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A Qualitative Study of Male Veterans' Violence Perpetration and Treatment Preferences

Andra Teten Tharp, PhD[*], **Michelle Sherman, PhD**[†], **Kristin Holland, PhD**[‡], **Bradford Townsend, BS**[†], and **Ursula Bowling, PsyD**[†]

[*] Centers for Disease Control and Prevention, 1006 Broad Bay Lane, League City, TX 77573.

[†] Oklahoma City VA Medical Center, South Central Mental Illness Research, Education and Clinical Center, University of Oklahoma Health Sciences Center, 921 NE 13th Street, Oklahoma City, OK 73104.

[‡] Centers for Disease Control and Prevention, 4770 Buford Highway NE, F-63, Atlanta, GA 30341.

Abstract

Prevention and treatment of intimate partner violence (IPV) has increasingly focused on engaging men; however, very little work has examined how men manage the negative emotions associated with relationship conflict, as well as their preferences for and perceived barriers to treatment. Given the overrepresentation of IPV among men with post-traumatic stress disorder, the perspectives of male veterans with and without post-traumatic stress disorder are critical to informing IPV prevention and treatment within the Veterans Administration (VA) healthcare system. This qualitative study involved interviews with 25 male veterans who reported recent IPV perpetration. Interview themes included coping with emotions associated with violence and preferences and barriers to seeking treatment related to IPV. Results found the participants were interested in receiving IPV treatment at the Veterans Administration, and interviews offered several suggestions for developing or adapting prevention and treatment options for male veterans and their families to take into account violence in their relationships.

INTRODUCTION

Although it is estimated that rates of intimate partner violence (IPV) victimization are similar between civilian and military samples,[1] studies have found that rates of veteran perpetration of IPV are up to three times higher than among civilians.[2] The higher rate of physical and psychological IPV perpetration among veterans is attributed, in part, to post-traumatic stress disorder (PTSD); PTSD symptom severity, in particular hyperarousal, is significantly associated with physical IPV perpetration in military samples.[3,4]

To address the issue of violence against women, including IPV, recent efforts have focused on engaging men in prevention and intervention strategies.[5] With men comprising the

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majority of Veterans Administration (VA) patients and the VA increasingly focusing on including veterans' partners/family in treatment,[6] the male veteran voice is crucial in this dialog. Understanding male veterans' perspectives is critical to effectively engaging them in violence prevention and reduction strategies. Therefore, the current study describes themes that emerged from interviews with male veterans (with and without PTSD) who were seeking treatment in a VA setting and who reported perpetrating physical and verbal IPV. Questions included coping strategies and preferences for and barriers to IPV treatment.

METHOD

Participants

Veterans (N = 125) were recruited via their mental health providers and announcements after group-based treatment sessions at one midwestern VA hospital. Providers were asked to refer male veterans (ages 18–80) who admitted to perpetrating IPV and had a live-in female partner. Exclusion criteria included current risk for suicide and homicide, active psychotic symptoms, and current substance intoxication. Veterans were recruited from a variety of group-based treatment settings including outpatient PTSD therapy groups, anger management groups, the substance abuse clinic, and a VA jail diversion program. These veterans completed a 4-item screening questionnaire, for which they received a five-dollar VA canteen voucher. Screening questions included frequency of argument (5-point scale, "less than once per month" to "daily"), level of tension in relationship (3-point scale, "not at all" to "very intense"), and frequency of verbal and physical aggression (1 item for each, 5-point scale, "never" to "every argument"). The mean of this screening instrument was 8.7 (standard deviation [SD] = 3.1; range, 4–18). Veterans who either scored one standard deviation above the mean or reported they perpetrated verbal or physical aggression in "most" or "every" argument were invited to participate in an interview. Thirty-seven veterans (29.6%) were invited to interview and 25 (68%) consented to participate.

Data Collection Protocol

Individual interviews, which lasted approximately 45 to 60 minutes, were conducted by a psychologist with extensive experience conducting qualitative research. The semi-structured interview addressed the nature of conflict, coping tools, preferences for VA services, and perceived barriers to veterans engaging in such care. A phenomenological qualitative approach was used, which promoted participants' description of actions, experiences, beliefs, and values as they viewed them. This approach is ideal for exploratory analysis where little is understood about the mechanisms that guide the phenomena under study.[7] All interviews were audio recorded, and verbatim transcripts were prepared for qualitative analysis.

