somewhat different than those of the treatment seeking samples. Cronin found that domestic violence was significantly higher in commissioned officers as compared to the enlisted personnel. Students whose parent was commissioned reported witnessing significantly more slapping and hair pulling than students whose parent was enlisted.

In a survey of 418 Army Medical Department personnel, respondents indicated that they believed domestic violence to be the third most common social problem in the military community (Hamlin, Donnewerth, & Georgoulakis, 1991). Although they placed DV third and after child abuse, there were actually more reported incidents of DV than child maltreatment across the Army. They also believed domestic violence to be more common in civilian families than military ones. Additionally, based on their experiences with domestic violence, they believed it to be both individually determined and initiated, and characterized by repeated incidents. Respondents also indicated that they believed that women stay in domestically violent relationships because of lack of financial resources and family circumstances. However, respondents were less well informed about the programs and services available within the Army for victims and perpetrators of DV. The authors suggested that family advocacy curriculum should be incorporated into all of the medical specialty courses offered.

### Significance

The VA health care system has done little to formally address the problem of domestic violence, despite the widespread need as indicated by the national survey

conducted on the VA FORUM, and despite the dire consequences for female veterans. This study will contribute both to a national dialogue about why men dropout of domestic violence rehabilitation, as well as highlight the need to address domestic violence in the veteran population. As indicated on the VA FORUM survey, few (only six), VA Medical Centers actually provide specialized batterers' rehabilitation. The remainder indicated employing methods that are either insufficient (e.g. anger management), or may even be dangerous to the victim (e.g. couples counseling) (Gondolf & Russell, 1986; Lindquist, Telch, & Taylor, 1982). VA health care practice is largely lagging in the area of domestic violence rehabilitation.

The national survey, initiated in response to a congressional inquiry, indicates that batterers' rehabilitation is gaining in importance on a national level. As competition for dwindling health care dollars increases, it is important that Veterans Service Integrated Network (VISN) directors recognize the impact of domestic violence on the health and welfare of *all* veterans, male and female alike, as well as the drain on the health care system that domestic violence creates. A general lack of awareness exists about the presence and impact of domestic violence on both the veteran and active duty military populations.

#### Significance for nursing.

In the past decade, the number of nursing studies on domestic violence has grown. Nurse scholars are joining psychologists, sociologists, and social scientists in examining this serious problem. Nurses care for victims of wife abuse in emergency rooms, provide health care for victims in battered women's shelters, (Sheridan, 1987), make predictions of

dangerousness and lethality (Milner & Campbell, 1995; Campbell, 1995), conduct perpetrator evaluations (Milner, 1995), and provide rehabilitation (Gerlock, 1997). While much of the nursing research in the area of domestic violence focuses on the victims, there is a growing need for nurses to take an active role in the research as well as rehabilitation of perpetrators of domestic violence.

## Chapter 3

### Project Methods

#### Project Design

This study uses a quasi-experimental design of a non-randomized convenience sample of male veterans/soldiers seeking domestic violence rehabilitation at the VA Puget Sound Health Care System (VAPSHCS) and Madigan Army Medical Center (MAMC).

#### Study population

The sample for this study is drawn from two populations, male veterans and active duty soldiers. Domestic violence rehabilitation groups are held at the American Lake Division of the VA Puget Sound Health Care System, Mental Health Clinic. In addition, a sharing agreement exists between the American Lake Division and Madigan Army Medical Center, thus including active duty military personnel in the study. Inclusion criteria for the study include men seeking rehabilitation with court-ordered and non-court-ordered, who meet administrative eligibility requirements (honorably discharged veteran or active duty military), and who meet program eligibility requirements. Program criteria require that all applicants must identify the use of physical battering against a female victim/partner, and acknowledge having a domestic violence problem. Exclusion criteria include those who do not meet program eligibility requirements (i.e. deny using physical force and deny having a DV problem, and those who are unable to participate in group due to psychosis or significant cognitive impairment). Batterers with substance abuse problems must either be concurrently in rehabilitation for their substance abuse, or have

successfully completed rehabilitation and be in a substance abuse aftercare program.

Three groups are defined in this study. Batterers who complete the rehabilitation phase and move into the maintenance phase are identified as the completers. Batterers who dropout of rehabilitation, at any point after the first assessment, or who are discharged from rehabilitation comprise the non-completers group. Batterers who are deployed or sent to another duty station are considered drop-outs.

### The Intervention

The rehabilitation program, from which the sample is drawn, is shaped theoretically and structurally to meet state standards. The state standards mandate a minimum of one year in the program. To move into the final phase of the program men must meet stringent criteria which includes stopping all physical battering, significantly reducing their use of psychological battering, and stopping both written and oral blaming of their partner and justification of their battering. The rehabilitation program is outlined below.

The domestic violence program is a Washington State certified program and as such meets all the requirements mandated by the law (WAC 388-60). Washington State law requires of all domestic programs: 1. To provide clinical assessment to each client and a minimum rehabilitation period of twelve or more months of accountability to the program (completion is defined by satisfactory completion of rehabilitation and not solely based on a certain number of sessions or time period). 2. Batterers self-identify they have a domestic violence problem. 3. Victims are notified that he is in rehabilitation, what they might expect, if he leaves rehabilitation, and of confidential victims' services in the

community. 4. Rehabilitation takes place in weekly group sessions. 5. Batterers are held accountable for their violence and for changing their behavior. 6. The primary concern is for the safety of victims. 7. No victim blaming program strategies are permitted.

All program staff has professional experience in mental health services. Each group leader has observed a minimum of two domestic violence assessments, use the interview protocol for gathering demographic, health status, and battering history information, and have observed the orientation phase and the intervention phase for one month prior to co-leading groups. All group leaders have also completed the state mandated domestic violence training of 30 hours of perpetrator issues and 30 hours of victim issues.

The intervention consists of four phases including assessment, orientation, rehabilitation, and maintenance.

1. The **assessment phase** includes a minimum of two one-hour domestic violence assessments that are conducted by group leaders with male batterers. If needed, additional assessment interviews may be conducted in order to complete the psychosocial history, mental status exam, and specific domestic violence interview. These interviews are conducted by group leaders and involve completing the standard mental health clinic and domestic violence intake forms. The information obtained during this assessment period is placed in the veteran's/soldier's medical record. The assessment time frame begins with the first contact the batterer makes with the program and is completed by the time he finishes orientation.

The program also requires a one-hour confidential interview with the

victim/partner, or someone else that knows about the batterer's pattern of abuse if the victim is not available or unwilling to be interviewed. The batterer must identify the person and sign a release of information form to contact the person. This interview involves standard information gathering about the batterer, and is conducted in a confidential setting by program staff.

2. The second phase of the program (designed by Ganley, 1980 - present), the **orientation phase**, consists of four consecutive two-hour group meetings that meet once a week. Orientation classes are held at the mental health clinic at the American Lake division. Class sizes vary, but may range from five to twelve men. Orientation classes are on going. Each of the classes utilize the same format outlined as follows:

Class A: Introductions, definitions of battering, and origins of domestic violence. Specific battering strategies are defined as a pattern of assaultive and coercive behaviors that include physical, economic coercion, psychological, and sexual tactics of control. All groups involve both group discussions of the topics as well as written board work directed by the group leaders. Origins of battering are examined from early learning experiences, military/war experiences, social/cultural beliefs based on gender, and other contributing factors (e.g. substance usage, stress, finances, anger). Homework is required each week. The first week's homework includes a reading assignment and making a personal inventory of each of the types of battering used by the batterer.

Class B: Discussion of homework, negative consequences of domestic violence, and introduction to cool downs/'time outs and how to complete the cool down/time out logs. A discussion is lead and board work directed by group leaders on negative

consequences of domestic violence to the batterer, the victim, and to others. Cool downs/time outs are introduced and how to complete the cool down/time out logs is discussed. Men are given homework assignments for the next week including a personal inventory of negative consequences of domestic violence to themselves, their victim, and their children, and the completion of one cool down/time out log.

Class C: Discussion of homework and barriers to changing domestically violent behaviors. During this class, group leaders lead a discussion and conduct board work on individual cool down/time out logs. Problems with taking cool downs/time outs are examined. Batterers are then assigned seven cool downs/time outs for the following week. Barriers to changing domestically violent behaviors are also examined. These include the use of minimization, denial, and lying, blaming, and justifying, as well as depression and suicide.

Class D: Discussion of homework and introduction to the battering check and rehabilitation materials. Group leaders once again lead a discussion and conduct board work on cool downs taken and documented by the batterers. They are also introduced to the 'battering check', which involves identifying any battering behaviors from the previous week. At this time they are given the action plan, which is a working individualized plan of changes they are making in their battering behaviors and specific steps they are taking to stop battering. In addition they are introduced to the control log and given an assignment to complete a log on a videotaped DV incident, and another on a time they used physical violence. Time is also spent discussing the rehabilitation curriculum.

3. The third phase of the program is the intensive **rehabilitation phase** that meets

weekly for two hours for a minimum of 24 sessions. Some batterers are successful in stopping all physical and most of the psychological battering in a six-month time frame, but many do not. Those who have not stopped physical battering or have not sufficiently decreased their psychological battering are required to contract for additional time in the intensive weekly rehabilitation phase. Four misses are allowed during the 24-week period, but must be made up. Men who miss more than four sessions in rehabilitation are asked to start rehabilitation over again. Two misses are allowed for each additional three months of intensive rehabilitation.

The batterers' rehabilitation program to be studied is an adaptation of the curriculum-based program developed by the Duluth Domestic Abuse Intervention Project, and is referred to as Education Groups for Men Who Batter: The Duluth Model (Pence & Paymar, 1993). The curriculum addresses the specific assaultive and coercive tactics that are used by batterers to control their partner. Each rehabilitation group is lead by co-therapist teams. Rehabilitation staff has varied educational backgrounds including nursing, psychology, and social work. Each group begins with introductions of any new members and a battering check. The curriculum is divided into eight - three week segments. Three weeks are devoted to each of the battering tactics. Group exercises include conducting board work on homework assignments, viewing videos of battering behaviors, viewing battered women's response to these tactics, and focusing in on specific skill-building exercises (e.g. use of negotiation, fair fighting, accepting women's anger and fear, expressing emotions, etc.). Homework is given weekly, primarily in the form of the control log. Batterers weekly fill out two logs on a time they used specific battering

tactics. The control logs are formatted to ask the batterers to describe the following:

- What controlling and abusive behaviors were used?
- What did they intend to happen?
- What belief did they have for using this particular tactic?
- What emotions were they experiencing?
- How did they minimize, deny or blame the incident on their partner?
- What was the impact of their behavior on themselves, on the victim, and on others?
- How did their past use of violence affect this situation?
- What could they have done differently that would have been non-controlling?

Group participants are given an opportunity, in-group, to practice non-controlling behaviors by participating in role-plays of battering incidents that have been previously described. (For a more complete description of the curriculum see, Education Groups for Men Who Batter: The Duluth Model, Pence & Paymar, 1993). Group participants are expected to comply with all group rules, which include arriving on time, being substance free, no use of racist or sexist language, completion of all homework assignments, and maintaining the confidentiality of other group members.

This program has time frame parameters, but completion is based on each of the individual batterers' behaviors. They move out of intensive rehabilitation when they have stopped battering. This assessment is made by program staff who gauges how he is doing in the rehabilitation groups with reports from victim/partners and probation officers. To remain in rehabilitation the batterer is expected to work with the program materials, complete his homework, stop both written and oral blaming and justification of battering,

and to halt all battering. Many men take longer than the minimum of six months of intensive rehabilitation to halt battering, but generally move on in less than a year. Others end up dropping out or being removed from rehabilitation, and become non-completers.

There are three intensive rehabilitation tracks. All three are located at the mental health clinic at the American Lake division. The American Lake division sees veterans as well as active duty military personnel. Each group may accommodate a maximum of 12 batterers, but generally average around eight to nine at a time. These groups are on going and new members may join at any time. When staff determine that physical battering has ended, when most of the psychological battering has ended, and when the victim/partner identifies that she is comfortable with his transition, the batterer then moves on to the final phase.

The final phase of rehabilitation is the **maintenance phase**. This phase is considerably less intensive and meets once a month for two hours. At the beginning of each group a battering check is conducted. If a man has resumed physical battering he will be placed in intensive weekly rehabilitation again. Other indications of psychological battering are assessed based on their intent to recreate fear and maintain dominance. If such tactics of psychological battering are evident, the batterer will be placed back into intensive weekly rehabilitation. One female therapist leads the maintenance group. Group sessions are spent addressing their current life concerns, especially as they relate to any resumption of abusive behaviors. Other group member involvement is highly important in helping men remain non-violent and non-controlling. Maintenance groups also vary in size. Maximum capacity is 12, but the groups generally average six to eight men. The

length of time in maintenance is also variable, and ranges from a minimum of six months if they maintain non-abusive and non-controlling behaviors. One maintenance group is located at the American Lake division.

### Procedure

Recruitment of the study sample is from batterers entering the DV rehabilitation program. An assessment interview is scheduled with one of the program staff members after the referral has been made. At the initial interview the research study is presented by the program staff member and the batterer may consent to participate at that time. A one-hour training session on how to approach subjects and the scripted solicitation is provided for the DV program staff (see Appendix A for scripted study solicitation). The program staff member explains the objectives of the study, answers any questions and obtains an informed consent. If questions arise and the subject requests further information, the study PI is available by phone to provide it.

Once the informed consent has been obtained, batterers choosing to participate in the study are given a packet containing the research tools and written instructions on how to complete the tools. The subject is instructed not to write his name anywhere on the tools or the research packet. Once the subject has completed the tools and signed the informed consent, the signed consent form is placed with the tools in the research packet and sealed (by the subject). The subject keeps a personal copy of the informed consent for their records. The completed and sealed research packet is given to the clinic receptionist who places it in a designated research box. The research assistant creates a master list linking the subject's name to their assigned number. All data is confidential and seen only

by the study PI and research assistant. The master list linking name and number is stored in a locked file cabinet separately from the data. Once the data is obtained, the master is destroyed. The data then becomes anonymous.

An initial assessment interview is also scheduled with the victim/partner as part of the program criteria for obtaining the battering history. The victim/partner is approached by one of the program staff members at this time to solicit her participation in the study. The objectives of the study are explained and questions answered. If the victim/partner is willing to participate in the study the same procedure is followed. She is given the research packet with the research tools and instructed not to write her name anywhere on the tools or the packet. Her informed consent includes a place for her to indicate her partner. Once the consent form is signed the program staff member asks the subject to place it with the tools in the research packet and seal it when the tools have been completed. The sealed research packet is placed in the research box and retrieved weekly by the research assistant. The victim/partner is assigned the same identification number as her partner, except that it will be alphanumeric so that victim/batterer dyadic information may be maintained. The PI maintains the log of the victim/batterer number dyads in a locked file cabinet separate from the data.

The batterers enter the rehabilitation program as outlined previously. The program lasts for a *minimum* of one year. Transition from the rehabilitation phase of the program to the maintenance phase is based on behavioral criteria and not merely time in the program (as outlined under the intervention section). Due to individual variability, it can take batterers as little as six months or as much as a year or more to make the transition.

For purposes of this study, batterers who have completed the rehabilitation phase and moved into the maintenance are considered program completers. Non-completers are batterers who dropout or are removed from the program at any time after their first DV interview. Men who dropout, but re-establish contacts with the program in a month are maintained and do not have to re-enlist in the study. Men who have not made contact with the program in over a month, but whom later does so to re-enter the program remain as program non-completers. The program staff members will notify the PI monthly on the subjects' status in the program.

### Threats to Validity

Due to the limitations in the design there are several threats to internal validity (Cook & Campbell, 1979; Campbell & Stanley, 1963). The variable, battering behaviors, is measured by the use of a transparent tool that very clearly asks questions such as, "how many times have you choked...slapped...called her names...etc." (See Appendix B for tools). It is quite possible that batterers may lie in order to appear not so abusive. For this reason a corresponding measure of battering behaviors is completed by the victim/partner identifying his use and frequency of battering. Biases resulting in a differential self-selection of those who complete and those who do not are also possible.

External validity is threatened by the location of this particular DV rehabilitation program. Due to the variability of individual state's responses to DV, generalizability is limited to states with similar laws, victim services, and criminal justice system response.

