

# Targeting Relational Aggression in Veterans: The Strength at Home Friends and Family Intervention

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## ABSTRACT

**Objective:** We evaluated the effectiveness of Strength at Home Friends and Families (SAH-F), a dyadic group intervention to prevent relational aggression and its negative consequences, in a community-based sample of service members/veterans and significant others who reported relational difficulties.

**Method:** Participants included 70 veterans and their loved ones. Recruitment was conducted from October 2010 through March 2012. Participants completed an initial assessment that included measures of relational aggression and functioning, depressive symptoms, and posttraumatic stress disorder (PTSD) symptoms. Participants were enrolled in the 10-week SAH-F targeting social information-processing mechanisms hypothesized to underlie the relationship between trauma and aggression and were reassessed at program completion and 3 months after intervention.

**Results:** Significant reductions in psychological aggression were seen both at program completion and at 3-month follow-up for both veterans (standardized mean gain effect size [ES<sub>g</sub>] = -0.45,  $P < .05$ ) and significant others (ES<sub>g</sub> = -0.30,  $P < .05$ ). Perpetration of physical aggression remained low after pretreatment and did not increase. Relationship adjustment reported by significant others, but not veterans, indicated a significant improvement from pretreatment to program completion (ES<sub>g</sub> = 0.33,  $P < .05$ ). Significant ( $P < .05$ ) decreases in depressive symptoms were observed from pretreatment to program completion for veterans (ES<sub>g</sub> = -0.30,  $P < .05$ ) and significant others (ES<sub>g</sub> = -0.55,  $P < .05$ ), and significant decreases in PTSD symptoms were observed from pretreatment to follow-up for veterans and significant others (ES<sub>g</sub> = -0.52,  $P < .05$ ).

**Conclusions:** Results provide support for the effectiveness of SAH-F in reducing relational aggression in military member/significant other dyads and enhancing relationship quality and mental health.

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The prevalence of relational aggression in the military community is a growing public health concern. Levels of intimate partner violence (IPV) perpetration among servicemen are higher than those of civilians when statistically adjusting for demographic and background differences between the cohorts,<sup>1</sup> and rates of IPV and general nonpartner violence reported in clinical Veterans Affairs (VA)-based samples are alarmingly high.<sup>2</sup> The psychological effects of relational aggression are profound, with depression and posttraumatic stress disorder (PTSD) as common consequences.<sup>3–5</sup> In the current investigation, we examined the effectiveness of Strength at Home Friends and Families (SAH-F), a dyadic group intervention designed to prevent relational aggression and its negative consequences, in a community-based sample of service members and veterans who reported relational difficulties with a significant other.

Prior research has not demonstrated empirical support for interventions to prevent relational aggression among military personnel or veterans exposed to combat trauma.<sup>6</sup> Moreover, beyond the military community, interventions for civilians have not been effective (see Babcock et al<sup>7</sup>), highlighting a need for alternative approaches. Prevention programs focused on improving relationships and reducing conflict are particularly indicated, given that relationship conflict serves as a precursor to relational violence,<sup>8</sup> and more subtle forms of aggression early in relationships are predictive of later violence.<sup>9</sup>

Research suggests that risk factors for aggression include individual factors such as depression and PTSD, relationship factors such as marital conflict and instability, and community factors such as lack of broader social connections to people and institutions.<sup>10</sup> Therefore, prevention strategies should address all levels of risk: individual, relationship, and community.<sup>10</sup> SAH-F incorporates psychoeducation about the impact of traumatic stress on relationships, skill-building to enhance communication and prevent conflict, and peer supports to encourage connection and create broader networks of support. The intervention is based on a social information-processing model that holds that trauma contributes to deficits in the interpretation and processing of social information, and these deficits contribute to relational conflict.<sup>11</sup>

We examined the effectiveness of a version of SAH-F that focused specifically on preventing IPV in military intimate couples in a previous pilot study.<sup>12</sup> All veterans who had engaged in physical aggression toward their female partner during the pretreatment period evidenced complete cessation of violence at the 6-month follow-up assessment. Findings suggested that mild psychological aggression, perpetrated by both the veterans and the female partners, decreased more in the intervention groups than the supportive therapy groups, and the effect sizes for these trends were large. Reductions in severe psychological aggression perpetrated by the veteran and partner were moderate and large, respectively.

