

# Strength at Home Couples Program to Prevent Military Partner Violence: A Randomized Controlled Trial

Casey T. Taft

National Center for PTSD, VA Boston Healthcare System,  
Boston, Massachusetts, and Boston University  
School of Medicine

Suzannah K. Creech

Providence VA Medical Center, Providence, Rhode Island, and  
VHA VISN 17 Center of Excellence for Research on Returning  
War Veterans, Waco, Texas

Matthew W. Gallagher

University of Houston

Alexandra Macdonald

National Center for PTSD, VA Boston Healthcare System,  
Boston, Massachusetts, and Boston University School of  
Medicine

Christopher M. Murphy

University of Maryland, Baltimore County

Candice M. Monson

Ryerson University

**Objective:** We evaluated the efficacy of Strength at Home Couples, a cognitive-behavioral trauma-informed intimate partner violence (IPV) preventive intervention for married or partnered military service members or veterans. No prior randomized controlled trial had supported the efficacy of such an intervention in this population. **Method:** Participants included 69 male service members or veterans and their female partners. Recruitment was conducted from February 2010 through August 2013, and participation occurred within 2 Department of Veterans Affairs hospitals. All couples completed an initial assessment including diagnostic interviews and measures of physical and psychological IPV and were randomized by cohort to a supportive prevention couples group or Strength at Home Couples. All couples were reassessed at postintervention and at 6 and 12 months follow-ups. **Results:** Both service members or veterans and their female partners engaged in fewer acts of reported physical and psychological IPV in the Strength at Home Couples condition relative to supportive prevention, and relative risk of physical violence was lower for both members of the dyad in Strength at Home Couples at follow-up assessments (male service member or veteran IPV relative risk [RR] = .53; female IPV RR = .43). Those in Strength at Home Couples evidenced significantly greater program completion than did those in supportive prevention (RR = 1.73; 95% confidence interval [1.00, 2.99]). Exploratory analyses did not find differences between groups on relationship satisfaction. **Conclusion:** Results provide support for the efficacy of Strength at Home Couples in preventing physical IPV and reducing psychological IPV. These results have important implications for preventing violence and associated physical and mental health problems. **Clinical Trials Registration:** Trial Registry Name: Strength at Home Couples Program;

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Casey T. Taft, National Center for PTSD, VA Boston Healthcare System, Boston, Massachusetts, and Department of Psychiatry, Boston University School of Medicine; Suzannah K. Creech, Providence VA Medical Center, Providence, Rhode Island, and VHA VISN 17 Center of Excellence for Research on Returning War Veterans, Waco, Texas; Matthew W. Gallagher, Department of Psychology and Texas Institute for Measurement, Evaluation, and Statistics, University of Houston; Alexandra Macdonald, National Center for PTSD, VA Boston Healthcare System, and Department of Psychiatry, Boston University School of Medicine; Christopher M. Murphy, Department of Psychology, University of Maryland, Baltimore County; Candice M. Monson, Department of Psychology, Ryerson University, Toronto, Ontario, Canada.

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Correspondence concerning this article should be addressed to Casey T. Taft, National Center for PTSD, VA Boston Healthcare System (116B-4), 150 South Huntington Avenue, Boston, MA 02130. E-mail: [casey.taft@va.gov](mailto:casey.taft@va.gov)

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***What is the public health significance of this article?***

This study suggests that the Strength at Home Couples program, a cognitive-behavioral trauma-informed intimate partner violence (IPV) preventive intervention for married or partnered military service members or veterans, is efficacious in preventing physical IPV and reducing psychological IPV.

*Keywords:* violence, veterans, partner aggression, domestic abuse, prevention

Intimate partner violence (IPV) is a serious public health problem in the general population and among those in the military community. Following military deployment, particularly if the service member has been exposed to war zone trauma and is experiencing problems such as posttraumatic stress disorder, there is an increased risk for IPV (Taft, Watkins, Stafford, Street, & Monson, 2011). IPV causes serious injury and/or death (Breiding et al., 2014; Sugg, 2015), increases risk for negative health behaviors (Coker et al., 2002; Rhodes et al., 2009), and impacts the health and well-being of other family members including children (Carlson, 2000; Smith, Fowler, & Niolon, 2014; Sugg, 2015). Prevention of IPV in at-risk veteran and military couples is therefore of vital interest.

To date no randomized clinical trial has demonstrated the efficacy of an IPV preventive intervention in military couples; that is, to prevent physical IPV from developing in the relationship before it begins. Particularly considering the lack of evidence for interventions focused on ending IPV once it develops (Babcock, Green, & Robie, 2004), preventive interventions take on considerable importance. It is likely more difficult to reverse longer standing negative relationship patterns and coercive and controlling interaction patterns than it is to identify and prevent them early, more proximal to war zone stress and trauma exposure.

The Strength at Home Couples (SAH-C) program was developed for military couples who are experiencing relationship difficulties but are not yet engaging in a pattern of physical IPV or coercive, controlling behavior. SAH-C is a 10-week trauma-informed dyadic group intervention to prevent IPV in returning male service members or veterans and their intimate female partners (Taft et al., 2014). This intervention is informed by a cognitive-behavioral social information processing model for IPV perpetration among military populations (Taft, Walling, Howard, & Monson, 2010). At the core of the social information processing model is the concept that trauma impacts how one interprets and otherwise processes information gathered from our social environment. Trauma exposure can produce biases and deficits in social information processing within couples that increase risk for engaging in violence. Results from a pilot study of SAH-C compared to a supportive intervention suggested SAH-C was effective in reducing physical and psychological IPV use for both partners from pre- to postintervention (Taft et al., 2014).