### Research Measures

The data collected in this study will allow for investigation of the research

questions of the study. The tools, sources of data, and measurement time frame are presented in Table 1 at the end of the methods section. Copies of the paper and pencil instruments are provided in Appendices B and C.

**Personal and Battering History Interview, (batterer & victim):** This interview tool is modified and expanded from the standard clinical assessment of the VA PSHCS' Domestic Violence Program. Information gathered from batterers includes demographics, perpetrator's battering history, exposure to violence from family history, substance use and abuse, and court-order status. The victim's interview gathers some general demographic information about the victim. The remainder of the interview is conducted to obtain a history of the batterer's pattern of abuse, substance usage, and police contact. This information is obtained through an interview protocol and is administered during the assessment phase.

**Health History Interview, (batterer & victim):** Specific questions are included in the interview protocol of recent and past medical and mental health history, diagnosed illnesses, utilization of health care services and specific health contacts due to domestic violence.

**Symptoms of Stress (SOS) Inventory, (batterer):** Adapted from the Cornell Medical Index, the SOS quantified self-perception of affective, behavioral, cognitive and physiological components of health and illness. Subjects indicate on a 5-point scale the frequency with which they experienced the symptoms during the past week. Physiological scales include peripheral manifestations, cardio-respiratory, neurological gastro-intestinal distress and muscle tension. Psychological sub-scales include habit patterns, depression,

anxiety, anger and cognitive disorganization. Averages are obtained by summing the responses to each statement within a sub-scale and dividing the total number of items in the sub-scale. Two-week test-retest reliabilities ranged from .47 to .86, and internal consistencies (Cronbach's alphas) ranged from .62 to .97 for sub-scales. Concurrent validity has been examined with the Symptoms Checklist-90R (SCL-90R). Global distress score correlated .84 with the Global Severity Index. The summated physiological sub-scales of the SOS correlated .86 with the somatization scale of the SCL-90. Correlations of the sub-scales of anger, anxiety and depression between the two tools ranged from .79 to .95. (Nagawa-Kogan, et. al., 1993).

**Abusive Behavior Inventory (ABI) (batterer & victim):** The ABI is used to assess a wide range and intensity of abusive behaviors including both physical and psychological abuse items (Shepard & Campbell, 1992). Both the batterer and his victim/partner will complete the ABI. Because batterers minimize and deny their abusive behaviors, corroborating information is desired, and the ABI lends itself to matched pair analysis between male and female ratings of the batterer's abuse (Edelson & Brygger, 1986). It is a self-administered 30-item instrument using a 5-point Likert-type scale to measure the frequency of abusive behaviors. This yields an individual score of 30 to 150. One third of the items relate to physical abuse (scores range from 10-50) and two-thirds are related to psychological abuse (scores range from 20-100). An adjusted difference score between men and women will be computed for the physical abuse sub-scale (ABI physical difference) and the psychological abuse sub-scale (ABI psychological difference). A high score would indicate considerable difference between the victim/partners rating of violence

compared to the batterer's. The ABI was tested on a sample of 100 male veterans and 78 female partners. The SEM for the four sub-scales ranged from .04 to .12, and the alpha coefficients for the four sub-scales ranged from .70 to .92. Analysis of co-variance revealed a statistically significant difference between abuse and no abuse groups (criterion-related validity), strong correlations on variables believed to be related to abuse (construct validity), and strong correlations on individual items (factor validity). These initial findings indicated that it was a reliable and valid measure of physical and psychological abuse of women by their partners. The ABI has been used and results have been reported in one published outcome study with male veteran batterers (Petrik et al., 1994).

**Self-Esteem Rating Scale (SERS), (batterer):** Measures of self-esteem are obtained from the SERS, a 40-item instrument that was developed to provide a clinical measure of self-esteem that can indicate problems as well as positive or non-problematic levels. Selective items are scored positively (p/+) with the remaining negative items (N/-) negatively. Thus the summed total score has a possible range from -120 to +120. The SERS has excellent internal consistency, with an alpha of .97. It was also reported as having good content and factorial validity. Construct validity of the SERS was significant with the Index of Self-Esteem and the Generalized Contentment Scale (a measure of depression) as predicted, and generally low correlations with a variety of demographic variables, also as predicted (Nugent & Thomas, 1993; Nugent & Thomas, 1994).

**Mutuality Psychological Development Questionnaire (MPDQ - Form A), (batterer & victim):** The MPDQ measures perceived mutuality in close adult relationships (Genero, Miller, Surrey, & Baldwin, 1992). By including two relationship perspectives (self and

other) the respondent provides rating from their own perspective as well as their partner's. The MPDQ assesses six conceptual dimensions of mutuality (mutuality being the bi-directional movement of feelings, thoughts, and activity between persons in a relationship): empathy, engagement, authenticity, zest, diversity, and empowerment. The shortened forms include 22 items with ratings ranging from *never* to *all the time* on a six-point scale. The interitem alpha coefficients ranged from .89 to .94 for the two perspectives (self and other). Initial reliability analyses enabled the authors to construct two shortened interchangeable forms to provide greater testing flexibility and to reduce item redundancy. Alpha coefficients for both forms were .92 for spouse or partner and .89 for a friend. Reliability estimates obtained when the sample was subdivided by gender were comparable and alphas ranged from .86 to .93. Construct validity was examined by comparing mutuality measures to social support, relationship satisfaction and cohesion, and negatively correlated with depression. For both of the shortened forms mutuality scores for spouse or partner were significantly correlated with social support, relationship satisfaction and cohesion, and significantly negatively correlated to depression. In addition, for women and men, relationship cohesion's and satisfaction emerged as being the most predictive of spouse or partner and friend mutuality. For every unit increase in relationship cohesion, perceptions of mutuality increased by either .38 or .37 (depending on the form used).

The stability of the instrument over a two-week period was assessed in a second study (Genero, Miller, Surrey, & Baldwin, 1992). The high alpha coefficients obtained in the first study were replicated in the second (alphas ranged from .87 to .93). The

correlation between Time 1 and Time 2 for spouse or partner mutuality on both forms ranged from  $r = .71$  to  $r = .83$  for the four groups tested. The correlations between Time 1 and Time 2 indicate that the MPDQ has very good test-retest reliability.

The MPDQ taps into elements such as empathy, authenticity, and zest that other global measures of relationship are lacking. By responding from both the self as well as partner's perspective, the MPDQ acknowledges and assesses the bi-directional nature of relationships. It has, so far, been used to assess levels of mutuality in a sample of battered Latina immigrants (Perilla, Bakeman, & Norris, 1994).

**Mutuality Psychological Development Questionnaire (MPDQ - Form B), (batterer):** Form B is a slight modification to Form A. This tool asks the batterer to rate himself on the same questions as the 'self' sub-scale of Form A. The only change made is the prefacing of the statement "When I talk about things..." with, "It is important to me, when I talk about things..." Form A asks the batterers to rate themselves and the victim on levels of mutuality. Form B asks the batterer how important these aspects of mutuality are to him.

**The Brief Michigan Alcoholism Screening Test (MAST), (batterer):** Ten items of the original 25 item MAST were identified as the 10 best questions to identify alcoholism (Selzer, 1971). Pokorny, Miller and Kaplan (1972) compared responses to the original 25-item MAST with those of the brief MAST for 60 alcoholic in-patients and 62 randomly selected patients with mixed psychiatric diagnoses. For the 60 alcoholics, the correlation coefficient between the two forms of the scale was .95, for the 62 non-alcoholic it was .96, and for the combined group it was .99. The short and long versions of the scale were

very highly correlated. The short version saves considerable time in administration and is superior to the longer version when brevity is needed. The MAST has proven to be a reliable and valid screening device for both clinical and non-clinical settings (Jacobson, 1976; Skinner, 1979).

**The Drug Abuse Screening Test (DAST), (batterer):** The 28 items of the self-administered DAST parallel the items on the MAST (Skinner, 1982). The total score for the DAST is accomplished by summing all items endorsed, with the total score range from 0 to 28. Except for question number seven, all items have moderate to substantial item-total scale correlations. The internal consistency reliability (alpha coefficient) of .92 indicates that subjects were quite consistent when responding to all DAST items. In a clinical sample, the DAST score was highly reliable and only minimally influenced by the response style biases of denial and social desirability. The authors caution, however, that more defensiveness in admitting to a drug problem would be expected in an employment or criminal justice setting.

A shortened version was developed using the 20 items with high item-total scale correlations (Skinner, 1982; Gavin, Ross, & Skinner, 1989). This shortened DAST correlated almost perfectly ( $r = .99$ ) to the original 28-item tool. The internal consistency reliability of the 20-item DAST was extremely high (.95) for the total sample and a subsample that excluded clients with only alcohol problems (.86). The 20-item DAST has excellent psychometric properties.

**The PTSD Checklist (PCL), (batterer):** The PCL is a new self-administered rating scale for assessing post-traumatic stress disorder (Weathers et al., 1993). It consists of 17 items

that correspond to the DSM-III-R symptoms of PTSD. Subjects rate how much they have been bothered by each symptom in the past month on a 5-point scale. Two versions of the PCL exist. The PCL-M specifically focuses the re-experiencing from military experiences, and the PCL-C is a generic measure of any traumatic event. The PCL can be used as a PTSD threshold measure by summing scores across the 17 items. This tool was tested on a sample of 123 male Vietnam Theater veterans. The mean PCL scores for the PTSD subjects was 63.6 (SD = 14), and for non-PTSD subjects 34.4 (SD = 14.1). The test-retest reliability was .96. The internal consistency (alpha coefficient) was .97 for all 17 symptoms. Item-scale total correlations ranged from .62 to .87. Convergent validity was demonstrated by strong correlations between the PCL and the Mississippi Scale for Combat-Related PTSD (.93), the PK scale of the MMPI-2 (.77), the Impact of Event Scale (.90), and the Combat Exposure Scale (.46).

In a second study of 1006 male and female veterans of the Persian Gulf theater, the results were similar (Weathers et al., 1993). The mean PCL scores for the PTSD group was 64.2 (SD = 9.1) and for the non-PTSD group 29.4 (SD = 11.5). The internal consistency for the 17 items (alpha coefficient) was .96. Item scale total correlations ranged from .52 to .80. There was a strong correlation between the PCL and the Mississippi Scale (.85) (convergent validity). The PCL is easily administered, has excellent test-retest reliability over a two to three day period, has high internal consistency, and correlates strongly with other PTSD measures.

**The Conflict Tactics Scale (CTS), (batterer):** The CTS has been greatly utilized in domestic violence research. The scale has been primarily used to measure the use of abuse

and non-abuse tactics in couple relationships. The authors have modified it for other uses including parent to child violence, sibling violence, child to parent violence, and child-witnessing of violence (Straus, Gelles, & Steinmetz, 1980). Dutton (1995) used the slightly altered CTS to measure child-witnessing of parental domestic violence.

Chronbach alpha reliability coefficients are high for the Verbal Aggression and Violence scales and low for the Reasoning scale. The Reasoning scale has only three items, which accounts for the low reliability score. Concurrent validity is low for the Reasoning scale, but high for both the Verbal Aggression and Violence scales. The CTS has a high degree of face validity as well as evidence of construct validity (Straus, 1979).

Table 1: Study variables, instruments, format, and informant

<b>Study variables</b>	<b>Instrument</b>	<b>Format</b>	<b>Informant</b>
<b>Demographics:</b> Ethnicity, SES, employment, education, status of relationship, age, compensation	Personal & Battering History Interview Medical record (Appendices D & E)	Interview	Batterer & victim Medical records
<b>Domestic violence variables</b>			
Prior DV intervention, legal history, & general violence	Personal & Battering History Interview	Interview	Batterer & Victim
Patterns of physical & psychological violence	Abusive Behavior Inventory (ABI)	Self-report	Batterer & Victim
Level of probation/court monitoring	Personal & Battering History Interview	Interview	Batterer Court records
<b>Cognitive/Behavioral/Affective variables</b>			
Relationship style	Mutuality Questionnaire (MDPQ) (Form A & B)	Self-report	Batterer & Victim
Psychological distress	Symptom of Stress (SOS) Inventory	Self-report	Batterer
Self-esteem	Self Esteem Rating Scale (SERS)	Self-report	Batterer
<b>Health Consequences/Issues</b>			
Health consequences	Health History Interview (*see Batterer/victim interview)	Interview	Batterer & Victim
<b>Individual Characteristics</b>			
Substance Abuse threshold (Batterers)	Health History Interview, the Brief MAST, & shortened DAST	Interview & Self-report	Batterer & Victim
PTSD Threshold	The PTSD checklist (PCL)	Self-report	Batterer
Family of origin violence & other violence	Personal & Battering History Interview, & Conflict Tactics Scale (CTS)	Interview	Batterer
<b>Outcome Variable</b>			
Completion/non-completion	Study notification	Program report	Program staff

### Power

Pilot data is not available to use to estimate the sample size for this research study. However, in the existing studies that examine characteristics of men who dropout versus those who complete domestic violence rehabilitation, sample size information is available. In the study conducted by Grusznski and Carrillo (1988) they had 59 men complete and 116 dropout of DV rehabilitation. In contrast, Saunders and Parker had more men complete than dropout. Their figures were 104 completers and 29 dropouts. And lastly, Hamberger and Hastings (1989) had less of a difference in dropouts and completers. They had 88 men complete and 68 dropout of DV rehabilitation.

### Data Analysis

Table two summarizes the data analysis plan. Descriptive statistics characterizing distributional center and scale for key interval variables will be developed and interpreted with respect to normative values. Frequency distribution of nominal and ordinal variables will complement this descriptive overview. All continuous variables will be examined for evidence of non-normality, skewness, and outliers. Mean substitutions will be used for missing data if 80% or more of the scale items are completed. The described statistical analysis for the research questions will be parametric, however, when the descriptive analysis is non-normative, non-parametric equivalent statistics will be substituted for the parametric statistic described.

Internal consistency reliabilities (Chronbach's Alpha's) will be computed for all instruments used in this study. Although the chosen tools/instrumentals have reported reliabilities established from similar samples, verification of reliability will be performed.

The research question will be analyzed in two ways. Using either a chi-squared statistic for nominal measures or a One way ANOVA for ordinal/interval measures, completers and non-completers will be compared on the study variables.

Finally, comparison of the completers and non-completers will be used to provide a basis for understanding who completes and who drops out and if this can be predicted based on data available from the study measures. Group membership (whether a batterer is a completer or non-completer) is the dependent variable. The independent or predicting variables were chosen from the literature and clinical knowledge. The variables of interest are: demographic characteristics; on-going substance use and/or abuse; level of probation monitoring; battering history; prior DV intervention; level of mutuality in the relationship; symptoms of stress; self-esteem; family of origin violence; and PTSD threshold. The study variables that reveal the greatest difference between completers and non-completers based on a one-way ANOVA will be entered into a multiple regression analysis to determine which ones account for the greatest variance. An additional data reduction analysis will be conducted to determine which variables are best able to predict completion vs. non-completion of DV rehabilitation.

Table 2: Plan for Data Analysis

RESEARCH QUESTION	DATA SOURCE	INSTRUMENTS	ANALYSIS
1A. Comparison of Completer and non-completers	Both Victims & Batterers  Batterers	Personal & Battering HX Interview ABI ABI Difference Measures MDPQ MDPQ Difference Measures SOS PCL Brief MAST; Brief DAST SERS CTS	Nominal: Chi-Squared Statistics Ordinal/Interval: t-tests
1B. Prediction of who will complete rehabilitation	Batterers	Research variables that are statistically significantly different on the chi-square and t-tests.	Regression Analysis

### Protection of Human Subjects

Participation in this study is voluntary. It is emphasized that rehabilitation or other medical or mental health follow up are not affected by the decision to participate and that the batterer or victim may withdraw their consent at any time with no questions asked. Included in the consent form are assurances that all data are confidential, that no individual can be identified, and that batterer and victim data are kept in separate locations. Data entered into the computer has no subject identification, aside from the necessary demographic information. No individual data can be identified in study reports or public presentations, and only group data is reported on.