- Relational aggression in military populations is a significant public health issue.
- The data suggest that veterans and loved ones receiving the trauma-focused, dyadic Strength at Home Friends and Families intervention experienced improved relationship and mental health functioning.
- Group-based intervention may foster a sense of community and social support in veterans and loved ones and may enhance therapeutic impact.

We designed this study to enhance the generalizability of the earlier piloted intervention by broadening its scope from intimate partners to other loved ones impacted by relational difficulties with the veteran. Another goal was to examine the intervention in a larger, community-based sample to evaluate its effectiveness when implemented in a real-world setting. We hypothesized that those receiving SAH-F would experience reduced relational aggression, increased relationship quality, and reduced depressive and PTSD symptoms.

## METHOD

### Recruitment and Retention

Participants were recruited through promotional materials and direct referrals from community veterans' organizations, as well as the local VA hospital and Vet Center from October 2010 to March 2012. All recruitment and research procedures were approved by the Cambridge Health Alliance institutional review board. To be eligible, 1 member of the dyad had to be a veteran, both the veteran and her/his loved one had to provide research consent to participate, and both dyad members had to be at least 18 years old. Potential participants were excluded if they reported reading difficulties that prevented valid completion of instruments, severe organicity or active psychosis, prominent suicidal or homicidal ideation, substance dependence as assessed by the Alcohol Use Disorders Identification Test (AUDIT<sup>13</sup>) or Drug Abuse Screening Test (DAST<sup>14</sup>), or any "severe" physical aggression (ie, used a knife or gun, punched or hit with something that could hurt, choked, slammed against a wall, beat up, burned or scalded on purpose, or kicked), perpetration, or victimization on the revised Conflict Tactics Scales (CTS2<sup>15</sup>) over the previous 3 months.

The baseline sample consisted of 140 individuals, or 70 dyads. Of the 186 potentially eligible participants who were assessed, 46 were excluded because of substance dependence, mental health problems, or severe physical aggression in their relationships. Seventeen participants were excluded for substance abuse and 9 for severe physical aggression; exclusion information was not recorded for 18 participants. Additionally, 1 potential participant relocated, and another had a partner that had a long-term hospitalization that prevented them from participating. The program completion assessment was completed by 63% of the participants (n = 88), and the 3-month postintervention

assessment was completed by 57% (n = 80). Participants were given a gift card at the 3-month postintervention assessment as compensation for their time to complete the assessment. Fifty-three percent of participants (n = 74) attended all 10 sessions, and 61% (n = 86) were deemed to have completed the program, having attended at least 7 sessions. No baseline differences in veteran or partner levels of aggression were found between completers and noncompleters.

### Measures

Participants completed several brief questionnaires detailing their demographic information including age, race/ethnicity, residential stability, and military history. Relational aggression was assessed via the CTS2<sup>15</sup>; we examined the 8-item Psychological Aggression subscale and 12-item Physical Assault subscale, modified for use with both intimate and nonintimate dyads. Veterans and dyad members reported the frequency with which they engaged in and experienced aggressive behaviors toward/from the other in the previous 3 months on a scale ranging from 0 (never) to 6 (more than 20 times). The scales were scored by summing the item responses to obtain a psychological and physical aggression total score. Highest values of veteran- and significant-other-reported perpetration were used.

Two measures were used to assess relationship quality. The Dyadic Adjustment Scale (DAS<sup>16</sup>) is a 32-item self-report measure that assesses relationship adjustment. Participants complete items reflecting dyadic cohesion, satisfaction, affective engagement, agreement, and overall adjustment on a series of Likert scales ranging from 2 to 6, with higher scores reflecting better relationship adjustment. The Quality of Relationship Inventory (QRI<sup>17</sup>) was used to measure perceived support from a particular significant other. The QRI contains 25 items rated on a 4-point Likert scale. The measure comprises 3 scales designed to measure availability of support within the relationship, conflict within the relationship, and depth of the relationship; a total score is obtained by summing all item responses.

Depressive symptoms were measured using the Personal Health Questionnaire (PHQ<sup>18</sup>). The PHQ-9 is a widely used 9-item self-report measure assessing frequency of depressive symptoms, including suicidal ideation. Responses are on a scale from 0 (not at all) to 3 (nearly every day) and are summed to create a severity score.