The purpose of the current randomized controlled trial was to examine the efficacy of SAH-C compared to a supportive prevention (SP) condition that involved minimal therapist-directed intervention beyond encouragement of a mutually supportive environ-

ment and focus on relationship conflict and preventing IPV. It was expected that couples who were assigned to SAH-C would evidence (1) prevention of IPV compared to couples assigned to SP and (2) reductions in their psychological IPV, as assessed using reports from both the male participant and his female partner. We also explored differences between the two conditions on relationship satisfaction.

## Method

### Participants and Procedure

Participants were recruited from February 2010 through August 2013 from two major metropolitan areas in the Northeast by clinician referral self-referral via flyers hung in area Veterans Affairs (VA) hospitals and community locations, and presentations at events for military service member organizations such as Yellow Ribbon and Strong Bonds. Our focus was on male veterans and their partners given prior research suggesting that trauma-related pathology was more strongly related to men's IPV than women's IPV (Taft, Walling, Howard, & Monson, 2011).

Inclusion criteria were (1) the male participant and his partner were over age 18; (2) the male participant was a veteran or a service member who deployed to the U.S. conflicts in Iraq or Afghanistan; (3) the couple was cohabiting; and (4) the couple indicated the need for IPV prevention through one of the following: (a) one or both partners scored below 30 on the six-item Quality of Marriage Index (Norton, 1983) or below 101 on the Dyadic Adjustment Scale (Spanier, 1976), which are the cutoffs for relationship distress (Slep, Heyman, Williams, Van Dyke, & O'Leary, 2006); (b) one or both partners reported service member or veteran psychological IPV above the 75th percentile on the Revised Conflict Tactics Scales (CTS2) Psychological Aggression subscale; or (c) any endorsement of service member or veteran severe Psychological Aggression on the CTS2 or Dominance/Intimidation on the Multidimensional Measure of Emotional Abuse (MMEA; Murphy & Hoover, 1999). Exclusion criteria were (1) reading difficulties prevented valid completion of the assessment instruments; (2) the participant evidenced severe organicity or active psychosis; (3) the participant expressed prominent suicidal or homicidal ideation; (4) the participant met diagnostic criteria for alcohol and/or drug dependence not in early full remission or sustained partial remission; (5) the female partner reported that her own violence included the use of weapons during the past 6 months in their current relationship; (6) violence by female

partner produced injuries; (7) the male partner indicated being fearful of the female partner; or (8) the male partner reported being violent in any way during the past 6 months in their current relationship.

There was no trauma requirement for inclusion, because SAH-C is trauma-informed and not a specific treatment for trauma symptoms, though all but one veteran and two partners reported at least one trauma on the Traumatic Life Events Checklist (Weathers et al., 2013). Over 85% of veterans reported exposure to military combat, and 67.7% of veterans indicated that this was the most distressing event experienced in their lifetime. Other most distressing events included “some other traumatic event” (10%) and sudden death of a friend or loved one (5.7%); all other events were endorsed by fewer than 5.0%. The most frequent types of combat

trauma reported were receiving small arms fire (73%), knowing someone seriously injured or killed (69.8%), seeing dead bodies or human remains (65.5%), being attacked or ambushed (61.9%), and seeing dead or injured Americans (52.4%); all other types of combat trauma were reported at rates of 50% or less. The most distressing events reported by partners were sudden death of a friend or loved one (23.1%), witnessing family violence as a child (12.8%), and some other traumatic event (10.3%); all other events were endorsed at rates of less than 10%.

Figure 1 provides a description of the participant flow from recruitment to study completion. All participant data were collected at the two VA hospitals in accordance with procedures approved by the institutional review board. Trained master’s- and doctoral-level psychology staff conducted all consent and assess-