## Chapter 4

### Results

A convenience sample of 62 male batterers and 31 female victim/partners was recruited from June 1997 through December 1997. Forty-eight men were veterans and 14 were active duty military. The women were the victims of the men entering the state certified intensive rehabilitation program for male batterers at the VA Puget Sound Health Care System, American Lake Division. Three men (African-American, Asian American, and Caucasian) declined to participate in the study, thus the sample represents 95% of all men entering domestic violence rehabilitation during the six-month period specified. While all victims were contacted by mailing information to them about the program and about the batterer's status in the program, only 50% of the most recent victims actually participated in the study and face-to-face interview (n = 31). Some of the victims declined to participate because they were no longer in the relationship.

#### Description of batterers' demographics

##### General demographic.

The men's ages were normally distributed and ranged from 20 to 62 years old, with an average age of 38.81 years. The men were African-American (29%, n = 18), Asian American (5%, n = 3), Native American (3%, n = 2), Caucasian (55%, n = 34), Latino (6%, n = 4), and of mixed racial identity (2%, n = 1).

Many of the men were still with the victim and children (n = 24). Those not living with the victim were either living alone or in an alternative living situation including military barracks at Fort Lewis Army Base or the Homeless Domiciliary at the American

Lake Division (n = 33). Only five men were living with a new partner and children.

Thirty-five men were married or partnered (56.5 %) and 27 were separated or divorced (43.5%).

The men's education levels ranged from a GED to bachelor's degree. Most of the men had a high school diploma (n = 28). The remaining education levels included a GED (n = 10), technical degree (n = 18), and bachelor's degree (n = 5). Education level was missing for one man.

For the most part the men's incomes were below \$30,000. Twenty-three men had incomes less than \$10,000, 31 men had incomes from \$10,000 to \$30,000, and eight men made over \$30,000. Although their incomes were low, most of the men were involved in gainful daily activity by working full time, part time, or as a student (n = 42). The remainder were unemployed, disabled, or retired (n = 20).

The following table summarizes the general demographic information of the batterers' sample:

Table 3: Demographic data from batterers' sample

<b>Variable</b>	<b>Data &amp; Frequencies</b>
<b>Age (n = 62)</b>	Minimum age: 20 Maximum age: 62 Mean age: 38.81 Mode age: 25 Standard deviation: 10.38
<b>Veteran/Active Duty Status (n = 62)</b>	Veterans = 48; Active Duty = 14
<b>Living Situation (n = 62)</b>	Victim & children (n = 24) New partner & children (n = 5) Alone (n = 14) Other (n = 19)
<b>Marital Status (n = 62)</b>	Married/partnered (n = 35) Separated/Divorced (n = 27)
<b>Employment Status (n = 62)</b>	Employed/Student (n = 42) Unemployed/disabled (n = 20)

Batterers' domestic violence and general violence variables.

While most men were court-ordered for treatment (85%, n = 53), some sought help for other than court-ordered reasons (14%, n = 9). The court-ordered men were also actively being monitored either by the courts or by probation services (n = 53). Although 94% (n = 58) had recent police response on a domestic violence call, only four men (6%) had neither court-ordered treatment nor recent police response.

By far the most frequent charge was misdemeanor assault (n = 29). Three men had felony level assault charges, 26 had assault and/or other charges, and only four men had no charges. Their time in jail ranged from no jail time (n = 13), one to seven days (n =

37), to over a week (n = 12).

For close to half of the men this was not their first conviction. The most frequent prior convictions included domestic violence (n = 11), driving under the influence (DUI) (n = 6), and a combination of DUI and domestic violence (n = 4). Some of the men had a number of priors including the above as well as others (n = 7). The final group were men who had convictions identified as 'other' (n = 4). Examples from the 'other' category included possession of illegal substances, general assault, and sexual assault. Either the court or victim had sought an order of protection in 49 of the cases. Thirteen batterers had no orders of protection in place.

For many of the men this was their first arrest for domestic violence, but not the first time the police had responded on a domestic call. Twenty-nine men had one to three prior police responses for domestic violence. Eleven men had over three prior police responses with one person having had 15 police responses for domestic violence. Twenty-two men had no prior police response for DV. Many of the men also had prior treatment for domestic violence problems in the form of anger management (n = 32) as well as domestic violence intervention (n = 18).

The men in this study reported that they were also generally violent. Forty-four men were violent towards other non-intimates, including children and other adults. A little over half (n = 34) also reported being violent toward other intimate partners. The average number of prior partners assaulted was three.

The men's experiences with violence began early in their lives. Nearly half (n = 30) witnessed domestic violence in their family of origin. Many of the men were also abused

as children. Thirty-seven reported they were physically abused, while 25 reported there was no abuse.

The men were asked if they had weapons in their possession. Most (n = 43) indicated that they did not. However, 18 reported that they had firearms at home.

Lastly the men were asked if the victim is afraid of them. Some of the men reported that they did not know (n = 6, 10%). The remainder reported yes (n = 27, 44%), and no (n = 29, 56%). Table 4 summarizes the violence history and domestic violence-related variables.

Table 4: Domestic violence variables for the batterers' sample

<b>Variable</b>	<b>Data &amp; Frequencies</b>
<b>Charge</b> (n = 62)	No charge (n = 4) Assault (n = 32) Assault & other (n = 26)
<b>Probation Status</b> (n = 62)	Court-monitored (n = 53) No monitoring (n = 9)
<b>Treatment mandated</b> (n = 62)	Court (n = 23) Probation (n = 29) Other (n = 10)
<b>Police Involvement</b> (n = 62)	No police involvement (n = 4) Arrest (n = 47) Other (n = 11)
<b>Prior police response on a DV call</b> (n = 62)	None (n = 22) 1 - 3x (n = 29) > 3 (n = 11)
<b>Protection orders</b> (n = 62)	No orders of protection (n = 13) Orders of protection in place (n = 49)
<b>Prior Convictions</b> (n = 62)	No priors (n = 30) DV (n = 11) DUI (n = 6) DV & DUI (n = 4) Other (n = 4) Several of the above (n = 7)
<b>Prior Anger Management/ DV Rehabilitation</b> (n = 62)	No prior anger management treatment (n = 30) Prior anger management treatment (n = 32) No prior domestic violence rehabilitation (n = 44) Prior domestic violence rehabilitation (n = 18)
<b>General Violence Towards Others</b> (n = 62)	Reports no general violence (n = 18) Reports yes (n = 44)
<b>Violence Towards Another Intimate Partner</b> (n = 62)	Reports no abuse (n = 28) Reports yes (n = 34)
<b>Physically Abused as Child</b> (n = 62)	No abuse (n = 25) Abused (n = 37)
<b>Witnessed DV as Child</b> (n = 62)	Reports none (n = 32) Reports yes (n = 30)
<b>Does he have weapons?</b> (n = 61)	No weapons (n = 42) Yes weapons (n = 18) Missing data (n = 1)
<b>Is She Afraid?</b> (n = 62)	Batterers report no (n = 29) Batterers report yes (n = 27) Batterers report unknown (n = 6)

### Batterers' substance use and abuse variables.

Substance usage has been linked to domestic violence in the literature. Few of the men actually acknowledged current alcohol usage. Those that did reported a frequency of daily to monthly usage. If they drank within the past month they were categorized as drinking. If they had not drunk within the past month, they were categorized as not drinking. Thirty men reported drinking, and 32 reported not drinking.

The same questions were asked regarding drug usage. Even fewer men acknowledged current drug usage, but some did. Five men reported a drug frequency range from two to four times a week up to weekly. Ten men were using drugs currently, but the frequency was undetermined by the interviewer. The men were categorized into two categories, "using" and "not using". There were a total of 15 men currently (within the past month) using drugs. The majority (n = 47), were not. The most frequently used drug was identified as marijuana (n = 6), followed by crack/cocaine (n = 4). Three men were using several categories of drugs, one man was using a drug classified as 'other', and data was missing for one of the men who acknowledged drug usage.

Also of interest in the substance usage category was prior treatment for a substance abuse problem and whether the men felt they had a substance abuse problem. The majority of men had prior substance treatment (n = 39). Twenty-eight of these men had substance abuse recorded as a diagnosis in their medical record. Interestingly, 28 men also acknowledged having a substance abuse problem.

### Batterers' health issues.

Other descriptive information gathered for the batterers' sample was health-care

visits and related health data. As part of the interview protocol the batterers were asked, "Have you ever-received health care treatment for injuries related to your domestic violence?" and, "Do you feel that either your medical or mental health problems are related to your domestic violence?" In addition, data was gathered on the number of health-care and mental health visits they had had in the past six months. Information on medical and mental health problems were also noted.

Thirty-nine (63%) of the men had numerous health-care visits in the past six months that ranged from one visit to more than 20 (see Figure 1). Twenty-three men (37%) had no medical visits to either the VA Puget Sound Health Care System or nearby Madigan Army Medical Center. By far the most frequent physical problem was musculoskeletal with thirty-one (50%) men seen for this problem. Other medical diagnoses included pulmonary (8%, n = 5), dermatology (10%, n = 6), gastrointestinal (13%, n = 8), cardiovascular (14%, n = 9), and neurological (10%, n = 6).

Also of interest was whether the men had received health-care treatment as a direct result of their domestic violence injuries. Fourteen (23%) men identified injuring themselves and receiving health-care intervention for domestic violence related injuries.

Their mental health visits in the prior six months were even more numerous. Fifty-six men (90%) had one to greater than 20 mental health visits (see Figure 1). Only six men (10%) had no mental health visits in the prior six months. Fifty-six of the men had psychiatric diagnoses to include mood disorders (27%, n = 17), anxiety disorders (24%, n = 15), psychosis (2%, n = 1), personality disorder (2%, n = 1), and substance abuse (45%, n = 28). There is some overlap in these numbers, as some of the men had more than one

physical and/or psychiatric diagnosis identified in their clinical record. Their interview for appropriateness for the domestic violence program was not included in this count.

Interestingly, 29% (n = 18) of the men felt that their medical and mental health problems were directly related to their domestic violence behaviors. They identified depression, anxiety, cardiovascular problems, lacerations, bruises, and broken bones as related to their domestic violence behaviors (see Figure 2 for the self-identified medical and mental health problems). Of the mental health consequences possible, none of the men identified anger.

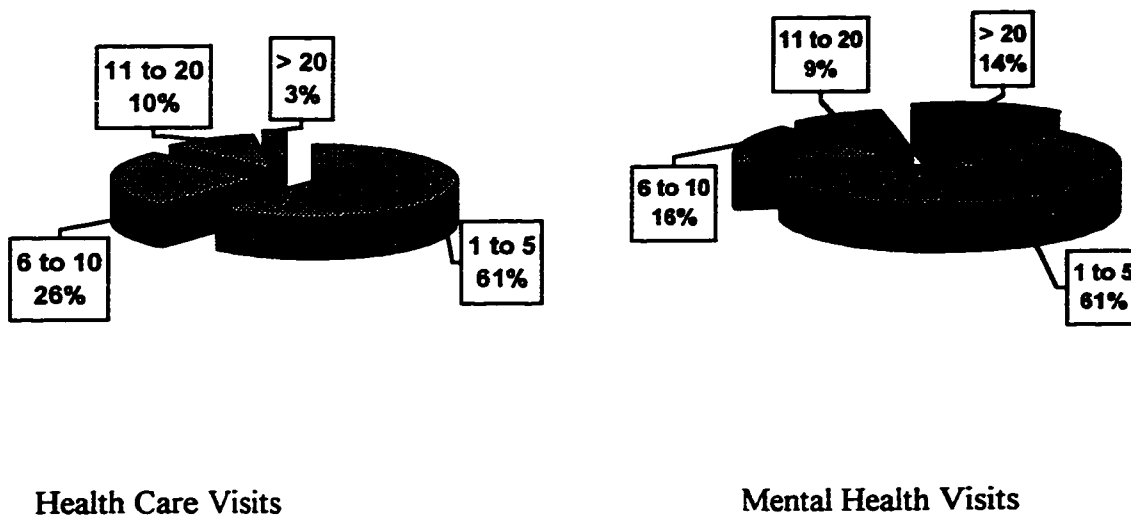


Figure 1: Percent by number of physical health (n=39) and mental health (n=56) care visits for batterers

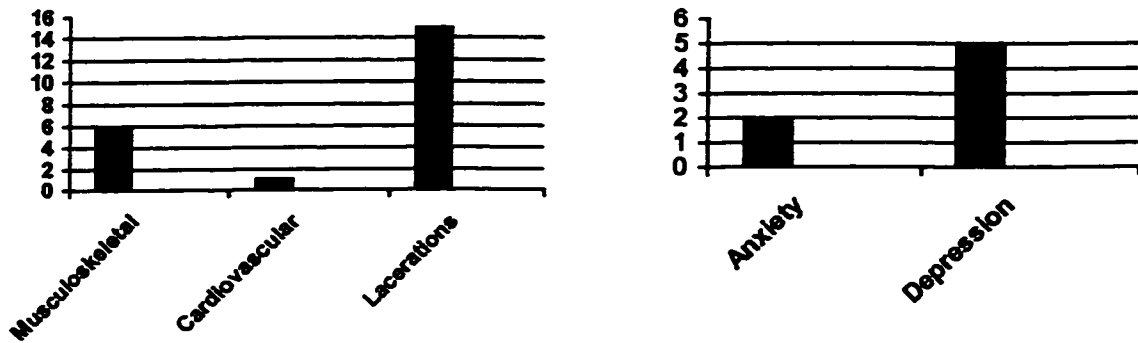


Figure 2: Medical (n = 22) and mental health (n = 7) consequences of domestic violence for batterers

### Description of victims' demographics

#### General demographics.

Victim's ages ranged from 18 to 55 years old. They were African-American (3%, n = 1), Asian American (13%, n = 4), Caucasian (71%, n = 22), Latina (3%, n = 1), and mixed or of another ethnic group (10%, n = 3).

Seventeen of the victims were still living with the batterer and their children. Fourteen victims were living alone and/or with their children. Most of the victims were either married or partnered (n = 28), with only three divorced or separated.

One of the reasons victims were unable to participate in the research study was a time conflict with work and child-care. Of the victims who did participate, most were involved in gainful daily activity and were employed fulltime (n = 16), part time (n = 3), or were a student (n = 1). Nine victims were unemployed or disabled, and data is missing for

two of the women on this question. Table 5 summarizes this demographic information.

**Table 5: Demographic data from victims' sample**

<b>Variable</b>	<b>Data &amp; Frequencies</b>
<b>Age (n = 29)</b>	18 - 25 (n = 4) 26 - 35 (n = 8) 36 - 45 (n = 10) 46 - 55 (n = 7) missing (n = 2)
<b>Living Situation (n = 31)</b>	Batterer & children (n = 17) Alone &/or children (n = 14)
<b>Marital Status (n = 31)</b>	Married/partnered (n = 28) Separated/Divorced (n = 3)
<b>Employment Status (n = 29)</b>	Employed/Student (n = 20) Unemployed/disabled (n = 9)

Victims' reports on the batterers' domestic and general violence variables.

Information was gathered from victims on the frequency and type of police response to the domestic violence. Twenty-seven reported that there had been police involvement in the form of either arrest or an investigative report of the batterer. Four victims reported no police involvement. The most frequent charge was assault (misdemeanor, n = 13; felony, n = 2), and a combination of assault and others (n = 9). Other charges included malicious mischief, interfering with a 911 call, and destruction of property. Seven of the victims reported that there were no charges made.

Most of the victims reported there were protection orders in place (n = 21). Ten stated that neither they nor the court sought protection orders. The women were also asked how many times the police had responded on a domestic violence call during the current relationship with the batterer. Most reported that the police had been out earlier

(n = 20). Eleven women reported no prior police response for DV in this relationship.

The most frequent police response was one to three times (n = 14). Six women reported police response on a DV call greater than three times.

Additional information regarding the batterers' violent behaviors were also sought.

The victims were asked whether he had been violent towards other non-intimates.

Eighteen victims reported that yes they knew of him being violent towards others. Two stated they did not know, and 11 reported no. When asked if he had been violent towards other intimate partners, 17 victims reported they were aware of his violence towards other partners. Six victims stated no he had not been violent towards other intimates, and eight said they did not know.

Victims were asked about his possession of weapons. Most of the victims reported that he did not currently have weapons (n = 21), but ten stated that he was in possession of firearms.

Is she afraid? Just as the batterers were asked their opinion about their victims' fear, the victims were asked directly. Sixteen victims reported that they were afraid. Fourteen reported they weren't afraid, and data is missing for one victim on this question. Table 6 summarizes the domestic and general violence data from the victim's perspective.