After the interview, veterans completed a demographic questionnaire and the following standardized measures: Post-traumatic Stress Disorder Checklist—Military version,[8] the Dyadic Adjustment Scale,[9] and selected items from the Conflict Tactics Scale Revised.[10] Each frequency category was recoded to its midpoint. Participants received $20 for participating in the interview and completing the questionnaire. This research was approved

by the University of Oklahoma Health Sciences Center Institutional Review Board and by the VA Research and Development Committee.

Data Analysis

Qualitative data were analyzed using content analysis techniques to identify emergent themes.[11] The research team first coded several transcripts together to mutually define key themes and create a code book; next, research members analyzed data from each interview transcript independently, identifying common patterns among each interviewee and coding data within the transcripts. For intercoder agreement, the group regularly discussed the data and emergent themes and came to a consensus regarding any discrepancies or differences in interpretation. The lead coder also double-coded some sections of interviews to guarantee reliability across coders. We used the constant comparison technique[12–14] to explore commonalties and differences in perspective from multiple interviews and to identify key themes present among aggregate data. Text excerpts related to common themes were compiled in an Excel database.

RESULTS

Participant characteristics are presented in Table I. Twenty veterans (80%) had a Posttraumatic Stress Disorder Checklist—Military[8] version score of 50+ (mean = 62.4, SD = 16.1), which is suggestive of PTSD. Sixteen veterans (64%) fell in the distressed range (above 16) of couple functioning on the Dyadic Adjustment Scale[9] (mean = 18.1, SD = 7.1). On the Conflict Tactics Scale Revised,[10] the average number of psychologically aggressive acts in the past year was 30.6 (SD = 23.0), physically assaultive acts was 7.84 (SD = 16.6), and sexually coercive acts was 3.68 (SD = 8.3). To contextualize these quantitative findings and provide additional information about the veterans' conflict and relationships, some additional information related to the nature of the violence that was obtained during the interview is provided as well.

Participants identified several common factors that preceded conflict in their relationships, including money (n = 10, 38%), infidelity (n = 5, 19%), alcohol (n = 3, 12%), partner bringing up the past (n = 4, 15%), veteran's feeling nagged and wanting space (n = 5, 19%), parenting differences (n = 4, 15%), and sexual activity (n = 2, 8%). For instance, two participants described factors that preceded relationship conflict: "Our last altercation was when I found out she was talking to her other baby daddy; it got physical then" (34-year-old single [with girlfriend] Persian Gulf War Veteran with PTSD); "I'm not as sexually active as she is, and she thinks there's a problem there (61-year-old married Vietnam Veteran with PTSD).

Of veterans who were able to describe length of fights, 6 (30%) noted <10 minute duration, 10 (50%) noted 11 to 20 minutes, and 4 (20%) noted over 20 minutes. Almost all veterans reported that their conflicts occurred in the home, with only 2 (8%) noting conflicts occurred in public. Nota–bly, almost half (n = 12, 48%) reported that their children or grandchildren are sometimes present during the arguments, 3 (12%) said friends are around, and 10 (40%) said no one is present. Although nine (36%) veterans reported that weapons (guns and knives) are accessible during the arguments, none of the veterans reported that they use the

weapons during the fights. Five (20%) of the veterans reported that they used alcohol in the 6 hours preceding the argument in all of the fights in the year before their interview; another 6 (24%) indicated they had been drinking before 50 to 75% of their recent arguments. Most veterans reported that their partners usually initiated fights (n = 10, 40%) or that both members sometimes initiated (n = 9, 36%); 6 veterans (24%) report that they initiate most fights. Veterans described a range of negative effects of their relationship violence including: damage to relationship/increased emotional distance between couple (n = 7, 27%), guilt/regret (n = 6, 23%), decreased trust (n = 3, 12%), and decreased communication (n = 3, 12%). Twelve (48%) participants indicated that they had been involved with the legal system because of fights with their current partner.

Qualitative Interview Results

Analysis of interview transcripts resulted in findings regarding themes related to coping with emotions of violence, and perceived barriers to and preferences for IPV treatment.

Coping With Emotions Associated With Violence—Although all of the respondents had exhibited some physical violence in the past, they also described a range of methods they used in an attempt to cope with their emotions before, during, and after violent or potentially violent incidents. The most commonly endorsed coping strategy, walking away, was used by 19% (n = 5) of respondents, followed by spiritual techniques (n = 3, 12%), choosing not to engage when they perceived they were being prompted by partner (n = 3, 12%), and physical exercise (n = 2, 8%; Table II). Participants often expressed how they avoid altercations: “I decide I’m not going to feed into argument—I’m not going to argue with my wife,” (57-year-old married post-Vietnam Veteran with PTSD); “I tell myself it’s not worth it,” (61-year-old married Vietnam Veteran with PTSD).