PTSD symptoms were measured for veterans using the PTSD Checklist—Military Version (PCL-M<sup>19</sup>). The PCL-M is a self-report measure assessing the 17 symptoms of PTSD based on diagnostic criteria from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision.<sup>20</sup> Respondents are asked to consider their most traumatic military experience and rate the degree to which they were bothered by each symptom in the past month. Loved ones completed the PTSD Checklist—Civilian Version (PCL-C<sup>19</sup>). For both versions of the PCL, individual items are rated on a 5-point scale ranging from 1 (*not at all*) to 5 (*extremely*), and these item scores are summed for an overall symptom score.

## Procedure

After an initial phone screening to confirm veteran status of 1 member of the dyad and that both members of the dyad were at least 18 years old, interested dyads were invited to the study site for an intake assessment. Interested veterans could select a partner, family member, or friend to participate with them. Prior to being enrolled in the program, each prospective group member met with a master's level clinician who obtained informed consent and administered an intake interview.

After eligibility was confirmed, participants were invited to attend the next available group intervention. At the end of the weekly, 10-session intervention, participants again completed the same questionnaires and an exit survey. Participants completed these same measures again via electronic survey or by mail 3 months after intervention.

## Intervention

Strength at Home Friends and Families is a 10-week dyadic group intervention designed to prevent relational aggression and improve relationships between returning veterans and their romantic partners, family members, or friends. Groups are conducted in a multidyad, closed-group format, with 3-to-5 dyads in each group. For this study, all sessions were led by 2 master's level clinicians. All clinicians participated in a 2-day training on SAH-F, led by the developer of the intervention (C.T.T), and received regular supervision by the intervention developer or a trained doctoral-level expert clinician who had conducted several prior SAH-F groups.

The SAH-F group atmosphere is supportive and nonconfrontational. Sessions are 2 hours long and contain 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. The program was designed to be highly sensitive to the fact that many military families have histories of traumatic stress exposure that negatively affect their relationships. The program targets social information-processing mechanisms that are hypothesized to underlie the relationship between trauma and aggression and common themes that may underlie trauma-related problems and relationship difficulties (see Taft et al<sup>12</sup>).

## Data Analysis

Analyses were conducted using Mplus 7.11.<sup>21</sup> Multiple imputation procedures were used to account for missing data. Ten thousand imputed data sets were generated, and the medians of the distributions of these imputed data sets were used as point estimates for all statistics. Our analyses of the impact of the SAH-F program focused on the means, standard deviations, correlations, and intraindividual effect sizes (standardized mean gain; ES<sub>sg</sub>) with 95% confidence intervals. These effect sizes can be interpreted on a metric similar to Cohen *d*, but include a correction for the associations between repeated assessments of constructs.

## RESULTS

### Sample Characteristics

Fifty-three percent of the sample ( $n = 74$ ) were male; 47% ( $n = 66$ ) were female. Ninety percent of veteran participants ( $n = 63$ ) were male; 10% ( $n = 7$ ) were female. The mean age of participants in the study was 45.15 years ( $SD = 13.26$ ). More than half (53%) were white, 40% were Latino, 13% were African-American, 9% were American Indian, 1% was Asian, and 23% were "other." (Please note that participants could select "Latino" and another ethnicity, and therefore the percentage exceeds 100%.) The majority (81%) had children, 41% had children under 18 years of age, and 41% had children living in their households. Nine percent of the sample held a bachelor's degree or higher, 49% had some college attendance, 12% had an associate's degree, 17% had a high school degree or GED equivalent, and 5% did not graduate from high school.

The composition of dyads included 49% married couples ( $n = 34$ ), 23% romantic partners ( $n = 16$ ), 17% friends ( $n = 12$ ), 7% family members ( $n = 5$ ), 1% parents ( $n = 1$ ), and 3% unknown ( $n = 2$ ). Among the veterans, 53% ( $n = 37$ ) served in the Army, 21% ( $n = 15$ ) served in the Navy, 20% ( $n = 14$ ) served in the Marines, and 6% ( $n = 4$ ) served in the Air Force (none served in the Coast Guard). Only 11% ( $n = 8$ ) were currently serving; of those separated of the military, 7% ( $n = 5$ ) were retired, 36% ( $n = 25$ ) were discharged with severance or military disability payments, 34% ( $n = 24$ ) were discharged without severance or payment, and 10% ( $n = 7$ ) indicated their separation status was "other." Thirty-three percent ( $n = 23$ ) served during the Vietnam era; 30% ( $n = 21$ ) served during the post-Vietnam era; 29% ( $n = 20$ ) served during the Persian Gulf War; and 34% ( $n = 24$ ) served during Operation Enduring Freedom/Operation Iraqi Freedom. Sixty-four percent ( $n = 45$ ) served in combat, and 57% ( $n = 40$ ) reported that the VA determined a service-connected disability. The number of tours served ranged from 0 to 8: 7% ( $n = 5$ ) had not served a tour; 49% ( $n = 34$ ) had served 1 tour; 20% ( $n = 14$ ) had served 2 tours; and 11% ( $n = 8$ ) had served 3 or more tours. The number of deployments ranged from 0 to 20: 14% ( $n = 10$ ) had not been deployed; 39% ( $n = 27$ ) were deployed once, 19% ( $n = 13$ ) were deployed twice, and 21% ( $n = 15$ ) were deployed 3 or more times. Only 3% ( $n = 2$ ) had been deployed in the previous year.