Table 6: Victims' reports on the batterers' general violence and DV variables

<b>Variable</b>	<b>Data Frequencies</b>
<b>Charge</b> (n = 31)	No charge (n = 7) Assault (n = 15) Assault & other (n = 9)
<b>Police Involvement</b> (n = 31)	No police involvement (n = 4) Arrest (n = 23) Other (n = 4)
<b>Protection orders</b> (n = 31)	No protection orders (n = 10) Orders of protection in place (n = 21)
<b>Prior police response on a DV call</b> (n = 31)	None (n = 11) 1 - 3x (n = 14) > 3 (n = 6)
<b>General Violence Towards Others</b> (n = 31)	Reports no general violence (n = 11) Reports yes (n = 18) Unknown (n = 2)
<b>Violence Towards Another Intimate Partner</b> (n = 31)	Reports no abuse (n = 6) Reports yes (n = 17) Unknown (n = 8)
<b>Does he have weapons?</b> (n = 31)	No weapons (n = 21) Yes weapons (n = 10)
<b>Is She Afraid?</b> (n = 30)	Victim reports no (n = 14) Victim reports yes (n = 16)

Victims' reports on batterers' substance use and abuse.

The victims were also asked about the batterer's substance usage. Seventeen victims identified that the batterer was using either alcohol or drugs. Fourteen said he was not currently using. When it came to his substance use pattern, victims reported his drinking ranged from daily to monthly (n = 7). Six victims did not know his current drinking pattern, and data was missing for three of the victims. In addition, victims noted that he was using a range of drugs including marijuana, cocaine, and a combination of

several drugs. Victims reported that the batterer's drug usage ranged from daily to monthly (n = 3). Four women did not know his current drug usage pattern, and data was missing for four of the victims on this question.

Victims' health issues.

Also of interest were the physical and mental health consequences due to the domestic violence. They were asked the following questions: "Have you ever-received health care treatment as a result of injuries caused by domestic violence?" and "Do you feel that either your medical or mental health problems are related to the domestic violence?" They, too, had numerous medical and mental health visits during the prior six months. Twenty women (64%) felt their medical and mental health problems were directly related to the domestic violence. Eleven (35%) received health-care intervention as a result of domestic violence injuries.

Thirteen women (42%) had been seen from one to more than 20 times for medical reasons during the past six months (Figure 3). They identified musculoskeletal problems, cardiovascular problems, lacerations, and bruises as a result of the domestic violence (Figure 4). They reported currently having the following medical diagnoses:

Cardiovascular (2%, n = 1), neurological (16%, n = 5), pulmonary (6%, n = 2), musculoskeletal (16%, n = 5), dermatology (3%, n = 1), and gastrointestinal (6%, n = 2).

Nine women (29%) had one to more than 20 mental health visits in the past six months (Figure 3). The women endorsed higher rates of mental health problems as a result of the domestic violence, than did the men. While only one woman (3%) stated that she felt she had anxiety due to the domestic violence, 18 (58%) felt they had depression

because of it (Figure 4). They identified having the following current psychiatric diagnoses: Mood disorders (52%, n = 16), anxiety (19%, n = 6), psychosis (3%, n = 1), personality disorder (3%, n = 1), and substance abuse (10%, n = 3).

Health Care Visits

Mental Health Visits

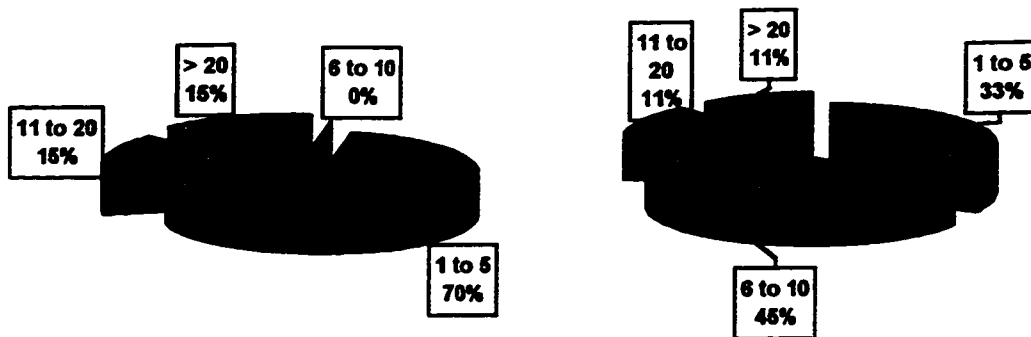


Figure 3: Percent, by number of physical health (n = 13) and mental health (n = 9) care visits for victims

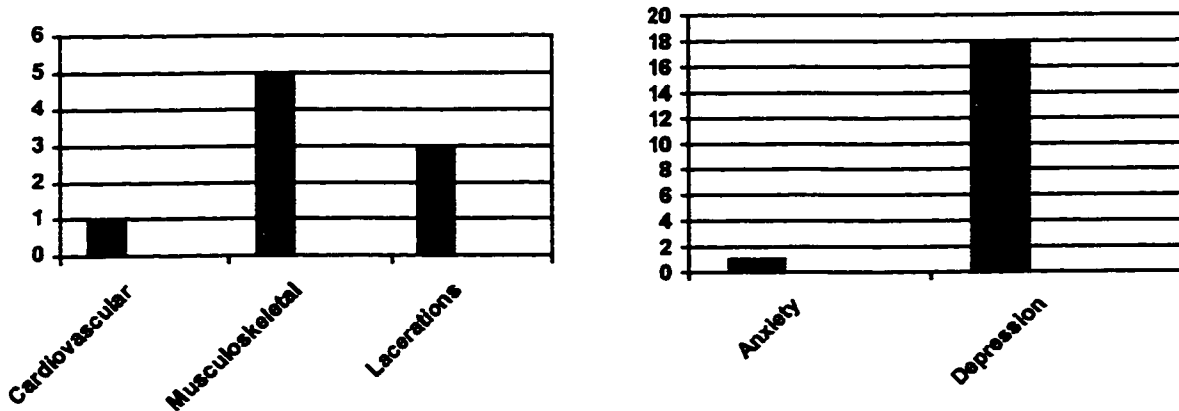


Figure 4: Medical (n = 9) and mental health (n = 19) consequences of domestic violence for victims

**Research question 1A: Comparison of completers and non-completers on the descriptive variables and research tools for batterers' sample**

Sixty-two men volunteered for the research study. One man was transferred to another duty station and was dropped from the statistical analyses comparing completers and non-completers on the research variables. The remainder comprises the research study group (n = 61) with 23 men making the transition from the rehabilitation phase to the maintenance phase, and 38 dropping out of the program.

In order to be considered a completer the men had to meet the criteria for transition from rehabilitation to maintenance. This included stopping all physical violence, patterns of coercive control, blaming the victim and justifying the abuse. In addition, each man had to demonstrate his understanding and practice of the material through weekly written homework assignments and oral participation in the group. Their oral participation was monitored for comments that support building partnership and equality in intimate relationships and ceasing attitudes and beliefs that support abusive behaviors. And lastly, a victim or partner check was conducted to determine the partner's comfort with him moving onto the next phase of the program. It took the men a minimum of seven months and a maximum of 15 months to make the transition.

Three of the non-completers have since restarted the program. They were out of the program from six weeks to eight months. The time frame for the study did not permit them to re-enter the study on a new status. They were maintained as non-completers because they had dropped out of the program during the time frame of the research protocol. Their reported reasons for not completing the program included personal stress

from injury and death of a parent, to feeling too unstable in their substance recovery work to do both programs at the same time. One man was paying for alcohol treatment in the community and reported that he could not afford the bus fare to make it to weekly DV rehabilitation classes.

The research question to be answered is, 'Who will remain in domestic violence rehabilitation and who will leave?' The first sub-question is, 'Are there significant differences between completers and non-completers on the study variables?'

The statistical analyses were conducted with SPSS version 8.02. Completers and non-completers were compared on the demographic variables first.

#### Comparison between completers and non-completers on demographic data.

There was a significant difference between completers and non-completers on age ( $t = -3.56, p = .002$ ). The mean age for completers was 33.87, and non-completers 42.16.

A higher percentage of the completers were employed as compared to the non-completers. Men who were unemployed, disabled or retired were not as likely to complete. Eighty-seven percent ( $n = 20$ ) of completers were employed or in school, while only fifty-five percent of the non-completers had jobs or were students ( $n = 21$ ). Only three of the unemployed/disabled/retired made the transition into the maintenance phase ( $X^2 = 7.07, p = .029$ ).

There were no further statistically significant differences on the demographic variables for the completers and non-completers. They did not differ according to their veteran or active duty status. Nor did they differ according to ethnicity in comparing Caucasians to African-Americans, or whites to non-whites. Most of the men's incomes

were less than \$30,000 (n = 54). There was no statistical difference between completers and non-completers on income or their educational attainment. They did not differ on their marital status of living situation either.

Comparisons between completers and non-completers on substance use data.

One might speculate that there would be a difference between completers and non-completers on the substance usage variables. Over half of the men (n = 39) self-identified that they had had substance abuse treatment. However, there was no statistically significant difference between completers and non-completers on drinking or drug usage, diagnosis of substance abuse, or self-identified substance abuse.

Comparison between completers and non-completers on DV and general violence data.

Statistically significant differences on the DV and general violence variables included court-monitored status and treatment-mandated status. If the men were being monitored through court or probation they were considered to be court-monitored. All nine of the men who were not being monitored left the program. While 29 of the non-completers were also being monitored, a Chi-square analysis revealed there was a statistically significance difference ( $X^2 = 6.65$ ,  $p = .036$ ) between the completers and non-completers on this variable. Completers were more likely to be court-monitored.

In addition, there was a statistically significant difference on the basis of court-mandated treatment ( $X^2 = 9.42$ ,  $p = .051$ ). All ten of the men who were in the program for other than court or probation mandated reasons left the program. These were men who were in the program because of recent police involvement, but had no arrest (n = 4), and those who had no police involvement (n = 4). In addition, these were men who

entered the program to have a protection order modified or dropped ( $n = 2$ ). Once that occurred, they dropped out.

Also of interest was how they might differ on their domestic violence and criminal history variables. As indicated above, there was a difference based on mandated treatment and court/probation monitoring. However, there was no difference on the remaining variables including, prior convictions, prior DV police response, current police involvement, jail time, charge, or protection orders.

Perhaps there is a difference based on whether they had prior anger management or domestic violence rehabilitation? No difference was found between completers and non-completers on these variables. Nor was there any difference based on their reports of witnessing DV as a child, being abused as a child, being generally violent, or assaulting prior intimate partners.

#### Comparison between completers and non-completers on health issues data.

The health and mental health questions also revealed no difference between completers and non-completers. Chi-square analysis was conducted on health and mental health visits, medical and mental health diagnoses, and whether they were serviced connected (receiving VA compensation) for posttraumatic stress disorder. No difference was found. In addition, comparisons were made on whether they had injured themselves during a domestic violence incident and whether they felt their health or mental health problems were related to their domestic violence. Once again, no difference was found.

Table 7 summarizes the general demographic comparisons of the completers and non-completers based on Chi-square analysis. Only job was found to be statistically

significantly different. The domestic violence descriptive variables revealed additional differences between the completers and the non-completers. Differences were found in their treatment mandated and court-monitoring status. The other DV and general violence variables were not found to be significantly different. Table 8 summarizes some of the domestic violence variables.

Table 7: Comparisons of completers and non-completers on general demographic variables

Variable	Completer	Non-completer	Chi-square statistic	Probability level
<b>Veteran/Active Duty Status</b>	<ul style="list-style-type: none"> <li>▾ Veteran/n = 16 (26%)</li> <li>▾ Active/n = 7 (12%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ Veteran/n = 32 (52%)</li> <li>▾ Active/n = 6 (10%)</li> </ul>	5.24	NS
<b>Ethnicity</b>	<ul style="list-style-type: none"> <li>▾ African American/n = 7 (12%)</li> <li>▾ Caucasian, n = 14 (23%)</li> <li>▾ Other, n = 2 (3%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ African American/n = 10 (16%)</li> <li>▾ Caucasian, n = 20 (33%)</li> <li>▾ Other, n = 8 (13%)</li> </ul>	4.10	NS
<b>Living Situation</b>	<ul style="list-style-type: none"> <li>▾ Victim/kids n = 8 (13%)</li> <li>▾ New partner/kid, n = 2 (3%)</li> <li>▾ Alone/ n = 7 (11.5 %)</li> <li>▾ Other/ n = 6 (10%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ Victim/kids n = 16 (26%)</li> <li>▾ New partner/kid, n = 3 (5%)</li> <li>▾ Alone/ n = 7 (11.5 %)</li> <li>▾ Other/ n = 12 (20%)</li> </ul>	3.57	NS
<b>Marital Status</b>	<ul style="list-style-type: none"> <li>▾ Married/partner n = 14 (23%)</li> <li>▾ Divorced/Separated, n = 9 (15%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ Married/partner n = 21 (34%)</li> <li>▾ Divorced/Separated, n = 17 (28%)</li> </ul>	1.5	NS
<b>Employment Status</b>	<ul style="list-style-type: none"> <li>▾ Employed/Student, n = 20 (33%)</li> <li>▾ Unemployed / Disabled, n = 3 (5%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ Employed/Student, n = 21 (34%)</li> <li>▾ Unemployed / Disabled, n = 17 (28%)</li> </ul>	7.07	.03
<b>Educational Level</b>	<ul style="list-style-type: none"> <li>▾ GED, n=3 (5%)</li> <li>▾ HS, n=9 (15%)</li> <li>▾ Technical, n=8 (13%)</li> <li>▾ Bachelors, n=3 (5%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ GED, n=7 (12%)</li> <li>▾ HS, n=18 (30%)</li> <li>▾ Technical, n=10 (17%)</li> <li>▾ Bachelors, n=2 (3%)</li> </ul>	3.07	NS

Table 8: Comparisons between completers and non-completers on domestic violence and general violence variables.

Variable	Completer (n = 23)	Non-completer (n = 38)	Chi-square statistic	Probability level
<b>Charge</b>	<ul style="list-style-type: none"> <li>▾ None, n = 0</li> <li>▾ Assault, n = 15 (25%)</li> <li>▾ Assault/other, n = 8 (13%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ None, n=4 (6%)</li> <li>▾ Assault, n = 16 (26%)</li> <li>▾ Assault/other, n = 18 (30%)</li> </ul>	5.44	NS
<b>Probation/court Monitored</b>	<ul style="list-style-type: none"> <li>▾ Not monitored, n=0</li> <li>▾ Monitored, n =23 (38%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ Not monitored, n = 9 (15%)</li> <li>▾ Monitored, n=29 (47%)</li> </ul>	6.65	.04
<b>Treatment mandated</b>	<ul style="list-style-type: none"> <li>▾ Court, n=11 (18%)</li> <li>▾ Probation, n=12 (20%)</li> <li>▾ Other, n = 0</li> </ul>	<ul style="list-style-type: none"> <li>▾ Court, n=11 (18%)</li> <li>▾ Probation, n=17 (28%)</li> <li>▾ Other, n=10 (16%)</li> </ul>	9.42	.05
<b>Police Involvement</b>	<ul style="list-style-type: none"> <li>▾ None, n=0</li> <li>▾ Arrest, n=18 (29%)</li> <li>▾ Other, n=5 (8%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ None, n=4 (7%)</li> <li>▾ Arrest, n=28 (46%)</li> <li>▾ Other, n=6 (10%)</li> </ul>	3.1	NS
<b>Prior Police Response on a DV Call</b>	<ul style="list-style-type: none"> <li>▾ None, n=11 (18%)</li> <li>▾ 1-3x, n=8 (13%)</li> <li>▾ &gt; 3x, n=4 (7%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ None, n=10 (16%)</li> <li>▾ 1-3x, n=21 (34%)</li> <li>▾ &gt; 3x, n=7 (12%)</li> </ul>	5.01	NS
<b>Prior Anger Management/DV Rehabilitation</b>	<ul style="list-style-type: none"> <li>▾ No AM, n=10 (16%)</li> <li>▾ Yes AM, n=13 (21%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ No AM, n=20 (34%)</li> <li>▾ Yes AM, n=18 (29%)</li> </ul>	1.43	NS
	<ul style="list-style-type: none"> <li>▾ No DV, n=18 (29%)</li> <li>▾ Yes DV, n=5 (8%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ No DV, n=26 (43%)</li> <li>▾ Yes DV, n=12 (20%)</li> </ul>	1.08	NS
<b>General violence towards others</b>	<ul style="list-style-type: none"> <li>▾ None, n=7 (12%)</li> <li>▾ Yes, n=16 (26%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ None, n=11 (18%)</li> <li>▾ Yes, n=27 (44%)</li> </ul>	.431	NS
<b>Violence towards another partner</b>	<ul style="list-style-type: none"> <li>▾ None, n=12 (20%)</li> <li>▾ Yes, n=11 (18%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ None, n=16 (26%)</li> <li>▾ Yes, n=22 (36%)</li> </ul>	1.42	NS
<b>Is She Afraid?</b>	<ul style="list-style-type: none"> <li>▾ No, n=12 (20%)</li> <li>▾ Yes, n=10 (16%)</li> <li>▾ Unknown, n=1 (2%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ No, n=17 (28%)</li> <li>▾ Yes, n=16 (26%)</li> <li>▾ Unknown, n=5 (8%)</li> </ul>	2.64	NS

Comparison between completers and non-completers based on research tools.