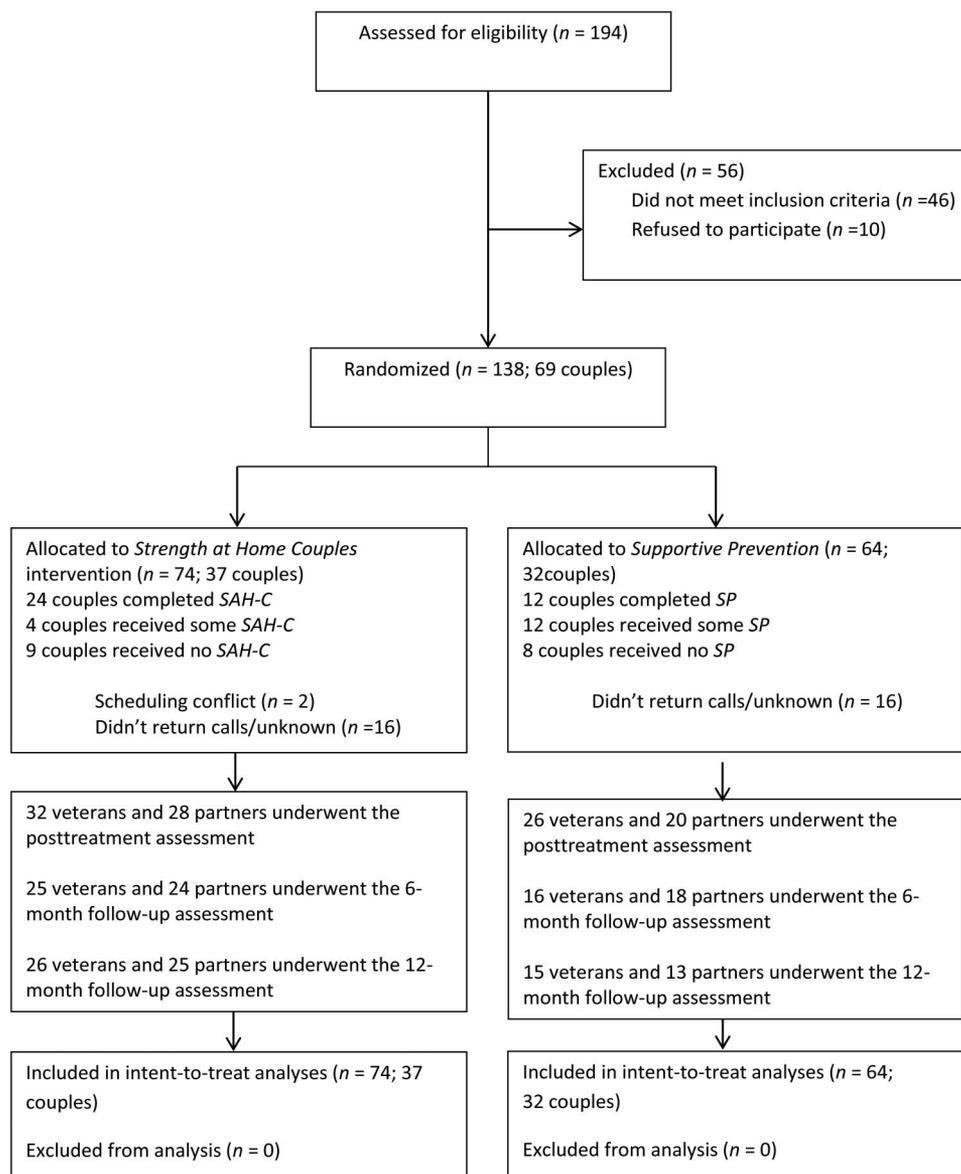


Figure 1. Participant flow from recruitment to study completion. SAH-C = Strength at Home Couples; SP = supportive prevention.

ment procedures. Written consent was obtained from both members of the couple prior to beginning study procedures. After the initial assessment, a cluster design was used to randomize participants by cohort to receive either SAH-C or SP. The study biostatistician generated and implemented the randomization. Service member or veteran and partner data were obtained from assessments completed onsite or through an online survey method for hard-to-reach participants at four time points: prior to initiating intervention, immediately following intervention, 6 months postintervention, and 12 months postintervention. Follow-up assessments were conducted from October 2010 through September 2013. All assessors were blinded to intervention condition. Participants were paid \$50 for completing each assessment.

In total, 69 couples were enrolled in the study and were included in intent-to-treat analyses. At baseline there were no differences by condition on any demographic characteristics or IPV outcomes.

Table 1 contains the characteristics of the sample presented by condition at study entry. As can be seen in this table, most dyads were married (81.1%), most of the male partners were on active duty or members of the National Guard or Reserves (72.5%) who had deployed an average of 1.74 times to the conflicts in Iraq and Afghanistan. In addition, nearly 87% of the male partners were employed at least part time or attending college. This rate is

consistent with reported national averages for veterans of this service era (Bureau of Labor Statistics, 2011). Nearly 70% of female partners were employed at least part time, a rate slightly higher than reported averages at the time (Institute for Veterans & Military Families, 2014). The majority of veterans (89.9%) and partners (86.9%) were white.

## Measures

**Mini International Neuropsychiatric Interview (MINI; Sheehan, Janavs, et al., 1998).** The MINI was used to evaluate study exclusion criteria. Clinicians assessed for organic mental disorder, psychotic symptoms, and substance dependence using this semistructured assessment. Estimates of validity and reliability for the MINI are good (Sheehan, Lecrubier, et al., 1998).

**Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995).** The CAPS was administered to male participants to assess for PTSD to assist in characterizing the sample. This is a widely used semistructured clinician interview that assesses PTSD diagnostic status and symptom severity consistent with the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; DSM-IV; American Psychiatric Association, 2000) criteria. The scale yields current and lifetime PTSD diagnoses as well as continuous scores

Table 1  
Descriptive Statistics for Randomized Veterans and Partners

Variable	Full sample (N = 69 dyads)		SAH-C (N = 37 dyads)		SP (N = 32 dyads)		Difference [95% CI]	$\chi^2$	t	p
	M (SD)	N (%)	M (SD)	N (%)	M (SD)	N (%)				
Age (V)	35.44 (9.46)		34.92 (10.01)		36.07 (8.88)		-1.15 [-5.85, 3.55]		-.49	.63
Age (P)	33.60 (9.05)		34.05 (10.02)		33.03 (7.77)		1.02 [-3.29, 5.33]		.46	.65
Nonwhite (V)		7 (10.14)		2 (5.40)		5 (15.63)		2.79		.25
Nonwhite (P)		10 (14.49)		5 (13.51)		5 (15.63)		.09		.77
Relationship status								6.37		.17
Married		53 (81.1)		26 (70.27)		27 (84.38)		-1		
Dating		11 (15.94)		7 (18.91)		4 (12.5)		3		
Engaged		3 (4.35)		3 (8.11)		0 (.00)		3		
Current military status								.47		.49
Active duty		5 (7.25)		2 (5.40)		3 (9.38)		-1		
National Guard		40 (57.97)		24 (64.86)		16 (50.00)		8		
Reserves		5 (7.25)		3 (8.11)		2 (6.25)		1		
No. deployments (OEF/OIF/OND)	1.74 (.89)		1.92 (.95)		1.52 (.77)		.40 [-.02, .83]		1.89	.06
Rank										
Enlisted		36 (52.17)		21 (56.76)		15 (46.88)		6	1.39	.24
NCO/O		33 (47.82)		16 (43.24)		17 (53.13)		-1		
Employed at least part time (V)		60 (86.96)		32 (86.49)		28 (87.50)		4	.56	.45
Employed at least part time (P)		48 (69.57)		26 (72.97)		22 (68.75)		4	.001	.98
PTSD diagnosis		32 (46.38)		17 (45.95)		15 (46.88)		2	.35	.55
CAPS—Total	50.73 (31.60)		46.66 (30.47)		56.05 (32.85)		-9.39 [-26.03, 7.26]		-1.13	.26
AUDIT (V)	4.53 (4.86)		5.08 (5.44)		3.83 (4.04)		1.25 [-1.13, 3.64]		1.05	.30
AUDIT (P)	2.15 (2.10)		2.57 (2.29)		1.67 (1.77)		.90 [.90, 1.90]		1.80	.07
PHQ-9 (V)	9.98 (6.97)		9.08 (6.97)		11.10 (6.91)		-2.01 [-5., 2-1.39]		1.18	.24
PHQ-9 (P)	5.95 (5.48)		4.83 (4.53)		7.24 (6.23)		-2.40 [-5.06, .26]		1.85	.09