### Aggression Perpetration

We began by examining the impact of the SAH-F intervention on psychological and physical aggression perpetrated by both veterans and their loved ones. Descriptive statistics and effect sizes representing intraindividual changes for these outcomes are presented in Table 1. Results indicated significant ( $P < .05$ ) decreases in psychological aggression from pretreatment to program completion for both veterans and their loved ones and that these effects were maintained when examining changes from pretreatment to follow-up. There were no significant changes in levels of physical aggression perpetrated by veterans or loved ones.

**Table 1. Means, Standard Deviations, and Intraindividual Effect Sizes (ESsg With 95% CI) for Aggression Perpetration and Secondary Outcomes**

Outcome	Pretreatment		Program Completion		Follow-Up		Pretreatment–Program Completion		Pretreatment–Follow-Up		Program Completion–Follow-Up	
	Mean	SD	Mean	SD	Mean	SD	ESsg	95% CI	ESsg	95% CI	ESsg	95% CI
Veteran psychological aggression	4.01	2.09	3.21	2.25	2.95	2.65	-0.36	-0.064 to -0.08	-0.45	-0.75 to -0.15	-0.11	-0.41 to 0.19
Veteran physical aggression	0.94	1.66	0.87	1.89	0.71	3.16	-0.05	-0.23 to 0.13	-0.09	-0.40 to 0.22	0.00	-0.32 to 0.32
Partner psychological aggression	3.54	2.13	2.92	2.06	2.84	2.49	-0.30	-0.56 to -0.03	-0.30	-0.59 to -0.02	-0.04	-0.35 to 0.27
Partner physical aggression	0.79	1.95	0.88	2.06	0.87	3.47	0.05	-0.14 to 0.23	0.03	-0.37 to 0.43	-0.04	-0.40 to 0.31
Veteran DAS	99.88	28.76	94.17	20.62	90.19	44.64	-0.22	-0.48 to 0.04	-0.26	-0.63 to 0.11	-0.14	-0.50 to 0.22
Veteran QRI	66.27	34.56	61.82	17.86	64.54	24.21	-0.02	-0.26 to 0.21	0.11	-0.10 to 0.32	-0.11	-0.30 to 0.09
Veteran PHQ	12.06	7.62	9.62	8.13	18.12	6.84	-0.30	-0.51 to -0.10	0.85	0.60 to 1.11	1.18	0.89 to 1.47
Veteran PCL	52.76	18.48	50.59	21.94	42.22	22.27	-0.12	-0.31 to 0.07	-0.52	-0.74 to -0.30	-0.40	-0.59 to -0.21
Partner DAS	91.51	17.29	96.64	17.84	89.69	32.50	0.33	0.09 to 0.57	-0.07	-0.48 to 0.33	-0.32	-0.72 to 0.07
Partner QRI	63.42	17.93	64.40	15.08	62.96	17.24	0.13	-0.22 to 0.47	-0.02	-0.36 to 0.31	-0.11	-0.37 to 0.15
Partner PHQ	9.30	7.22	5.79	5.35	13.96	5.60	-0.55	-0.77 to -0.33	0.72	0.45 to 0.99	1.51	1.17 to 1.85
Partner PCL	43.33	17.00	32.33	15.75	32.52	16.78	-0.54	-0.76 to -0.31	-0.52	-0.72 to -0.32	-0.02	-0.23 to 0.19

Abbreviations: CI = confidence interval; DAS = Dyadic Adjustment Scale; ESsg = standardized mean gain effect size; partner = romantic partner, parent, family member, or friend; PCL = PTSD Checklist; PHQ = Patient Health Questionnaire-9, QRI = Quality of Relationship Inventory; SD = standard deviation.