The men were asked to complete nine research tools after the first or second domestic violence intake interview, and before they started the orientation phase. Scores on the research tools revealed additional differences between completers and non-completers.

Split-half reliability testing was conducted on each tool for over-all scores, sub-scales (where indicated), and by Caucasian and African American groups. The over-all Guttman split-half correlation's for the SOS Inventory and sub-scales ranged from .78 to .93. Guttman split-half's on the Caucasian group for SOS sub-scales ranged from .57 to .90, and for African Americans .83 to .96.

Comparisons between completers and non-completers on SOS scores were made using t-test analysis (2-way). Completers had lower over-all SOS scores than did the non-completers ( $t = -2.84, p = .007$ ). In addition, the completers had statistically lower scores on the following sub-scales: Central Neurological ( $t = -2.58, p = .02$ ); Habitual Patterns ( $t = -2.71, p = .007$ ); Depression ( $t = -3.06, p = .003$ ); Anxiety/Fear ( $t = -3.40, p = .002$ ); Anger ( $t = -2.72, p = .009$ ); and Cognitive Disorganization ( $t = -3.66, p = .001$ ). The remaining sub-scales were not statistically different at the .05 probability level. These sub-scales were Peripheral Manifestations, Cardiopulmonary Arousal, Upper Respiratory Symptoms, Gastrointestinal Symptoms, and Muscle Tension. Table 9 shows the differences between completers and non-completers on the SOS Inventory.

Table 9: Comparisons between completers and non-completers on the Symptoms of Stress Inventory

SOS Inventory Scores	Completer (n = 23)		Non-completer (n = 38)		t-test statistic*	Probability level
	Mean	SD	Mean	SD		
<b>SOS Over-all</b>	96.91	63.20	145.40	66.12	-2.84	.007
<b>Peripheral</b>	5.65	5.67	8.58	6.57	-1.84	NS
<b>Cardiopulmonary</b>	6.22	5.39	9.32	6.87	-1.96	NS
<b>Respiratory</b>	7.96	5.90	10.92	5.84	-1.91	NS
<b>Neurological</b>	2.56	3.06	5.10	4.62	-2.58	.01
<b>Gastrointestinal</b>	9.83	7.02	12.42	7.19	-1.39	NS
<b>Muscle Tension</b>	12.13	7.76	15.13	8.66	-1.4	NS
<b>Habitual Patterns</b>	18.39	12.42	26.92	10.98	-2.71	.01
<b>Depression</b>	8.96	6.51	14.74	8.10	-3.06	.003
<b>Anxiety/Fear</b>	7.91	7.70	15.29	8.98	-3.40	.001
<b>Anger</b>	11.17	7.17	16.29	7.00	-2.72	.009
<b>Cognitive Disorganization</b>	6.22	5.73	12.01	6.38	-3.66	.001

\* Equal variances not assumed

By examining Table 9 it is evident that the non-completers indicated that they were feeling higher levels of symptoms of stress over-all and on several sub-scales. The only physiological sub-scale that was significant was the Central Neurological sub-scale. All of the sub-scales on the psychological indices were significantly different. Non-completers indicated that they were feeling more depression, anxiety, anger, cognitive disorganization, and displaying more habitual patterns of stress than were the completers.

The Post-traumatic Stress Disorder Checklist (PCL) also revealed differences between completers and non-completers. Guttman split-half reliability over-all for the PCL was .95, for Caucasian's .93, and for African American's .95. The PCL directed respondents to rate their PTSD symptoms. These included such things as nightmares and intrusive imagery of a traumatic event. Completers indicated significantly lower symptoms of PTSD symptoms than did the non-completers ( $t = -3.74, p = .000$ ).

No statistically significant difference, however, was found between completers and non-completers on the Abusive Behavior Inventory (ABI) over-all or on the psychological or physical sub-scales. The Guttman split-half reliability over-all was .72. Reliability checks were also done for each sub-scale and by Caucasian and African-American groups. The reliabilities for the Caucasian sub-group were .80 on the psychological sub-scale and .78 on physical sub-scale. For African Americans the reliabilities ranged from .81 on the psychological sub-scale and .77 on the physical sub-scale.

Differences between completers and non-completers also failed to reach the .05 significance level on the Self Esteem Rating Scale (SERS). The Guttman split-half reliability over-all for the SERS was .95, for Caucasian's .96, and for African American's .92. In addition, batterers' reports of witnessed abuse by their father and mother when growing up also failed to reach significance at the .05 level. Each man was asked to rate his father and mother on the modified Conflict Tactics Scale (CTS). Reliability scores on the Guttman split-half on the father sub-scale over-all was .90, and on the mother sub-scale .93. For Caucasian's the reliability score on the father sub-scale was .90, and on the mother sub-scale .93. For African American's the father sub-scale reliability score was .91, and the mother sub-scale reliability was .92.

The anticipated differences between completers and non-completers on the substance usage scales were also not found to be significant at the .05 level. The batterers were given the ten question brief MAST and the shortened 20 question DAST. Guttman split-half reliability for the brief MAST over-all was .90, for Caucasian's .92 and for

African American's .90. The split-half reliability on the shortened DAST over-all was .91. The Caucasian group had a reliability score of .85, and the African American group .97.

And lastly, comparisons were made on how the men rated themselves and their partners on levels of mutuality (MPDQ). An additional form was developed utilizing the same questions, but asked the men to respond on how important the aspects of mutuality were to them. Form A, where men rated their levels of mutuality, and Form B where they rated how important it was to them had a correlation of .73 ( $p = .000$ ). Significant differences were found between completers and non-completers on all of these scales. Completers rated both themselves and their partners higher on levels of mutuality ( $t = 3.12, p = .003$  and  $t = 2.08, p = .04$ ). In addition, completers responded that mutuality in the relationship was more important to them than did the non-completers ( $t = 2.29, p = .03$ ).

Table 10 summarizes the men's perceptions of themselves and others based on their responses on the PCL, ABI, SERS, MAST, DAST, CTS, MPDQ Form A, and MPDQ Form B. Comparisons between completers and non-completers indicate significant differences on the PCL, MPDQ Form A, and MPDQ Form B.

Table 10: Comparisons between completers and non-completers on their perceptions of self and others.

Tool	Completer (n = 23)		Non-completer (n = 38)		t-test statistic*	Probability level
	Mean	SD	Mean	SD		
<b>PCL</b>	35.09	15.21	50.84	17.04	-3.75	.000
<b>ABI (over-all)</b>	47.42	13.33	51.57	13.44	-1.18	NS
<b>ABI (psychological)</b>	34.46	10.57	37.69	10.48	-1.16	
<b>ABI (physical)</b>	12.96	3.40	13.88	4.32	-.93	
<b>SERS</b>	56.13	32.98	37.74	40.25	1.94	NS
<b>Brief MAST</b>	7.49	7.63	11.76	10.57	-1.82	NS
<b>Short DAST*</b>	2.98	4.30	5.20	5.96	-1.68	NS
<b>CTS (father)*</b>	47.33	39.23	66.62	43.37	-1.68	NS
<b>CTS (mother)*</b>	43.78	36.61	60.38	41.25	-1.59	NS
<b>MPDQ-A (self)*</b>	47.77	7.08	41.76	7.42	3.12	.003
<b>MPDQ-A (partner)*</b>	42.56	8.61	37.59	9.44	2.08	.04
<b>MPDQ-B*</b>	52.04	8.30	46.80	8.98	2.29	.03

\* Equal variances not assumed

\* Shortened DAST: non-completer (n = 37)

\* CTS (father): completer (n = 21), non-completer (n = 34)

\* CTS (mother): non-completer (n = 34)

\* MPDQ-A (self): non-completer (n = 36); MPDQ-A (partner), non-completer (n = 36); MPDQ-B, non-completer (n = 36)

A review of Table 10 verifies the differences between the completers and non-completers on the tools. Completers indicated higher levels of mutuality for themselves and partners, as well as identifying that mutuality in the relationship is more important to them. Completers also had significantly lower levels of PTSD symptoms on the PCL than did the non-completers.

#### Comparisons between completers and non-completers based on victims' reports

The program contacted all victims. Thirty-one victims joined the research study. The women also participated in the research protocol to evaluate the batterer's pattern of abuse and the impact on the victim. In addition, the women were asked to complete two

of the tools to compare their responses on the abuse pattern to that of the batterers' (ABI), and to compare their assessments of mutuality in the relationship (MPDQ).

Victims' demographics and batterers' completion status.

There were no statistically significant differences on victim characteristics and batterer completion or non-completion of the program. Their ages followed the men's in a normal distribution, with the highest age of 55 years. In contrast to the men, there was no statistical difference in the age of the victim and the completion status of the batterer. Nor was there a difference on their marital/partnered or living situation data. Two of the living categories dropped out for the women. None of the women who entered the study were in a new relationship, and none were living in alternative housing such as the barracks. They were still with the batterer, alone, or with their children. In addition, the victim's employment status was unrelated to whether the batterer completed the rehabilitation phase of the program or not.

Table 11: Comparison of completers and non-completers on general demographic information from the victims' reports

Variable	Completer (n = 12)	Non-completer (n = 19)	Chi-square statistic	Probability level
<b>Living Situation</b>	<ul style="list-style-type: none"> <li>▾ Batterer/kids, n = 5 (16%)</li> <li>▾ Alone &amp; kids, n = 7 (23%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ Batterer/kids, n = 12 (38%)</li> <li>▾ Alone &amp; kid, n = 7 (23%)</li> </ul>	1.37	NS
<b>Marital Status</b>	<ul style="list-style-type: none"> <li>▾ Married/partnered n = 12 (39%)</li> <li>▾ Divorced/Separated, n = 0</li> </ul>	<ul style="list-style-type: none"> <li>▾ Married/partnered n = 16 (52%)</li> <li>▾ Divorced/Separated, n = 3 (9%)</li> </ul>	2.1	NS
<b>Employment* Status</b>	<ul style="list-style-type: none"> <li>▾ Employed/Student, n = 8 (28%)</li> <li>▾ Unemployed / Disabled, n = 3 (10%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ Employed/Student, n = 12 (41%)</li> <li>▾ Unemployed / Disabled, n = 6 (21%)</li> </ul>	.12	NS

\* Employment status (victim): completers, n = 11; non-completers, n = 18

Victims' reports on DV and general violence and batterers' completion status.

Only two of the DV descriptive variables, based on the victims' reports, demonstrated differences between completers and non-completers. Batterers whose victims reported that the batterer had a combination of assault and other charges were not as likely to complete ( $X^2 = 6.06, p = .05$ ). Additionally, batterers whose victims reported that he assaulted others were not as likely to complete ( $X^2 = 6.67, p = .01$ ). As with the batterers' reports, victims' reports revealed no other statistically significant differences on the general DV variables. (See Table 12 for a summary of the domestic violence descriptive variables.)

Table 12: Comparison of completers and non-completers on the general DV variables based on the victims' reports of batterers' behaviors

Variable	Completer (n = 12)	Non-completer (n = 19)	Chi-square statistic	Probability level
Charge	<ul style="list-style-type: none"> <li>▾ None, n = 2 (6%)</li> <li>▾ Assault, n = 9 (29%)</li> <li>▾ Assault/other, n = 1 (3%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ None, n=5 (16%)</li> <li>▾ Assault, n = 6 (20%)</li> <li>▾ Assault/other, n = 8 (26%)</li> </ul>	6.06	.05
Police Involvement	<ul style="list-style-type: none"> <li>▾ None, n=0</li> <li>▾ Arrest, n= 9 (29%)</li> <li>▾ Other, n=3 (10%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ None, n=4 (13%)</li> <li>▾ Arrest, n=14 (45%)</li> <li>▾ Other, n=1 (3%)</li> </ul>	4.75	NS
Prior Police Response on a DV Call	<ul style="list-style-type: none"> <li>▾ None, n=5 (16%)</li> <li>▾ 1-3x, n=6 (20%)</li> <li>▾ &gt; 3x, n=1 (3%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ None, n=6 (20%)</li> <li>▾ 1-3x, n=8 (25%)</li> <li>▾ &gt; 3x, n=5 (16%)</li> </ul>	1.54	NS
Protection orders	<ul style="list-style-type: none"> <li>▾ None, n=2 (6%)</li> <li>▾ Orders, n=10 (32%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ None, n=8 (26%)</li> <li>▾ Orders, n=11 (36%)</li> </ul>	2.18	NS
General violence towards others	<ul style="list-style-type: none"> <li>▾ None, n=7 (23%)</li> <li>▾ Yes, n=3 (10%)</li> <li>▾ Unknown, n=2 (6%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ None, n=4 (13%)</li> <li>▾ Yes, n=15 (48%)</li> <li>▾ Unknown, n=0</li> </ul>	9.73	.008
Violence towards another partner	<ul style="list-style-type: none"> <li>▾ None, n=3 (10%)</li> <li>▾ Yes, n=5 (16%)</li> <li>▾ Unknown, n=4 (13%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ None, n=3 (10%)</li> <li>▾ Yes, n=12 (38%)</li> <li>▾ Unknown, n=4 (13%)</li> </ul>	1.37	NS
Does he have weapons?	<ul style="list-style-type: none"> <li>▾ None, n=8 (26%)</li> <li>▾ Yes, n=4 (13%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ None, n=13 (41%)</li> <li>▾ Yes, n=6 (20%)</li> </ul>	.01	NS
Is She Afraid?*	<ul style="list-style-type: none"> <li>▾ No, n=6 (20%)</li> <li>▾ Yes, n=5 (17%)</li> </ul>	<ul style="list-style-type: none"> <li>▾ No, n=8 (27%)</li> <li>▾ Yes, n=11 (36%)</li> </ul>	.43	NS

\* Is She Afraid: completer (n = 11)

While there was a significant difference between completers and non-completers on the victims' reports of the charges, there were some differences in their reports compared to those of the batterers' on this variable. As is evident in the above table, victims reported that there was 'no charge' in seven situations. However, the batterers indicated that there was 'no charge' in only four. For purposes of this study the most recent victim was interviewed. Some of the women indicated that there were, as yet, no assault charges. Three of these batterers had unresolved charges from prior assaults.

Victims' reports of batterers' substance use and abuse and completion status.

Similar to the batterers' reports, victims' reports of the batterers' substance usage were not significant when comparing the completers to non-completers. Victims reported that 17 batterers had a substance abuse problem, but only seven were currently drinking. Fewer still were reported as currently using drugs. Only three victims reported the batterer as currently using.

Victims' health issues and batterers' completion status.

The final Chi-square analyses were conducted on the health and mental health variables as reported by the victims. The victims were asked, "Have you even been injured during a domestic violence incident," and "Do you feel that any of your health or mental health problems were related to the DV?" In addition, general health care and mental health care visits were looked at. When comparing these variables based on completion and non-completion, there were no statistically significant differences found.

Victims' reports of batterers' violence and relationship mutuality.