Note. SAH-C = Strength at Home Couples; SP = supportive prevention; CI = confidence interval; V = veteran; P = partner; OEF/OIF/OND = Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn; NCO/O = noncommissioned officer or officer; PTSD = posttraumatic stress disorder; CAPS = Clinician-Administered PTSD Scale; AUDIT = Alcohol Use Disorders Identification Test; PHQ-9 = Physical Health Questionnaire—Depression Subscale.

reflecting PTSD symptoms. The CAPS has strong convergent and discriminant validity, internal consistency, and interrater reliability (Weathers, Keane, & Davidson, 2001; Weathers, Ruscio, & Keane, 1999). PTSD diagnostic status was based on meeting the *DSM-IV* symptom cluster criteria (minimum frequency = 1 and intensity = 2 to count as a symptom) and a total CAPS severity score of 45 or higher. The possible range of scores on the CAPS is 0 to 136, with higher scores indicating greater PTSD symptom severity.

**Alcohol Use Disorders Identification Test (AUDIT; Saunders, Aasland, Babor, de la Fuente, & Grant, 1993).** The AUDIT is a 10-item questionnaire that was used to assess problematic drinking behavior in the past 30 days. This measure was used to characterize the sample. Items record the amount or frequency of drinking, symptoms of alcohol dependence, and problems caused by alcohol. The possible range of scores on the AUDIT is 0–40. Higher scores on the AUDIT are indicative of greater problematic alcohol use, with a score of 8 or higher representing more-harmful drinking patterns (Conigrave, Hall & Saunders, 1995). The AUDIT has a reported median reliability coefficient of .83 and adequate construct and criterion related validity (Reinert & Allen, 2007).

**Physical Health Questionnaire—Depression Subscale (PHQ-9; Kroenke, Spitzer, Williams, & Lowe, 2010).** The PHQ-9 is a nine-item, brief, self-report screening tool that was also used to characterize the sample. The items are based directly on the diagnostic criteria for major depressive disorder in the *DSM-IV*. This measure provides both a presence and severity of depressive symptoms. The possible range of scores on the PHQ-9 is 0–27, with higher scores representing greater depressive symptomatology. Items query how often over the past 2 weeks respondents have been bothered by nine symptoms of depression on a 4-point scale ranging from 0 (*not at all*) to 3 (*nearly every day*). The PHQ-9 has evidenced good to strong sensitivity and specificity, test–retest reliability, and internal consistency across a large volume of studies (see Kroenke et al., 2010, for a systematic review).

**Revised Conflict Tactics Scales (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996).** Physical and psychological IPV were measured using the 12-item Physical Assault subscale and the eight-item Psychological Aggression subscale of the CTS2. At each time point, participants reported the frequency with which they had engaged in IPV behaviors (e.g., “I twisted my partner’s arm or hair” or “I insulted or swore at my partner”) during the assessment window (6 months except for the 3-month time frame between baseline and postintervention) on a scale ranging from 0 (*never*) to 6 (*more than 20 times*). In accordance with previous literature using this measure (Taft et al., 2010), participant-reported and partner-reported items were compared, and the greater of the two responses was used in the calculation of CTS2 scores. Straus and colleagues (1996) reported internal consistency estimates ranging from .79 to .95, good evidence of discriminant validity, and strong evidence of construct validity for the measure (Vega & O’Leary, 2007). Other studies have reported excellent test–retest reliability for the CTS2 when administered to a sample of partner-violent men who were court-mandated to treatment (Moffitt et al., 1997).

From these ratings, Physical IPV scores were then calculated as variety scores by dichotomously scoring each physical assault item as either “occurring” or “not occurring” and then summing the

total number of items in which the behavior had occurred, yielding a possible range of 0 to 12 for the Physical Assault scale. This method of scoring reduces skewness caused by a small number of high-rate offenders, gives equal weight to each abusive behavior, and is most defensible with respect to memory limitations regarding behavior frequencies (Moffitt et al., 1997). For analyses of Psychological IPV, frequency scores were calculated. Each item was recoded to represent the estimated frequency of the behavior, with midpoints used for responses containing a range of scores (e.g., 3 to 5 times received a score of 4 (Straus et al., 1996), and reports of *more than 20 times* recoded as 25. Items were then summed to represent a total frequency score. This is more appropriate due to the greater overall incidence of each variety of psychological IPV in the sample (LaMotte, Taft, Weatherill, Scott, & Eckhardt, 2014).

**Multidimensional Measure of Emotional Abuse (MMEA; Murphy & Hoover, 1999).** The MMEA was included as an additional measure of psychological IPV. The measure contains 28 items, with four 7-item subscales: Restrictive Engulfment, Hostile Withdrawal, Denigration, and Dominance/Intimidation. Respondents reported on the frequency of their and their partners’ aggression on an 8-point scale ranging from 0 (*never*) to 7 (*more than 20 times*), and these scores were recoded as frequencies in the same manner as CTS2 Psychological IPV frequency scores. Recent research has indicated the MMEA overall evidences high internal consistency and moderate to high convergent and discriminant validity (Murphy & Hoover, 1999), as well as good internal reliability (Ro & Lawrence, 2007).