Another participant described the escalation of events in his relationship that can lead to violence or a desire to act violently and the way he copes with those emotions in the moment:

> “She says something to me and it makes me mad, and I want to say something back to her. And she’ll get mad, and we escalate from there. And it gets to a point where I’d like to whoop her butt and then I have to go outside and walk around a little bit. Then I come back in and tell her I’m sorry and do whatever I need to make her happy.” (64-year-old married Vietnam Veteran without PTSD)

Participants also indicated that they have used professional services to help manage their anger. Veterans reported a range of mental health services they had participated in, including couples therapy (n = 8, 31%), anger management classes (n = 7, 27%), psychiatric care (n = 5, 19%), PTSD treatment (n = 5, 19%), and substance abuse treatment (n = 3, 12%). However, most veterans stated they did not find these services helpful for addressing IPV issues. For example, one veteran said, “We went to couples therapy twice—she [my wife] said a bunch of stuff she was angry about and she refused to return,” (31-year-old married Operation Enduring Freedom/Operation Iraqi Freedom [OEF/OIF] Veteran without PTSD). Only 4 veterans (16%) had been formally referred to a domestic violence treatment program, 3 of whom reported that they followed through with the referral.

Perceived Barriers to and Preferences for IPV Treatment—Interview participants described a range of barriers that may deter veterans with IPV problems from seeking services, including pride or embarrassment (n = 8, 31%); fears about seeking mental health treatment (e.g., privacy, stigma) (n = 7, 27%); denial or belief their violence perpetration is not a problem (n = 6, 23%); distrust of the government (n = 4, 15%); and fear the partners/wives would not participate in treatment (n = 4, 15%; Table II). For example, one participant indicated that some veterans are reluctant to see their own violence as a problem:

> "Again sometimes it's that guys will look at their own personal violence as well deserved by whoever their violence has been turned towards. You know I've talked to a lot of guys that don' t feel guilty about stuff going wrong like that." (63-year-old married Vietnam Veteran with PTSD)

Veterans did express a need and desire for treatment. Almost half of the veterans (n = 12, 46%) expressed a preference for couples therapy, 5 (19%) desired individual treatment, and 4 (15%) requested multifamily groups. Several indicated a preference for treatment of the whole family (e.g., "Bring the family in and talk to them and train them in how to deal with us when we get the way we get ... need treatment for [my] whole family ... [my] daughter doesn't understand" [31-year-old married Iraq/Afghanistan Veteran with PTSD]).

Further, all participants believed the VA should offer treatment specifically for IPV, and almost all (n = 23, 92%) thought partners/wives should be involved in the services. Finally, almost every participant (n = 24, 96%) indicated they would participate in such a program if the VA offered it. Participants had a number of suggestions for ways that treatment could be offered. One participant suggested that veterans who had a history of IPV, but received treatment for it, should serve as counselors and provide treatment to other veterans suffering from IPV problems. Other suggestions included mixed therapy groups—some with and some without their partners, videos with real stories of others who have experienced violence in their relationships, and having different levels of treatment based on the severity of violence experienced in relationships.

DISCUSSION

This study is a first step in filling a critical gap in the knowledge base about IPV among veterans; although prevention and intervention efforts for IPV typically focus on men, very little work has examined men's perspectives on violence or engagement in treatment. A particular gap exists for male veterans, a population whose relationships are at high risk for violence as a function of the social and emotional sequelae of PTSD. Two major themes relevant to engaging men in treatment emerged in our interviews, including (1) coping mechanisms used to avoid and handle violent incidents and (2) perceived barriers to and preferences for IPV treatment. Although the anger management strategies the participants used to cope with violence were not always successful, this understanding of their efforts can guide the development and refinement of treatment strategies. Importantly, the entire sample indicated a need and desire for IPV treatment. They preferred for such treatment to be offered through the VA, a place that may be more comfortable for many veterans than the private sector. Although such services are not widely available throughout the VA system at

this time, further examination of these issues may be a potential opportunity for the VA system to strengthen veterans' relationships.