Victims completed two tools to provide comparison information with the batterers' reports. The ABI partner form asks victims to rate the batterer's physical and psychologically abusive behavior in the past six months. Guttman split-half reliabilities were conducted on the ABI over-all and the two sub-scales. The over-all reliability was .81, the psychological sub-scale .86, and the physical sub-scale .87. Comparisons of the women's perspectives of the men's abuse based on completion/non-completion status were conducted using an independent t-test analysis. As with the batterers' data, there was no statistical difference found between the completers and non-completers based on victim reports of past abuse for the over-all ABI, or the physical or psychological sub-scales (see Table 13). ABI difference scores (women's perception of the men's abuse vs. the men's perceptions of themselves) were computed for completers and non-completers for the ABI over-all score, the physical and the psychological sub-scales. No difference was found based on completion/non-completion status using an independent t-test analysis (see Table 14).

A final comparison was made of just the women's reports of the abuse vs. the men's reports, irrespective of completion status. In this case differences were found. Using a paired t-test analysis, the over-all difference between batterer's and victim's ratings on the ABI had a t-value of -3.36,  $p = .002$ . Both sub-scales were significant as well with the psychological t-value of -3.25 ( $p = .003$ ), and physical t-value of -16.65 ( $t = .000$ ) (see Table 15). In general, victims reported significantly more frequent physical and psychological abuse when comparing their reports on the ABI to those of the batterer.

The other tool completed by the victims was the MPDQ Form A. Victims were asked to rate the batterer on his level of mutuality in the relationship, and then asked to rate themselves. Guttman split-half reliabilities for this tool rated .91 for the victim's 'self' sub-scale, and .61 for the victim's 'partner' sub-scale. In contrast to the batterers' report, there were no statistical differences found between completers and non-completers on victims' rating of batterers' mutuality. Nor were differences found in how victims rated themselves on mutuality and the batterers' completion status (see Table 13). However, when conducting comparisons between completers and non-completers on the difference scores, an interesting result was found. Comparisons were made between how the men rated their own levels of mutuality and how the victims rated the men's levels of mutuality. The completers were found to have a statistically greater difference score than did the non-completers ( $t = 2.39$ ,  $p = .025$ ). There was a greater amount of disagreement between victims' and batterers' reports of batterer mutuality for the completers than the non-completers. No statistical difference was found though when comparing completers and non-completers on difference scores between how the men rated the victim's mutuality versus the victims rating of themselves (see Table 14).

Table 13: ABI and MPDQ victims' reports by batterer completion/non-completion status

Tool	Completer (n = 12)		Non-completer (n = 19)		t-test statistic*	P level
	Mean	SD	Mean	SD		
ABI (over-all)	68.67	21.32	63.37	18.90	.70	NS
ABI (psychological)	50.83	16.47	45.79	14.42	.87	
ABI (physical)	17.83	5.80	17.58	5.53	.12	
MPDQ (victim self report)	50.25	8.89	47.05	7.83	1.02	NS
MPDQ (victim partner report)	34.50	6.76	38.05	6.11	-1.48	NS

\* Equal variances not assumed

**Table 14: ABI and MPDQ difference scores between victims' and batterers' reports by completion/non-completion status**

Tool	Completer (n = 12)		Non-completer (n = 19)		t-test statistic*	P level
	Mean	SD	Mean	SD		
<b>Difference Batterers' reports - victims' reports</b>						
<b>ABI difference score for total</b>	-17.5	18.87	-9.80	22.53	-1.03	NS
<b>ABI difference psychological sub-scale</b>	-12.92	14.97	-7.19	16.79	-.99	
<b>ABI difference physical sub-scale</b>	-16.51	5.57	-16.08	5.43	-.21	
<b>MPDQ Difference MPDQ men (partner) - MPDQ women (self)</b>	-11.25	9.19	-11.26	10.16	.004	NS
<b>MPDQ Difference: MPDQ men (self) - MPDQ women (partner)</b>	9.62	9.41	1.23	9.7	2.39	.025

\* Equal variances not assumed

But, once again, when making comparisons of victim's ratings of mutuality to the batterers', irrespective of completion status, significant differences were found. Using a paired t-test analysis, batterers were found to consistently rate themselves higher in levels of mutuality than the victims' ratings of them ( $t = 2.42, p = .02$ ). When comparing batterers' ratings of victims' mutuality to victims' ratings of themselves, victims consistently rated themselves higher in mutuality compared to how the batterers rated them ( $t = -6.50, p = .000$ ) (see Table 15 for ABI and MPDQ victim vs. batterers' scores). Thus, self-reports of mutuality (whether victim or batterer) were higher than the partner's rating of their mutuality.

Table 15: Victim vs. batterer scores on ABI and MPDQ irrespective of completion/non-completion status

Tool	Victim (n = 31)		Batterer (n = 31)		t-test statistic	Probability level
	Mean	SD	Mean	SD		
ABI (over-all)	2.18	.66	1.75	.471	-3.36	.002
ABI (psychological)	2.39	.53	1.92	.76	-3.25	.003
ABI (physical)	1.77	.55	1.43	.43	-4.18	.000
MPDQ-A Victim (self) vs. batterer (partner)	48.29	8.27	37.03	7.70	-6.50	.000
MPDQ-A Victim (partner) vs. batterer (self)	36.68	6.50	41.16	7.13	-2.42	.02

Victims rate the psychological and physical abuse as statistically higher than do the batterers (more frequent episodes of physical and psychological abuse). In addition, batterers' rate their own levels of mutuality statistically higher than victims' ratings of batterer mutuality, while also rating victims' levels of mutuality statistically lower than victims rating themselves. Comparisons of difference scores for completers and non-completers, however, reveal little difference. Batterers' and victims' ratings of abuse and mutuality were generally similar for completers and non-completers, except in the comparison of batterers' self-ratings of mutuality vs. victims' ratings of batterer mutuality. In this case, the completers had a statistically greater difference score compared to the non-completers.

#### Summary of comparison of completers and non-completers

There are several variables on which completers and non-completers differ. Of the general demographic variables, completers are more likely to be young and employed. Non-completers, on the other hand are older and unemployed or disabled. The domestic violence descriptive variables for the men's sample reveal that completers are both court-

ordered for DV rehabilitation and monitored by the court, while non-completers are not. The victims' reports of domestic violence descriptive variables indicated that non-completers had a greater number of charges and were more generally violent.

Comparisons of the research tools revealed even more differences between completers and non-completers. Completers indicated that they had fewer emotional responses to stress with lower levels on the psychological indices of the SOS. They also revealed that they had less post-traumatic stress disorder symptoms. In the area of mutuality the completers rated themselves and their partners as having statistically higher levels of mutuality in the relationship than did non-completers. In addition, completers identified that mutuality in the relationship was more important to them.

The non-completers, on the other hand, were older, unemployed/disabled, and indicated that they felt more general and post-traumatic stress. They also revealed that their mutuality in the relationship was lower than completers, and not as important to them. Those variables that had the greatest levels of significance in comparing completers to non-completers were age, employment, symptoms of stress (SOS) psychological indices, post-traumatic stress (PCL), and levels of mutuality (MPDQ).

**Research question 1B: Can completion or non-completion of the rehabilitation phase of the domestic violence program be predicted?**

As is evident from the above comparisons, completers and non-completers differ on several variables. The second research question is, based on these differences, can completion and non-completion be predicted?

Due to the categorical nature of the dependant variable, a logistical regression analysis was performed. Only data from the batterers' sample was entered into the regression analysis because of the small sample size of the victims' data. To determine what to enter into the regression analysis, correlate tables were computed for all the statistically significant variables. The psychological sub-scales (depression, habitual patterns, anger, anxiety, and cognitive disorganization) had Pearson Correlation values ranging from .68 to .86. All were statistically significant at  $p = .000$ . The other sub-scale of the SOS that was significant was central neurological. It too correlated with the psychological indices at values that ranged from .45 to .65, all were significant at  $p = .000$ . Due to the significant correlation of these indices, they were summed and a mean computed for each sub-scale. A new variable called 'mean psychological' (Mean Psych.) was created.

There was a high correlation between court-monitored and treatment mandated (Spearman's  $\rho = .65$ ,  $p = .000$ ) status as well. The treatment-mandated variable was dropped in favor of court-monitored due to the higher Chi-square statistic of the latter. The other variables that were considered for the regression analysis were age, employment status, PCL, and MPDQ (batterer self report). By examining the correlate tables further it was evident that the PCL scores also correlated significantly with the SOS indices (Mean Psych.) (Pearson correlation range from .60 to .78,  $p = .000$ ). With the first regression performed, collinearity existed between the PCL and 'Mean Pscyh.' variables, thus competing for the same variance. In addition, employment status did not contribute to the model in a statistically significant way.

It is desirable to have at least 15 subjects per variable entered into the regression analysis to reduce the chance of a Type II error. The variables were age, PCL, MPDQ (batterer, self-report), and court-monitored status. Two additional subjects were rejected due to missing data, resulting in a sample of 59 for the final logistical regression.

The results of the logistical regression was a Model Chi-square statistic of 31.08 ( $p = .0000$ ). The significant variables entering the regression analysis were age at  $p = .03$ , MPDQ at  $p = .03$ , PCL at  $p = .02$ , and court-monitored at  $p = .73$ . Only court-monitored failed to reach significance at the .05 level. This is likely due to the small number of batterers ( $n = 9$ ) who were not being monitored. This model predicted 88.89% of the non-completers, 78.26% of the completers, and had an over-all predictive ability of 84.75%.

Based on this model completers are likely to be young, have low levels of post-traumatic stress symptoms, rate themselves as having high mutuality in the relationship, and be court-monitored. Non-completers are just the opposite and are older, have high levels of post-traumatic stress, low levels of mutuality, and are less likely to be court-monitored.

## Chapter 5

### Discussion

Batterers' rehabilitation in the form of specialized batterers' treatment programs has continued to change and transform since the last DV attrition study was published in 1989. Public awareness campaigns have increased the general awareness of domestic violence as a problem. Despite the gains made in identification and intervention in domestic violence, DV continues to represent a major problem for families, communities and nations.

As suggested by the high rate of prior mental health interventions in this sample, general mental health care in the form of addictions treatment or other forms of psychotherapy do little to actually stop DV. In addition, many of the men had prior police response for DV without court-mandated treatment. They continued to batter and eventually ended up in this program and hence this study. It is apparent that without successful completion of a specialized domestic violence program, battering is likely to continue. For a number of the men the physical violence continued to escalate, increasing the dangerousness to both victims and perpetrators.

Completion of domestic violence intervention has historically been low. As apparent in this study, most of the men did not even make it to the once-a-month maintenance phase of the program. A few more will discontinue the program before they actually complete it in its entirety. It is likely that they will continue to batter, even possibly physically. They will continue to terrorize victims, model abusive behaviors to children, and set a poor example for their community. They will likely be visited by the police, and may even be referred to a DV program again.

## Discussion of how completers compare to non-completers from the batterers' perspectives

It is important to better understand why men complete or do not complete DV rehabilitation. The results of this study contained interesting and some expected and unexpected outcomes. Three of the significant variables found in this study were consistent with existing research on domestic violence rehabilitation attrition. As in five previous studies age, employment, and court-mandated status were important variables related to completion/non-completion of DV rehabilitation (Hamberger & Hastings, 1989; Pirog-Good & Stets, 1986; Saunders & Parker, 1989; Gruznski & Carrillo, 1988).

### Age

As expected, age was a significant factor in completion or non-completion of the domestic violence rehabilitation phase. However, in contrast to the prior attrition studies, it was the younger men in this study who were more likely to make the transition to the once-a-month maintenance phase. Saunders and Parker (1989) found completers to be older. Hamberger and Hastings (1989) also found completers to be older than those who dropped out.

### Employment

The employment finding in this study was consistent with prior research. The employed were more likely to complete. This finding was not necessarily anticipated for this sample. Given that the program has no out-of-pocket expenses for participants, the program cost would be no more prohibitive to the unemployed than to the employed. In fact, attending this program was potentially more costly for the employed in that they had to take leave, miss work, or change their work hours around to attend during the times

available. And yet, even when given the opportunity to pay for a program in the community with more flexible hours, the employed men opted to stay. The men have reported that they stay because they have more in common with the other men in the program because of their military experiences.

There was a slight positive correlation between age and employment (Spearman's  $\rho = .25$ ,  $p = .05$ ). By examining the data the greatest number of employed were younger than 36, with the unemployed in the 36 to 55 age group. The young and employed were also more likely to complete.

In the national survey conducted by Pirog-Good and Stets (1986), completers were more likely to be employed. Hamberger and Hastings (1989) found completers to have a higher level of employment than the non-completers. Saunders and Parker (1989) also found completers more likely to be employed.

#### Court-ordered and court-monitored status.

This study was consistent with prior attrition research in finding that court-ordered were more likely to complete DV rehabilitation. A new variable never looked at before in DV attrition research was included in this study. The variable was the court-monitored status of batterers. The men who were probation monitored had a face-to-face monthly appointment with their probation officer. If they were on administrative probation, the monthly probation reports were read and monitored by a probation officer or court official. The batterers' court-monitored status turned out to have a greater statistically significant difference between completers and non-completers than did the court-ordered variable. As would be expected, there was a high positive correlation between court-

mandated and court-monitored status (Spearman's rho = .65,  $p = .000$ ). For both the court-ordered and the court-monitored variables, all of those who were not ordered or monitored did not complete. Thus, there was no variability on these two variables.

When evaluating how age relates to court-monitored status, a significant correlation exists (Spearman's rho = .42,  $p = .001$ ). Young batterers were much more likely to be court-monitored than older batterers were ( $X^2 = 18.96$ ,  $p = .001$ ). This was not the case when looking at age and court-mandated status, however. The majority of monitored batterers were in the 20 to 45 age group. Eight of the nine non-monitored batterers were in the 46 to 62 age group. All nine non-monitored did not complete.

It is interesting that older batterers were not as likely to be court-monitored as younger batterers given the possible extent of the criminal history for older batterers. However, older batterers were not more likely to have more prior convictions, police response, or arrests. In fact, there was no relationship to the criminal and DV history variables and age. It is not readily clear why older batterers were significantly less likely to be court-monitored. Perhaps the younger men were seen as potentially more violent than the older men, and thus were more likely to be monitored.

Saunders and Parker (1989) found court-referred status significant for the younger, less educated clients, but not so for the older client. In a second study in the same publication by these authors, the older client was more likely to complete if they had a greater than high school education and were voluntary. In the work done by Hamberger and Hastings (1989), court-ordered were also more likely to complete. In the national

survey conducted by Pirog-Good and Stets (1986), completers were more likely to be court-referred.

#### Criminal history and levels of violence.

In contrast to the existing studies on domestic violence rehabilitation attrition, criminal history was unrelated to completion or non-completion in this study. The only domestic and general violence variables found to be significant in this study were the victims' reports of the assault charges and the victims' reports of the batterers' level of general violence. The levels of abuse and violence of completers and non-completers, as measured by the ABI, were not significantly different based on either batterer or victim report. Nor was there a difference in the level of abuse and violence witnessed as a child (as measured by the modified CTS). In addition, reports of being physically abused as a child, and witnessing domestic violence when growing up were not related to completion/non-completion of the DV rehabilitation component of the program.

Pre-intervention violence, both general and domestic, did not statistically relate to completion for this sample. None of the general and domestic violence variables to include number of arrests, prior DV response, and frequency and severity of domestic violence were statistically different for the two groups. What the men had witnessed or done had less to do with their completion than their readiness for the program (see the section on prediction of completion/non-completion).

Three existing studies looked at levels of violence and completion/non-completion of DV intervention. Found to be related to completion of DV intervention were reports of the use of direct threats, history of being abused as a child, witnessing domestic violence

in the family of origin (Gruznski & Carrillo, 1988), frequent violence and lower rates of life-threatening violence, and more frequent but less severe abuse (Saunders & Parker, 1989). In addition, Hamberger and Hastings (1989) found that pre-treatment miscellaneous offenses were related to program dropout.

### Ethnicity.

Ethnicity was found to be unrelated to completion/non-completion in this study. The program intervention is based on an anti-oppression model and thus provides numerous opportunities to examine how practices of oppression support and lead to violence. With the large minority representation in this program, these discussions create a bridge linking personal experiences of being oppressed to the oppression of women. The program model lends itself to application by a broad range of ethnic groups.

Reports of completion rates by ethnicity are inconsistent in the DV attrition literature. One study reported whites as more likely to drop out (Pirog-Good & Stets, 1986), and another reported that men of minority status were more likely to drop out (Saunders & Parker, 1989).