**Quality of Marriage Index (QMI; Norton, 1983).** The QMI was used to assess relationship distress for inclusion into the study and for exploratory analyses. The range of possible scores on the QMI is 6–45, and lower scores represent greater relationship distress. Respondents are asked to rate the degree to which they agree or disagree with five statements (e.g., “We have a good relationship.”) on a 7-point scale ranging from 1 (*very strongly disagree*) to 7 (*very strongly agree*). The last item on the QMI (e.g., “What degree of happiness best describes your relationship?”) is rated on a 10-point scale ranging from 1 (*unhappy*) to 10 (*perfectly happy*). The QMI has evidence of a single factor structure (Norton, 1983), adequate to strong internal consistency reliability across a variety of relationship lengths and characteristics (Graham, Diebels, & Barnow, 2011), and concurrent validity with other measures of relationship satisfaction (Calahan, 1997).

**Dyadic Adjustment Scale (DAS; Spanier, 1976).** The DAS was also used to assess relationship distress for inclusion criteria for the study and for exploratory analyses. This 32-item measure consists of, in addition to a global satisfaction score, four subscales: Dyadic Consensus, Affectional Expression, Dyadic Satisfaction, and Dyadic Cohesion. Several studies have provided evidence for this measure’s strong psychometric properties (Hendrick, 1988; Heyman, Sayers, & Bellack, 1994; Kurdek, 1992). Almost all items on the DAS are rated on a 6-point Likert scale with varied anchor points depending on the item. For example, one item querying about dyadic agreement on finances ranges from 5 (*always agree*) to 0 (*always disagree*), whereas another, querying frequency of thoughts about ending the relationship, ranges from 0 (*never*) to 5 (*all the time*). Items are summed, with higher scores reflecting greater satis-

faction. The possible range of scores on the DAS is 0–150, and higher scores represent greater satisfaction.

## Intervention

SAH-C is a 10-week couples group intervention designed to prevent relationship conflict and IPV among military couples. The program content and delivery are highly sensitive to the unique stressors of deployment separation and combat exposure and the ways that traumatic stress exposure can negatively affect relationships. The program incorporates elements from couples and non-couples interventions for PTSD (Monson & Fredman, 2012; Resick & Schnicke, 1992) and IPV (Murphy & Scott, 1996). SAH-C targets social information processing mechanisms hypothesized to explain the relationship between trauma and IPV and that are commonly used in IPV treatment, as well as common themes that may underlie trauma reactions and relationship difficulties emphasized in PTSD interventions. Didactic material includes modules focused on understanding IPV and the impact of trauma on intimate relationships, conflict management (e.g., “time outs”) and assertiveness skills, listening skills, strategies for enhanced emotional expression, and avoidance of common communication pitfalls. The group atmosphere is supportive and nonconfrontational. Each 2-hr session contains brief didactic material; group activities to discuss, learn, and practice new behaviors; and flexible time to solve ongoing problems, explore change efforts, and build group cohesion. Across all sessions, group members are encouraged to increase the positive elements of their relationships via intimacy-enhancing exercises (e.g., self-monitoring of positive relationship behaviors) and complete practice assignments to consolidate material covered in group (see Taft, Murphy, & Creech, 2016, for more detailed information on SAH-C program elements).

Supportive prevention (SP) is a group intervention that was derived from the manualized intervention used by Morrel, Elliott, Murphy, & Taft, 2003) in their examination of the efficacy of cognitive-behavioral therapy for reducing IPV perpetration. The intervention is based on the work of Jennings (1987) and on Yalom’s (1995) primary therapeutic factors for group intervention. SP involves minimal therapist-directed intervention beyond encouraging group members to provide a mutually supportive environment and focus on relationship issues and preventing IPV. SP therapists allow group members to set the session agenda and address themes and topics that spontaneously emerge in the group interaction. Therapists emphasize a collaborative group norm and refrain from using active skills-training interventions. Therapists are instructed to address the group as a whole rather than individuals and to use brief verbalizations and nonverbal gestures to stimulate vigorous and helpful group interactions. This intervention was chosen to examine the relative benefits of the cognitive and behavioral skills taught in SAH-C.

Both interventions were conducted in a multicouple, closed-group format, with three to five couples in each group. Both interventions were delivered by two coleaders: one doctoral-level male therapist and one doctoral or predoctoral-level female therapist. The treating clinicians attended weekly supervision with the first author. All sessions were videotaped, and an expert clinician in SAH-C rated a randomly selected 10% of the possible SAH-C intervention sessions for protocol adherence and therapist competence in delivering the specific elements of the treatment as pre-

scribed for each session. Expert clinician raters were licensed clinical psychologists who were familiar with the SAH-C treatment but who were not involved in the clinical trial. Ninety-four percent of SAH-C protocol essential elements were rated as completed, 3% were rated as partially completed, and 3% were rated as not completed. The mean adherence rating for all SAH-C session elements was 1.90 ( $SD = .39$ ).

In order to measure therapist competence in delivery of non-specific group facilitation behaviors such as warmth, empathy, building alliance and facilitating group discussion, the expert clinician also rated 10% of all SAH-C and SP sessions, scored on a 7-point Likert scale ranging from 1 (*poor therapist competence*) to 7 (*excellent therapist competence*). The therapist competence mean scores were 5.54 ( $SD = .43$ ) for SAH-C and 5.50 ( $SD = .45$ ) for SP. There was no significant difference in therapist competence ratings between groups ( $p > .05$ ). Mean therapist competence for all groups was 5.52 ( $SD = .42$ ), and the mean competence rating for 96.6% of all sessions was “good,” “very good,” or “excellent.”

There were 18 groups conducted, with an average of 3.83 dyads assigned to each. The average number of sessions attended was 5.44 ( $SD = 3.89$ ), with 61.9% of the sample attending five or more sessions and 43.9% attending eight or more sessions.