Interviews underscored the importance of considering the dyad and family when addressing IPV rather than simply focusing on the male perpetrator. For example, male veterans reported that a substantial amount of the conflict-related violence was perceived as mutual or initiated by their female partner, a finding that has been supported by quantitative research.[15] In addition, most were interested in treatment that included their partner or family. Almost half of participants reported that their conflict occurred in front of children or grandchildren, which highlights the potential negative effects on the broader family. Children's exposure to family violence is subject to mandated reporting in some states, so treatment providers should be aware of their state's requirements when working with distressed couples. The current study adds to research highlighting the importance of considering including both partners in IPV prevention and treatment.[16] Clinical determinations about the appropriateness of this must be carefully made based on a thorough assessment of the nature, chronicity, and severity of the violence.[17]

Alcohol use was also identified as a precursor to couple violence. This finding is consistent with a large literature on alcohol use as a predictor of IPV.[18] Similarly, research has found that addressing substance abuse in couples is associated with reductions in IPV[19] as a function of reductions in alcohol use and increases in relationship functioning achieved during substance abuse treatment. It is possible that VA's efforts to address substance abuse in couples, such as the recent pilot work with Behavioral Couples Therapy for Alcoholism,[20] may result in decreases in IPV in these relationships; however, this warrants specific investigation.

The findings from this study are limited in several ways. We interviewed a small sample of male veterans who had self-reported previous IPV perpetration and agreed to participate in an interview. Many participants also had diagnoses of PTSD and/or other mental health problems. This sample may not be representative of other groups of veterans. Responses may have been influenced by social desirability. Given that the interview questions focus on conflict-related IPV, it is unlikely that responses apply to sexual IPV or stalking, as these forms of violence are typically not conflict related. It is noteworthy that we initially attempted to recruit veterans' female partners in the study to provide both partner's perspectives of the conflict and services; however, only 2 women completed interviews. Although many women initially expressed willingness to participate, most cancelled the appointment or did not attend the scheduled appointment. Because of the small number of interviews, the partner data were not analyzed. Despite these challenges, it is critical to gain both perspectives and future research may consider barriers veterans' partners may face in engaging in couples research or couples therapy; exploration of recruitment and study methods to safely and confidentially obtain this information is warranted.

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TABLE I.

Demographics of Key Informant Interviews With Male Veterans (n = 125)

Variable	*n* (%)
Age (Mean [SD, Range])	55.0 (12.0, 31–69)
Race	
White	14 (56%)
Black	9 (36%)
Hispanic	3 (12%)
Indian	1 (3%)
Education	
Some High School	5 (20%)
High School Diploma or GED	5 (20%)
Some College	12 (48%)
College Graduate	3 (12%)
Currently Employed	6 (24%)
Relationship Characteristics and History	
Currently Living With Partner	19 (76%)
Separated At Least Once From Partner	12 (48%)
Length of Current Relationship (Mean [SD, Range])	19.1 Years (16.4), 3 Months–56 Years
Has Children	19 (76%)
Marital Status	
Married or Living as Married	14 (56%)
Divorced	3 (12%)
Separated or Widowed	3 (12%)
Single, Never Married	4 (16%)
PTSD (50+ on PTSD Checklist)	20 (80%)
Served in a War Zone	17 (68%)
Service-Connected Disability for PTSD	13 (52%)

TABLE II.

Overarching Themes Identified and Examples of Supporting Quotes

Overarching Themes	Example Quotes in Support of Overarching Themes
Coping With Emotions Associated With Violence	"[I] pray, read Bible, choose positive attitude, read motivational books, use good language..." (57-year-old married post-Vietnam Veteran with PTSD)"
	Use the Catch, Challenge, Change technique." (65-year-old single Vietnam Veteran with PTSD)
	"[I] tried the gym thing—that usually causes more anger than anything." (31-year-old married OEF/OIF Veteran with PTSD)
Perceived Barriers to and Preferences for IPV Treatment	
Perceived Barriers	"[My] wife doesn't understand PTSD... doubt she'll come [to treatment with me]." (47-year-old married OEF/OIF Veteran with PTSD)
	"[My] wife is busy with her job." (61-year-old married Vietnam Veteran without PTSD)
Preferences	"..have counseling together and separate—people hold things back in groups" (58-year-old married Vietnam Veteran with PTSD)"
	[We] need aftercare with spouses and PTSD counselors" (47-year-old married OEF/OIF Veteran with PTSD)
	"Open group counseling of 4–6 couples; wife should be involved—should be weekly for 8 weeks–should have food/party at the end and certificates; [we] need mutual support" (57-year-old married post-Vietnam Veteran with PTSD)

Several participants had the same age, marital status, and war era, so the quotes above may appear to be the same individual but were likely obtained from different participants.