### Substance usage.

It was anticipated that substance usage would be a significant variable in this study. This was not found to be the case. The substance use variables included the MAST, DAST, DUI arrests, diagnoses of substance abuse problems, reports of currently drinking and using, and self-reported substance abuse problems. While completers did score lower on both the DAST and the MAST, it was only marginally so (one-tailed,  $p < .1$ , and  $p <$

.05 respectively). Nor was there a difference between completers and non-completers based on the victims' reports of batterers' substance usage.

In addition, this study differs from previous ones in that substance use/abuse treatment is available for both veterans and active duty military at their respective medical centers. Program criteria mandated that batterers, identified as having a substance abuse problem, need to have either completed or be in addiction's treatment concurrently. DV program staff worked with the addictions treatment staff in coordinating care, modifying treatment, and sharing pertinent information re: the batterer's substance usage. Because substance usage has been identified as an important element in response to domestic violence intervention, a great deal has been done already to better address this issue by the current program. While the majority of batterers (39%) reported having a substance abuse problem, most of them had already started to address the issue by seeking substance abuse treatment. This may have contributed to findings on the substance use variables. Under reporting on the DAST and the MAST is also a possibility.

Substance usage was looked at and found to be significant in only one prior study (Hamberger and Hastings, 1989). The researchers found the dropouts had higher pre-treatment police contact for drug and alcohol-related offenses and had higher levels on the MCMI-alcohol scale.

### Relationship.

The main thrust of the DV program is to help men halt all forms of psychological abuse and physical violence while building equality and partnership in intimate relationships. Thus relationship variables were also of interest in this study.

While the general relationship variables (marital status and living situation), in this study were not significant, the level of mutuality, as measured by the MPDQ, in the relationship was significant. The completers were significantly more likely to rate themselves as having high mutuality in the relationship. In addition, completers indicated that mutuality was more important to them than did the non-completers. Batterers' scores on the MPDQ indicated that it was either more desirable to appear to value mutuality, or it was indeed more important to them. Batterers who completed may have had an easier time working on building equality and partnership in the relationship because they valued aspects of mutuality more than the non-completers. The concept of partnership may also have been less foreign to them because they identified themselves as actually behaving more as a partner than the non-completers.

Of the two studies that included relationship variables (Pirog-Good & Stets, 1986; Gruznski & Carrillo, 1988) in the analysis of attrition from DV intervention only Gruznski and Carrillo found a relationship between completion and relationship indices. Higher scores on the FIRO-B control expressed sub-scale and more children distinguished completers from dropouts in this study.

#### Psychological indices.

The consequences of domestic violence are stressful. The men reported losing jobs, homes, marriages, and families. They reported feeling embarrassment and shame when handcuffed in front of family and neighbors. The men completed the research tools at the initial or second DV interview. The majority of the men were likely to be experiencing the stress from the public shame and multiple losses. But it was the

completers that indicated lower levels of stress on the depression, neurological, cognitive disorganization, anger, habitual patterns and anxiety sub-scales of the SOS. And it was the completers that indicated lower levels of post-traumatic stress symptoms as measured by the PCL.

There may be a number of explanations for the differences on the psychological indices between completers and non-completers. Non-completers' stress symptoms may have been more disruptive for them, thus making it more difficult to focus on the work required in domestic violence rehabilitation. Men who were identified as having mental health problems were referred for appropriate intervention and follow-up. While many of the men were concurrently receiving other forms of interventions for mental health problems, there was not a significant difference between completers and non-completers based on mental health diagnoses and number of mental health visits. In addition, psychological distress and mental health problems may have been missed in some, thus making it more difficult for them to engage in domestic violence rehabilitation without the on-going intervention for their general mental health problems.

Six of the men had diagnoses for neurological problems. All six of them did not complete. The rehabilitation model lends itself to a wide range of applications, including alterations made for those with cognitive impairment. The program has graduated men with neurological diagnoses and cognitive impairments in the past. The number with such impairments in this study is so small it is difficult to draw inferences from the data. However, a future study looking at how cognitively impaired men response to

rehabilitation in contrast to those without such impairments, may provide further information on this finding.

Anecdotal evidence in the form of reports from batterers or fellow group members reveals a number of reasons given for not completing the program. Of the four who have since re-started the program, three of them stated that either life stress or the stress of participating in both addictions and DV rehabilitation was too much for them. Another man identified time-conflict and bus fare as the reason he stopped coming. Fellow group members have informed the group leaders that another absent participant said his court jurisdiction ran out and he said he was going to drop out.

Another reason that may explain non-completion by some of those with the high psychological indices: They were allowed to satisfy their court mandate through general and PTSD treatment and by staying on medications. This is a potential confound to the study by creating an unknown sample bias. When batterers are allowed to satisfy court mandates through other treatment modes that do not focus on their pattern of abuse and violence, or hold them accountable for stopping all forms of abuse, the batterer is likely to drop out of DV rehabilitation. Continued victim contact for some of these non-completers reveals that the men are still battering.

Of the prior work on domestic violence rehabilitation attrition, only one other study looked at psychological variables. Hamberger and Hastings (1989) found dropouts to have higher levels of borderline and schizoid tendencies than the completers.

### Discussion of how completers compare to non-completers from the victims' perspectives

This study differed from all others looking at completion of domestic violence rehabilitation by including victim reports. Victim reports of batterers' behaviors displayed differences between completers and non-completers on the type and number of charges and violence against non-intimates.

As expected the over-all victims' ratings of the abuse and the mutuality in the relationship, irrespective of completion status, were significantly different from batterers' ratings. When looking at the difference scores of victims' and batterers' reports and completion status, only the MPDQ report of batterers' mutuality and victims' ratings of batterers' mutuality was significant. In this case there was a greater difference between how batterers who completed rated themselves on mutuality than how their victims rated them on mutuality. While these batterers identified mutuality as being important to them, and rated themselves higher than non-completers, their victims did not agree with the batterers' assessments. Because batterers tend to minimize, deny, and blame, it is expected that there would be differences in the victims' and batterers' reports. In addition, some of the women were out of the relationship. Their recollections could be clearer with the immediate threat out of the way. For women still coping with and surviving the abuse, their recollections may have been buffered by the immediacy of the danger. They may have rated batterers' mutuality as higher and the frequency of the abuse as less than those who were out of the relationship as a way of defending themselves against the on-going abuse.

### Summary of prediction model

Variables selected for the logistical regression were chosen for one or more of the following reasons: 1. The variable was found to be consistent with existing literature, 2. Significant differences were found in comparing completers to non-completers, and 3. The level of correlation with the other variables was low. The resulting Chi-square model predicted non-completion for 89%, completion for 78%, with an over-all predictability of 85%. Completers were more likely to be young, have low levels of stress and post-traumatic stress, rate themselves as having higher mutuality, and be court-monitored. The predictability of this model was better for non-completers (89%) than completers (78%). The non-completers were older, unemployed or disabled, had high levels of stress and post-traumatic stress, and rated their levels of mutuality lower than completers.

The DV program staff have carefully followed up with substance abuse problems in batterers by requiring them to complete or be in addictions treatment concurrently. DV rehabilitation is delayed allowing the men time to initiate their addiction treatment and obtain some stability in their recovery work. This same approach may also aid those batterers who have high levels of psychological distress or post-traumatic stress to complete DV rehabilitation. This would only work, however, if their court/probation jurisdiction were extended while maintaining their DV rehabilitation mandate.

Admission into the domestic violence program is already undergoing some changes. Two men have been delayed in initiating their DV rehabilitation because of instability in their living situation and a worsening of their major mental health disorder symptoms. Both were given referrals to other care providers and homeless case managers

to specifically work on these issues. Neither has been denied DV intervention, but follow up will be contingent on evident stability in these areas. A recommendation to the court and probation has been made to modify the conditions to reflect these changes, while lengthening the jurisdiction and maintaining the domestic violence rehabilitation requirement. Only time and continued monitoring will disclose whether this will make a difference in improving completion rate for some of the batterers.

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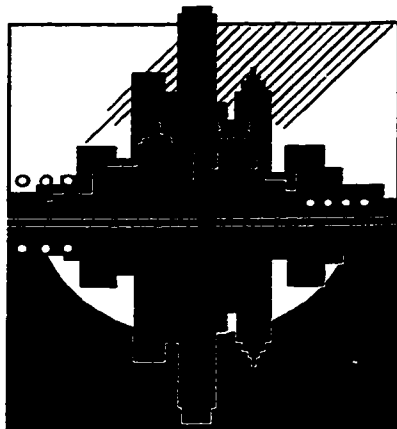
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**Appendix A**  
**Recruitment Protocol**

**Research Study:  
Script to Approach Prospective Research Participants**

We are currently conducting a study on looking at who completes and who drops out of domestic violence rehabilitation. We are looking for both men in treatment and their partners to participate in the study. Are you interested in some information about the study? I have this for you to read.

(Prospective participants may either read the information right there or read it later. These individuals may either enroll immediately or contact the research investigator for information and make arrangements to enroll in the study. Provide them with the informational flyer. If they wish to enroll immediately, obtain the informed consent, answer questions about the consent, and provide them with a copy.)

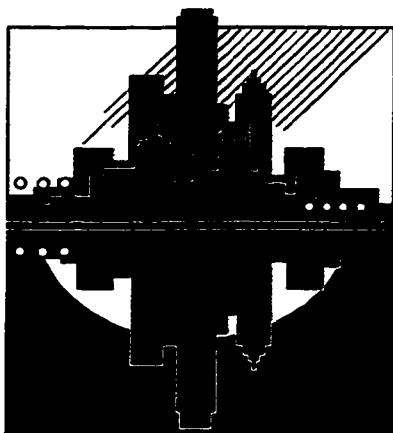


**Saying no to the violence...  
In ourselves, families, and communities**

We are currently conducting a study on looking at who completes and who drops out of domestic violence rehabilitation. We are looking for both men in rehab. and their partners to participate in the study. If you are interested, here is some basic information about the study:

1. Participants for this study are being recruited for six months. You are asked to complete several research questionnaires at the time you join the study. These questionnaires should take about 30' - 45'. There are no further obligations to the study.
2. All information will be kept confidential by the research team. No one, other than the principal researcher and the research assistant, will see your responses.
3. You may drop out of the study at any time. This will not affect your follow-up in the rehabilitation program.
4. If you have questions, contact the following:  
  
American Lake: 206-582-8440  
April Gerlock, ext. 6819  
  
Madigan Army Medical Center:  
April Gerlock: 582-8440, ext. 6819  
G. Thomas Mitchell: 206-968-4151

Thank you for your interest!



**Saying no to the violence...  
In ourselves, families, and communities**

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1. Participants for this study are being recruited for six months. You are asked to complete several research questionnaires at the time your partner enrolls in domestic violence rehabilitation and joins the study. These questionnaires should take about 15' - 20'. There are no further obligations to the study.

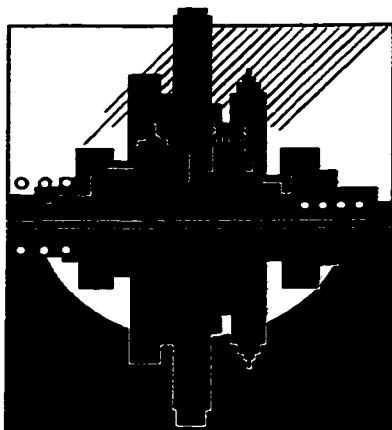
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Madigan Army Medical Center:  
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G. Thomas Mitchell: 206-968-4159

Thank you for your interest!

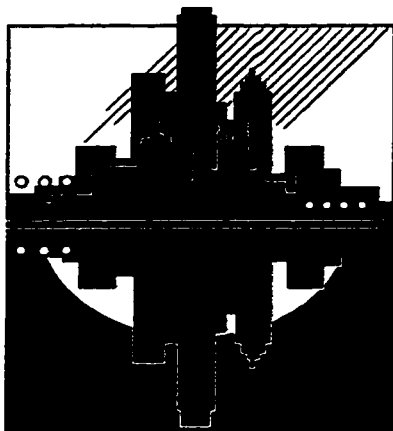


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1. Participants for this study are being recruited for six months. You are asked to complete several research questionnaires at the time you join the study. These questionnaires should take about 30' - 45'. There are no further obligations to the study.
2. Your treatment providers will not see your responses. The project investigator will see all responses, but will have no knowledge of who completed the questionnaires. Active duty command *may* request access to questionnaires.
3. You may drop out of the study at any time. This will not affect your follow-up in the rehabilitation program.
4. If you have questions, contact the following:  
  
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1. Participants for this study are being recruited for six months. You are asked to complete two research questionnaires at the time your partner enrolls in domestic violence rehabilitation and joins the study. These questionnaires should take about 15' - 20'. There are no further obligations to the study.
2. You may drop out of the study at any time.
3. The treatment providers will not see your responses. The project investigator will see all responses, but will have no knowledge of who completed the questionnaire. If you are active duty, command *may* request access to the questionnaires.
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Thank you for your interest!

**Appendix B**  
**Research Tools**  
**(Men's packet)**

## **NOTE TO USERS**

**Copyrighted materials in this document have not been filmed at the request of the author. They are available for consultation in the author's university library.**

**Appendix B  
130-148**

**UMI**

**Appendix C**  
**Research Tools**  
**(Women's packet)**

## **NOTE TO USERS**

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**Appendix C  
150-152**

**UMI**

**Appendix D**  
**Personal & Battering History Interview**  
(Batterers' coding sheets)

VA Puget Sound Health Care System  
 Personal & Battering History  
 (Batterer Report)

\*1 = yes; 2 = no (unless specified otherwise)

1. Age:

2. Relationship Status

- 1 Single
- 2 Married(how long \_\_\_\_\_)
- 3 partnered (how long \_\_\_\_\_)

- 4 Divorced/Separated
- 5 other (specify)

3. Highest education acquired:

- 1 High school
- 2 GED
- 3 Technical/community degree ( ) incomplete ( )

- 4 Four-year college degree ( ) incomplete ( )
- 5 Master's degree degree ( ) incomplete ( )
- 6 Doctorate degree ( ) incomplete ( )

4. Ethnic Identity:

- 1 Afro-American
- 2 Asian-American
- 3 Native American
- 4 Caucasian

- 5 Hispanic American
- 6 mixed, specify \_\_\_\_\_
- 7 other, specify \_\_\_\_\_

5. What was the total gross income for you and your family living in the house in the last tax year, not just from wages but from all sources before taxes and other deductions.

- 1 = < \$10,000
- 2 = 10,000+ - 30,000
- 3 = 31,000 - 50,000
- 4 = 51,000 - 70,000
- 5 = >\$70,000

6. Living situation:

- 1 with victim
- 2 with new partner
- 3 with victim & children
- 4 with children

- 5 new partner & kids
- 6 alone
- 7 other

7. Primary Job or occupation:

Are you: (mark all that apply)

- 1 full-time employee
- 2 part-time employee
- 3 two or more jobs

- 4 student
- 5 unemployed, outside the home
- 6 disabled
- 7 other

## 8. Treatment mandated through:

- 1 Court order
- 2 Probation
- 3 CPS
- 4 other than mandated treatment

## 9. Most recent police involvement:

- 1 Arrest
- 2 Investigative report
- 3 Warrant request
- 4 none

## 10. Assault charge:

- 1 = Assault #4
- 2 = Felony assault
- 3 = Malicious mischief
- 4 = violation of court order

- 5 = destruction of property
- 6 = interference with justice
- 7 = assault & other
- 8 = none

## Other charges:

## 11. Type of court order:

- 1 no contact
- 2 temp order of protection
- 3 permanent protection order
- 4 restraining order
- 5 none

## 12. Jail time served:

- 1 = none
- 2 = 1 - 7 days
- 3 = several weeks
- 4 = several months
- 5 = > 1 yr.

## 13. Fine:

- 1 = no fine
- 2 = \$50 - \$ 300
- 3 = \$301 - \$500
- 4 = \$501 - \$1000

- 5 = \$1001 - \$2000
- 6 = >\$2000

## 14. Probation conditions:

- 1 none
- 2 DV assessment/treatment
- 3 Drug/Alcohol Assessment/treatment

- 4 DV & substance
- 5 DV & no contact
- 6 DV, substance, & no contact

15. Court-monitored probation? \_\_\_\_\_yes \_\_\_\_\_no

16a. Have you had a previous conviction?