## Data Analysis

Analyses were conducted using Mplus 7.11 (Muthén & Muthén, 1998–2015). Multiple imputation procedures were used to account for missing data. Ten thousand imputed data sets were generated, and the means of the distributions of these imputed data sets were used as point estimates for all statistics. Analyses of the impact of SAH-C relative to SP focused on the means, standard deviations, and effect sizes. Hedges’s  $g$  (with the correction for small sample sizes) effect sizes were calculated to examine between-conditions effects. Odds ratios and relative risk ratios were calculated to examine between-conditions effects on intervention completion rates and a dichotomized physical IPV outcome that was created by classifying participants as nonviolent (0 physical IPV) or violent ( $>0$  physical IPV). The number needed to treat effect size was also calculated to examine differences in violence rates at the final assessment point. Ninety-five percent confidence intervals are presented for all effect sizes.

## Results

### Program Retention

We began by examining differences in intervention retention because this is an especially challenging issue in interventions for distressed couples (Doss, Hsueh, & Carhart, 2011). The majority (59.5%) of individuals in the SAH-C condition were classified as program completers (attended eight or more sessions), whereas the minority (34.4%) of individuals in the SP condition were classified as intervention completers. The odds ratio (2.80; 95% confidence interval [CI: 1.05, 7.47]) and relative risk (1.73; 95% CI [1.00, 2.99]) effect sizes indicated that SAH-C was associated with significantly greater retention and that participants were almost twice as likely to complete SAH-C as SP.

## Physical IPV

We next examined differences in physical IPV by both service members or veterans and partners across time by intervention condition. Imputed means, standard deviations, and between-conditions effect sizes with confidence intervals for physical IPV by condition are presented in Table 2. Service members or veterans who received SAH-C engaged in less physical IPV at Times 2–4 (T2–T4) than did those who received SP. The magnitude of the effect sizes for the comparisons of physical IPV by service members or veterans was small at each time point. Similarly, although partners in the SAH-C condition reported greater baseline physical IPV, partners who received SAH-C engaged in less physical IPV at T2, T3, and T4 than did partners who received SP, with the magnitude of the effect sizes at T2 and T3 in the small to medium range.

SAH-C also evidenced relatively better outcomes than did SP when examining the proportion of service members or veterans (see Figure 2) and female partners (see Figure 3) who were

classified as physically violent or nonviolent. The proportion of physically violent participants across time as well as the odds ratios (with 95% CI) and relative risk (with 95% CI) effect sizes are presented in Table 3. The proportion of physically violent service members or veterans was similar in both conditions at T2 and T3, but at T4 the relative risk of physical violence by men assigned to SAH-C was .53 compared to those assigned to SP. The results were more pronounced when examining the proportion of physically violent female partners. The proportion of physically violent female partners was lower in the SAH-C condition at every time point. The relative risk of physical violence at T4 for female partners assigned to SAH-C was .43 compared to those assigned to SP. The number needed to treat to prevent physical violence at T4 was 5.26 for service members or veterans and 4.02 for female partners, which suggests that SAH-C may provide a relatively efficient intervention strategy for preventing violence in both members of military dyads.

Table 2  
*Means (and Standard Deviations) and Between-Conditions Effects Sizes for Physical and Psychological Intimate Partner Violence (IPV)*

Perpetrator and outcome by time point	SP (n = 32)	SAH-C (n = 37)	Hedges's $g^a$	95% CI
<b>Veteran</b>				
CTS2 Physical IPV				
T1	.00 (.00)	.00 (.00)	.00	[.00, .00]
T2	1.47 (4.32)	.67 (1.67)	-.25	[-.73, .23]
T3	1.38 (3.08)	1.06 (2.09)	-.12	[-.60, .36]
T4	.62 (.90)	.42 (.89)	-.22	[-.70, .26]
CTS2 Psychological IPV				
T1	35.06 (25.53)	30.95 (26.08)	-.16	[-.64, .32]
T2	37.84 (28.26)	25.74 (22.98)	-.47	[-.96, .01]
T3	26.22 (27.52)	18.13 (19.57)	-.34	[-.83, .14]
T4	26.33 (25.82)	13.89 (17.33)	-.57	[-1.06, -.08]
MMEA				
T1	88.06 (69.31)	64.76 (47.38)	-.40	[-.88, .09]
T2	84.19 (67.07)	62.41 (50.35)	-.37	[-.86, .11]
T3	59.28 (79.31)	46.32 (57.40)	-.19	[-.67, .29]
T4	59.09 (118.05)	38.84 (64.88)	-.22	[-.70, .26]
<b>Partner</b>				
CTS2 Physical IPV				
T1	.41 (1.27)	.70 (2.28)	.16	[-.32, .64]
T2	1.96 (5.28)	.72 (2.22)	-.32	[-.80, .17]
T3	1.62 (3.46)	.66 (1.64)	-.36	[-.85, .12]
T4	2.01 (3.56)	1.69 (6.13)	-.06	[-.54, .42]
CTS2 Psychological IPV				
T1	29.31 (20.38)	30.57 (24.81)	.05	[-.43, .54]
T2	32.35 (29.29)	21.78 (21.98)	-.41	[-.90, .07]
T3	21.94 (24.23)	13.48 (15.65)	-.42	[-.91, .06]
T4	24.94 (33.99)	12.91 (18.52)	-.45	[-.93, .04]
MMEA				
T1	53.67 (59.48)	50.03 (34.18)	-.08	[-.56, .40]
T2	80.67 (107.21)	51.12 (51.88)	-.36	[-.84, .12]
T3	42.54 (63.74)	31.80 (39.61)	-.21	[-.69, .28]
T4	65.77 (107.95)	37.32 (57.95)	-.34	[-.82, .15]

*Note.* Mean scores for Physical IPV are presented as variety scores, representing the number of types of physical IPV used during the respondent period. Mean scores for Psychological IPV and the MMEA are presented as frequency scores, representing how often psychological IPV was used in the respondent period. SP = supportive prevention; SAH-C = Strength at Home Couples; CI = confidence interval; CTS2 = Revised Conflict Tactics Scales; T1–T4 = Time 1 to Time 4; MMEA = Multidimensional Measure of Emotional Abuse.

<sup>a</sup> Negative effect sizes indicate lower levels of IPV for individuals in the SAH-C condition.

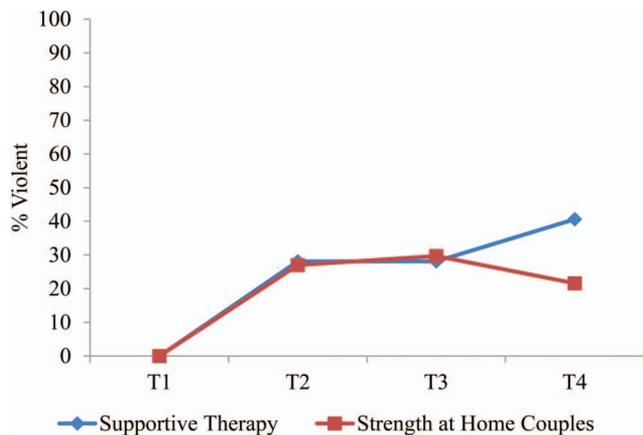


Figure 2. Percentage of physically violent veterans across time by treatment condition. T1–T4 = Time 1 to Time 4. See the online article for the color version of this figure.

**Psychological IPV**

SAH-C also resulted in stronger outcomes when examining psychological IPV outcomes for both dyad members. Table 2 presents the imputed means, standard deviations, and between-conditions effect sizes with confidence intervals for the two psychological IPV outcomes by condition. For the CTS2 Psychological Aggression outcome, levels of psychological IPV decreased in both conditions, but service members or veterans and female partners assigned to SAH-C engaged in less psychological IPV at each time point than did those assigned to SP. The magnitude of the effect sizes for these differences was small to moderate. For the MMEA psychological IPV outcome, results indicated small to moderate effect sizes favoring SAH-C at T2, T3, and T4, but these differences may have been an artifact of baseline differences on this measure. For female partners, SAH-C resulted in lower MMEA psychological IPV levels at T2, T3, and T4. The magnitude of the effect size for these psychological IPV differences was small to moderate.

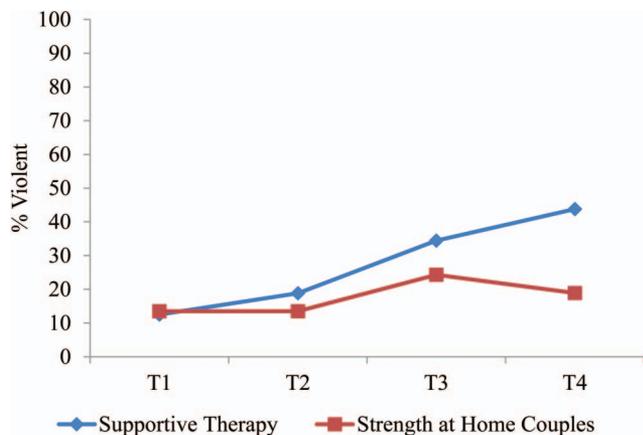


Figure 3. Percentage of physically violent partners across time by treatment condition. T1–T4 = Time 1 to Time 4. See the online article for the color version of this figure.

Table 3  
Proportion of Veterans and Partners With Any Physical Intimate Partner Violence Across Time by Condition

Perpetrator and time	Supportive prevention	Strength at Home Couples	OR	95% CI	RR	95% CI
<b>Veteran</b>						
T1	0	0				
T2	28	27	.95	[.33, 2.73]	.96	[.44, 2.07]
T3	28	30	1.08	[.38, 3.07]	1.06	[.50, 2.22]
T4	41	22	.40	[.14, 1.16]	.53	[.25, 1.12]
<b>Partner</b>						
T1	13	14	1.09	[.27, 4.47]	1.08	[.32, 3.68]
T2	19	14	.67	[.18, 2.46]	.72	[.24, 2.13]
T3	34	24	.61	[.21, 1.74]	.71	[.34, 1.49]
T4	44	19	.30	[.10, .88]	.43	[.20, .94]

Note. OR = odds ratio; CI = confidence interval; RR = relative risk; T1–T4 = Time 1 to Time 4. ORs and RRs less than 1.00 indicate that Strength at Home Couples is associated with a decreased proportion of violent veterans and their partners.

**Relationship Satisfaction**

Exploratory analyses indicated that there were minimal differences between the two conditions in relationship satisfaction as measured by the DAS and QMI. Table 4 presents the imputed means, standard deviations, and between-conditions effect sizes with confidence intervals for the two relationship satisfaction

Table 4  
Means (and Standard Deviations) and Between-Conditions Effects Sizes for Relationship Satisfaction

Respondent and outcome by time point	SP (n = 32)	SAH-C (n = 37)	Hedges's g <sup>a</sup>	95% CI
<b>Veteran</b>				
<b>DAS</b>				
T1	96.19 (25.94)	98.00 (17.21)	.08	[–.39, .56]
T2	96.85 (27.14)	102.15 (26.64)	.19	[–.28, .67]
T3	102.13 (21.38)	101.73 (23.79)	–.02	[–.49, .46]
T4	100.39 (30.48)	98.19 (25.79)	–.08	[–.55, .4]
<b>QMI</b>				
T1	30.25 (8.15)	28.78 (7.44)	–.19	[–.66, .29]
T2	28.3 (9.99)	30.31 (11.6)	.18	[–.29, .66]
T3	29.63 (11.29)	29.45 (10.76)	–.02	[–.49, .46]
T4	27.81 (11.9)	29.75 (12.03)	.16	[–.31, .63]
<b>Partner</b>				
<b>DAS</b>				
T1	97.28 (27.59)	97.22 (17.85)	.00	[–.48, .47]
T2	97.03 (22.91)	100.81 (26.02)	.15	[–.32, .63]
T3	108.99 (19.36)	97.93 (29.5)	–.43	[–.91, .05]
T4	98.93 (24.42)	100.11 (29.6)	.04	[–.43, .52]
<b>QMI</b>				
T1	28.9 (8.93)	27.57 (7.99)	–.16	[–.63, .32]
T2	28.16 (9.27)	28.81 (11.95)	.06	[–.41, .53]
T3	30.21 (10.85)	27.78 (11.89)	–.21	[–.68, .26]
T4	29.3 (8.93)	27.49 (12.22)	–.17	[–.64, .31]

Note. SP = supportive prevention; SAH-C = Strength at Home Couples; CI = confidence interval; DAS = Dyadic Adjustment Scale; T1–T4 = Time 1 to Time 4; QMI = Quality of Marriage Index.