- 1 = none
- 2 = 1 - 3
- 3 = 4 - 7
- 4 = 8 - 15
- 5 = > 15

16b. Priors:

- 1 = DV
- 2 = DUI
- 3 = DV & DUI
- 4 = general assault
- 5 = possession of illegal substance
- 6 = sexual offense
- 7 = several of these

17. Have the police responded previously for domestic violence?

- 1 = none
- 2 = 1- 3x
- 3 = 4 - 7x
- 4 = 8 - 15x
- 5 = > 16x

18. Have you ever been involved in DV counseling before? \_\_\_\_yes \_\_\_\_no

19. Have you ever been involved in anger management before? \_\_\_\_yes \_\_\_\_no

20. Have you even had drug and alcohol treatment before? \_\_\_\_yes \_\_\_\_no

21. Did you witness physical violence between your father and mother? \_\_\_\_yes \_\_\_\_no

22. Were your parents abusive to you? \_\_\_\_yes \_\_\_\_no

23. Diagnosed medical\psychiatric illnesses (list all):

\_\_\_\_\_

\_\_\_\_\_

23a). Diagnosed medical: 1 = none; 2 = cardiovascular; 2 = neurological; 2 = pulmonary; 2 = musco-skeletal; 2 dermatologic; 2 = gastrointestinal

23b). Diagnosed psychiatric: 1 = none  
2 = mood disorders; 2 = anxiety disorders; 2 = psychosis; 2 = persouality disorder; 2 = substance abuse

24. Have you received health treatment for any injuries related to domestic violence?

\_\_\_\_\_ yes \_\_\_\_\_ no

25. Do you believe any of your medical or mental health difficulties are related to domestic violence? \_\_\_\_\_ yes \_\_\_\_\_ no

26 List all medical and mental health problems related to domestic violence:

26). Medical related to DV:

- 1 = musco-skeletal
- 2 = cardio-vascular
- 3 = lacerations/bruises
- 4 = none

26b). Psychiatric related to DV:

- 1 = anxiety
- 2 = depression
- 3 = none

27. How many health care visits to a physician, nurse, physician's assistant, etc. have you had in the past 6 months:

- 1 = none
- 2 = 1 - 5x
- 3 = 6 - 10x
- 4 = 11 - 20x
- 5 = >20x

28. How many mental health care visits to a psychologist, psychiatrist, nurse, social worker, etc. have you had in the past 6 months:

- 1 = none
- 2 = 1 - 5 x
- 3 = 6 - 10x
- 4 = 11 - 20x
- 5 = > 20x

29. Do you have a current drug or alcohol problem? \_\_\_\_yes \_\_\_\_no

29a). What is your alcohol consumption pattern?

- 1. Daily
- 2. 2-4 x per week
- 3. Weekly
- 4. Less than monthly
- 5. Monthly
- 6. Binge
- 7. Unknown

29b). What type of drugs do you use?

- 1. None
- 2. Cocain/Crack
- 3. Marijuana
- 4. Depressants
- 5. Stimulants
- 6. Other
- 7. Several

29c). What is your drug usage pattern?

1. Daily
2. 2 - 4 x per week
3. Weekly
4. Less than monthly
5. Monthly
6. Binge
7. Unknown

30. Do you have weapons? \_\_\_\_ yes \_\_\_\_ no

31. Have you been violent towards another intimate partner? \_\_\_\_ yes \_\_\_\_ no

32. Have you been violent towards other non-intimate persons? \_\_\_\_ yes \_\_\_\_ no

33. Is your partner afraid of you? \_\_\_\_ yes \_\_\_\_ no \_\_\_\_ unknown

34. Serviced connected for PTSD? \_\_\_\_ yes \_\_\_\_ no

35. Status: \_\_\_\_ veteran \_\_\_\_ active duty \_\_\_\_ other

36. Completer \_\_\_\_ Noncompleter \_\_\_\_ Dropout \_\_\_\_

**Appendix E**  
**Personal & DV Impact Interview**  
**(Victims' coding sheets)**

VA Puget Sound Health Care System  
 Personal & Domestic Violence Impact  
 and Health History Interview  
 (Victim Report)

## 1. Age

## 2. Marital Status

- |                             |                      |
|-----------------------------|----------------------|
| 1 Single                    | 4 Divorced/Separated |
| 2 Married(how long ____)    | 5 other (specify)    |
| 3 partnered (how long ____) |                      |

## 3. Ethnic Identity:

- |                   |                        |
|-------------------|------------------------|
| 1 Afro-American   | 5 Hispanic American    |
| 2 Asian-American  | 6 mixed, specify _____ |
| 3 Native American | 7 other, specify _____ |
| 4 Caucasian       |                        |

## 4. Living situation:

- |                                 |                      |
|---------------------------------|----------------------|
| 1 with batterer                 | 5 new partner & kids |
| 2 with new partner              | 6 alone              |
| 3 with batterer & kids          | 7 other              |
| 4 with children (how many ____) |                      |

## 5. Primary Job or occupation:

- |                                |                                |
|--------------------------------|--------------------------------|
| Are you: (mark all that apply) | 4 student                      |
| 1 full-time employee           | 5 unemployed, outside the home |
| 2 part-time employee           | 6 disabled                     |
| 3 two or more jobs             | 7 other                        |

## 6. Most recent police involvement:

- 1 Arrest
- 2 Investigative report
- 3 Warrant request
- 4 none

## 7. Assault charge:

- |                              |                               |
|------------------------------|-------------------------------|
| 1 = Assault #4               | 5 = destruction of property   |
| 2 = Felony assault           | 6 = interference with justice |
| 3 = Malicious mischief       | 7 = assault & other           |
| 4 = violation of court order | 8 = none                      |

## 8. Type of court order:

- 1 no contact
- 2 temp order of protection
3. restraining order
4. permanent protection order
5. none

9. Have the police responded previously?

- 1 = none
- 2 = 1 - 3x
- 3 = 4 - 7x
- 4 = 8 - 15x
- 5 = > 15x

10. Diagnosed medical\psychiatric illnesses (list all):

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10a). Diagnosed medical: 1 = none

- 2 = cardiovascular; 2 = neurological; 2 = pulmonary; 2 = musco-skeletal; 2 dermatologic;
- 2 = gastrointestinal

10b). Diagnosed psychiatric: 1 = none

- 2 = mood disorders; 2 = anxiety disorders; 2 = psychosis; 2 = personality disorder;
- 2 = substance abuse

11. How many health care visits to a physician, nurse, physician's assistant, etc. have you had in the past 6 months:

- 1 = none
- 2 = 1 - 5x
- 3 = 6 - 10x
- 4 = 11 - 20x
- 5 = >20x

12. How many mental health care visits to a psychologist, psychiatrist, nurse, social worker, etc. have you had in the past 6 months:

- 1 = none
- 2 = 1 - 5x
- 3 = 6 - 10x
- 4 = 11 - 20x
- 5 = >20x

13. Have you ever received health care as a result of a domestic violence injury?

\_\_\_\_\_ yes \_\_\_\_\_ no

14. Do you feel that any of your medical or mental health difficulties are related to domestic violence? \_\_\_\_\_ yes \_\_\_\_\_ no

15. List all medical and mental health problems related to domestic violence

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15a). Medical related to DV:

- 1 = musco-skeletal
- 2 = cardio-vascular
- 3 = lacerations/bruises
- 4 = none

15b). Psychiatric related to DV:

- 1 = anxiety
- 2 = depression
- 3 = none

16. Does your partner/former partner use drugs or alcohol? \_\_\_\_yes \_\_\_\_no

17a). What is *his* alcohol consumption pattern?

- 1. Daily
- 2. 2-4 x per week
- 3. Weekly
- 4. Less than monthly
- 5. Monthly
- 6. Binge
- 7. Unknown

17b). What type of drugs does *he* use?

- 1. None
- 2. Cocain/Crack
- 3. Marijuana
- 4. Depressants
- 5. Stimulants
- 6. Other
- 7. Several

17c). What is *his* drug usage pattern?

- 1. Daily
- 2. 2 - 4 x per week
- 3. Weekly
- 4. Less than monthly
- 5. Monthly
- 6. Binge
- 7. Unknown

18. Does he have any weapons? \_\_\_\_yes \_\_\_\_no \_\_\_\_unknown

18. Has been violent towards others? \_\_\_\_yes \_\_\_\_no \_\_\_\_unknown

19. Has he been abusive towards other intimate partners? \_\_\_\_yes \_\_\_\_no \_\_\_\_unknown

20. Are you afraid of him? \_\_\_\_yes \_\_\_\_no

## VITA

## April A. Gerlock

**Academic and Professional Preparation:**

- February '97 Doctoral Candidate (Ph.C.), University of Washington, School of Nursing.
- July 1980 M.A., Community-Family Nursing, U. of Iowa, Iowa, City, Iowa.  
Thesis: Factors Associated with the Seclusion of Psychiatric Patients.
- July 1977 B.S.N., Nursing, U. of Iowa, Iowa City, Iowa.
- 1973 - 1975 Pre-nursing at Iowa State University, Ames, Iowa.

**Refereed articles:**

- Gerlock, A.A., & Solomon, H.C. (1983). Factors associated with the seclusion of psychiatric patients. Perspectives in Psychiatric Care, 21 (2), 46-53.
- Gerlock, A.A. (1991). Vietnam: Returning to the scene of the trauma. Journal of Psychosocial Nursing, 29 (2), 4-8.
- Gerlock, A.A. (1994). Veterans' response to an anger management intervention. Issues in Mental Health Nursing, 15 (4), 393-408.
- Gerlock, A.A. (1997, September-October). New directions in the treatment of men who batter women. Health Care for Women International, 18 (5), 481-493.
- Gerlock, A.A. (in press). Health impact of domestic violence. Issues in Mental Health Nursing.

**Invited publications:**

- Gerlock, A.A. (1996, Summer). An eight week anger management intervention model for veterans with PTSD. National Center for Posttraumatic Stress Disorder, Clinical Quarterly.

**Refereed proceedings:**

- Gerlock, A.A. (1981). "The quiet room experience for psychiatric patients." *First National Nursing Conference on Affective Disorders* (article), pp. 162-175.

- Gerlock, A.A. (1987). "Factors associated with the seclusion of psychiatric patients." *Second National Theory and Research-Based Psychosocial Nursing Practice Conference* (abstract).
- Gerlock, A.A., & Scurfield, R. (1991). "Return to Vietnam: Experiences of two veterans groups." *The Fifth Annual International Meeting on the Society for Traumatic Stress Studies* (abstract).
- Gerlock, A.A. (1991). "Visiting the site of trauma." *The Fourth National Theory and Research-Based Psychosocial Nursing Conference* (abstract).
- Gerlock, A.A. (1993). "PTSD and trauma: Intervention for the anger component." *The Fifth National Theory and Research-Based Psychosocial Nursing Conference* (abstract).
- Gerlock, A.A. (1994). "Trauma and PTSD: Intervention for the anger component." *The 3rd National VA Nursing Research Conference* (abstract).

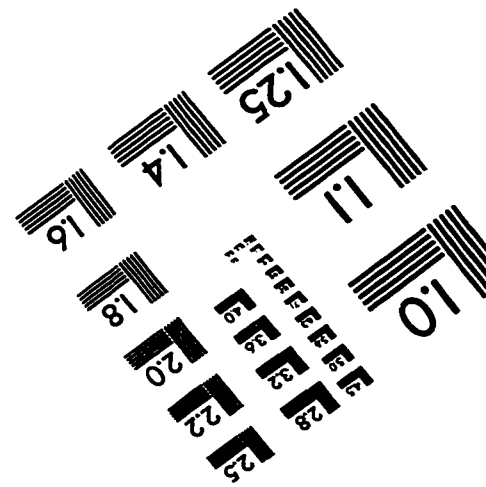
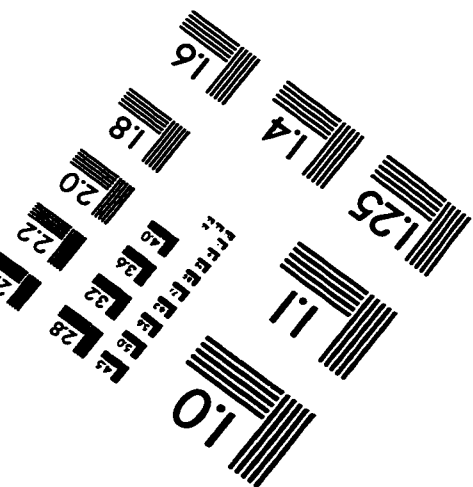
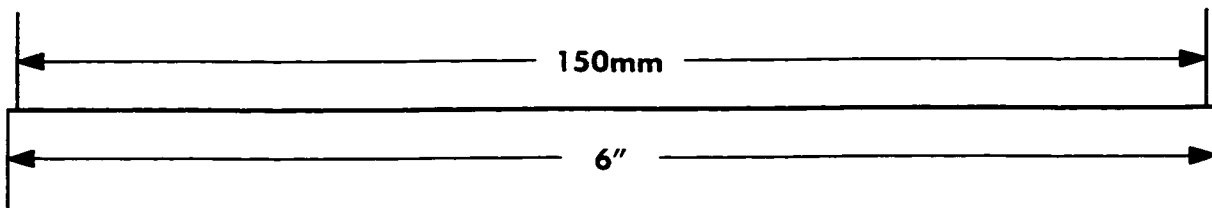
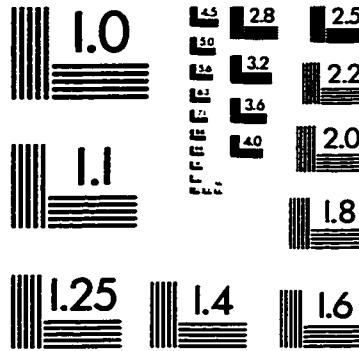
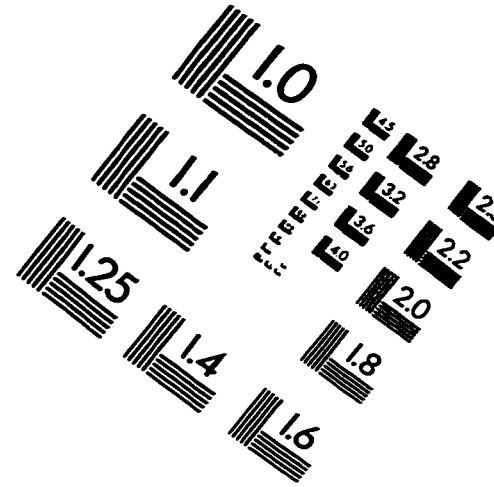
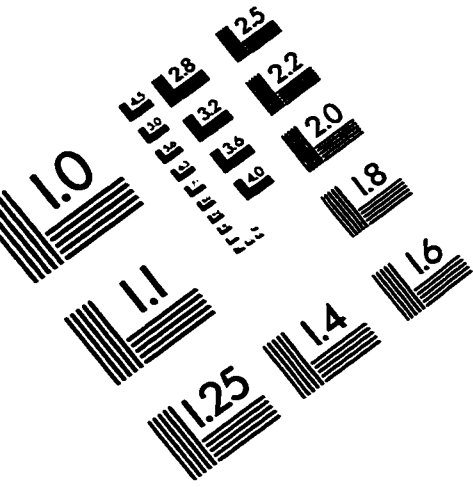
**Research:**

- 6/98           Sigma Theta Tau grant funding for: *Comparison and Prediction of Completers and Non-completers of a Domestic Violence Program*. Grant award: \$1500.
- 4/97           Hester McLaws Nursing Scholarship Award, University of Washington, School of Nursing, Seattle, WA. Research award amount: \$3500.
- 11/95           *An Analysis of Who Enters and Succeeds in Domestic Violence Treatment*, Department of Veterans' Affairs, National Nursing Research Initiative, Letter of Intent accepted for a full grant proposal.

**Current professional practice:**

- 6/80 - current. *Advanced Practice Nurse*, Department of Veterans' Affairs. Current position is with the Post-traumatic Stress Outpatient Clinic and supervisor of the Domestic Violence Program at the American Lake Division, VA Puget Sound Health Care System.

# IMAGE EVALUATION TEST TARGET (QA-3)



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