<sup>a</sup> Positive effect sizes indicate higher levels of relationship satisfaction for individuals in the SAH-C condition.

outcomes by condition for both veterans and partners. Relationship satisfaction was generally consistent or increased slightly across the four assessments for both measures and for both veterans and partners. The exception was veterans' scores on the QMI in the supportive condition, where scores decreased slightly from T1 to T4. The magnitude of the effect size differences between the two conditions was generally small and inconsistent in direction.

### Discussion

Findings from this randomized controlled trial were consistent with hypotheses that SAH-C would evidence more-positive outcomes to SP in preventing physical IPV and reducing psychological IPV. Across all IPV analyses, both service members or veterans and their female partners engaged in relatively lower frequency of physical IPV toward their partners in SAH-C than in the alternative program, indicating that SAH-C assists in preventing the emergence of physical violence in relationships. Analyses also demonstrated lower risk for engaging in IPV at follow-up for service members or veterans and their partners. Similarly, all analyses for psychological IPV, which included two psychological IPV measures for both members of the dyad, indicated that SAH-C was associated with relatively greater reductions in psychological IPV.

Further attesting to the efficacy of SAH-C was that those who were assigned to this intervention were considerably more likely to complete the program than were those assigned to SP (59.5% and 34.4% completion rate for SAH-C and SP, respectively). Therefore, not only was SAH-C more effective but it also was better tolerated by participants and associated with higher retention. Our anecdotal observation was that couples appreciated the structured cognitive-behavioral format for SAH-C, and without continuous psychoeducational material incorporated into group discussions by group leaders, participating groups would at times struggle to maintain change-relevant discussions.

Considering that interventions for ongoing IPV have very small average effects (Babcock et al., 2004) and that service members and veterans exposed to trauma have elevated risk for engaging in IPV (Taft et al., 2011), these findings have important implications for preventing violence in recently returning service members. Implementation efforts on bases that house military couples, as well as medical settings that serve military couples, are clearly warranted. It is important to note that military families often receive supportive forms of counseling, such as family support groups, during and following deployments. Current findings indicate that although supportive interventions may be helpful for military couples, trauma-informed cognitive and behavioral change strategies are more effective in preventing the development of IPV over time.

Current findings may also have important implications for indicated violence prevention in civilian populations exposed to stress and trauma. Some empirical support is available for IPV primary prevention approaches using relationship skill enhancement for at-risk youth with maltreatment histories and premarital couples (Whitaker, Murphy, Eckhardt, Hodges, & Cowart, 2013), though we are not aware of any empirically supported intervention designed to prevent partner violence for adult couples affected by stress and trauma. Because trauma and social information processing difficulties relate to IPV in civilian populations in addition to

military populations (Taft, Schumm, Marshall, Panuzio, & Holtzworth-Munroe, 2008), it is possible that SAH-C can be adapted to the broader population, an area for future research.

It is interesting that the female partners reported higher rates of IPV than did their male dyad members. This difference may be accounted for by the use of stricter inclusion criteria for participation across gender such that women were eligible with lower level IPV at baseline so long that it did not produce fear or injury in their partner. However, prior epidemiological studies have shown a similar pattern, whereby the partners of trauma-exposed veterans reported relatively high rates of aggression (Taft et al., 2008). Some of this violence may be in self-defense, and some may be a maladaptive response to veterans' emotional numbing systems, which hinders the expression of emotion and frustrates partners who want to feel more connected to the veteran.

Exploratory analyses focusing on relationship satisfaction outcomes did not demonstrate differences across conditions over time. These results are consistent with our pilot data findings suggesting that the SAH-C intervention is most effective with respect to relationship conflict and IPV and is less effective for enhancing overall relationship satisfaction and well-being (Taft et al., 2014). It is possible that couples participating in SAH-C learned to communicate in a less-conflictual and -abusive manner and developed awareness about IPV and abusive relationship patterns, though such new patterns of handling conflict did not necessarily lead to greater happiness with one's partner and a desire to continue the relationship.

Due to the relatively small sample size and effect sizes obtained, it is premature to draw firm conclusions until findings are replicated. The small sample also precluded us from examining factors that may moderate intervention outcome or retention, such as the presence of PTSD or other forms of psychopathology, type of traumas experienced, relationship characteristics, or specific skills acquisition. Future research is also needed to determine whether the program is effective for women veterans and those in same-gender relationships and to clarify the impact of the intervention on other important relationship outcomes such as relationship satisfaction. In addition, more research is needed to determine the necessary level and type of training and background for those delivering the intervention, given that the intervention was delivered by professionally trained staff under close supervision by the intervention developers in clinical research settings.

These limitations notwithstanding, results from this study are promising in that they suggest that one can effectively prevent IPV in trauma-exposed at-risk couples. It appears that a cognitive-behavioral trauma-informed prevention approach can prevent physical IPV, reduce psychological IPV, and help reduce the myriad negative consequences of IPV. It is our sincere hope that this study will stimulate further program refinement and research in this area of inquiry to prevent partner violence on a larger scale.

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