**Table 2. Correlation Table for Aggression Perpetration Counts of Veterans and Partners<sup>a</sup>**

	1	2	3	4	5	6	7	8	9	10	11	12
1. Pretreatment veteran psychological aggression	1											
2. Program completion veteran psychological aggression	0.32	1										
3. Follow-up veteran psychological aggression	0.24	0.19	1									
4. Pretreatment veteran physical aggression	0.53	0.41	0.06	1								
5. Program completion veteran physical aggression	0.35	0.51	0.03	0.70	1							
6. Follow-up veteran physical aggression	0.19	0.20	0.60	0.11	0.11	1						
7. Pretreatment partner psychological aggression	0.80	0.30	0.25	0.34	0.17	0.09	1					
8. Program completion partner psychological aggression	0.41	0.81	0.11	0.31	0.42	0.11	0.39	1				
9. Follow-up partner psychological aggression	0.27	0.18	0.91	0.08	0.00	0.52	0.27	0.11	1			
10. Pretreatment partner physical aggression	0.34	0.31	-0.19	0.53	0.36	-0.42	0.42	0.29	-0.03	1		
11. Program completion partner physical aggression	0.37	0.35	-0.19	0.50	0.69	-0.30	0.32	0.47	-0.10	0.70	1	
12. Follow-up partner physical aggression	0.18	0.21	0.55	0.14	0.34	0.90	-0.01	0.14	0.43	-0.47	-0.16	1

<sup>a</sup>All correlation estimates represent the median estimates from the 10,000 imputed data sets. Abbreviation: partner = romantic partner, parent, family member, or friend.

Associations among the aggression perpetration outcomes were examined next. Table 2 presents the median correlation coefficients across the 10,000 imputed data sets. Large associations were observed between veterans' levels and loved ones' levels of psychological aggression at each time point (*r* values ranging from 0.80 to 0.91), indicating a very strong relationship between these aggression outcomes. Although smaller in magnitude than the associations of psychological aggression, large associations were observed between veterans' and loved ones' levels of physical aggression at each time point (*r* values ranging from 0.53 to 0.90), indicating a strong relationship between these aggression outcomes. There were also robust associations between veterans' perpetration of psychological and physical aggression at each time point (*r* values ranging from 0.51 to 0.60) and between their loved ones' perpetration of psychological and physical aggression at each time point (*r* values ranging from 0.42 to 0.47). Together, these findings suggest that, although levels of psychological aggression decreased significantly (*P* < .05) and levels of physical aggression were stable, there were robust links between the perpetration of both psychological and physical aggression by veterans and their loved ones.

**Secondary Outcomes**

We also examined veterans' and their loved ones' perceived relationship quality (DAS and QRI) and mental health (depressive and PTSD symptoms) as secondary outcomes of the SAH-F intervention. Descriptive statistics and effect sizes representing intraindividual changes for these outcomes are also presented in Table 1. Loved ones, but not veterans, reported a significant (*P* < .05) improvement from pretreatment to program completion in relationship adjustment as measured by the DAS. There were no significant changes for veterans or loved ones on the QRI. Veterans and their loved ones also reported significant (*P* < .05) decreases in depressive and PTSD symptoms from pretreatment to program completion, and the PTSD symptom improvements were maintained at follow-up.

**DISCUSSION**

This study represents an important community-based application of a relational aggression-prevention effort. Results suggest the effectiveness of the SAH-F intervention in reducing psychological aggression both at program completion and at follow-up 3 months later. Perpetration

of physical relational aggression remained stable through the follow-up period, which was expected given that dyads endorsed little physical aggression at baseline and those with severe aggression were screened out, as a primary goal of the intervention is to prevent such aggression. Our findings are consistent with results from a pilot trial of the intervention delivered to intimate couples in which reductions in psychological aggression perpetration were observed.<sup>12</sup> These reductions in psychological aggression are particularly salient given prior findings indicating that for both women and men, psychological aggression victimization is associated with greater physical and mental health impairment, above the impact of physical aggression victimization.<sup>22</sup> In addition, our findings indicating high correlations among types of relational aggression are consistent with prior work<sup>23</sup> and suggest that reductions in psychological aggression may be protective against later physical aggression perpetration.

Regarding secondary outcomes, loved ones, but not veterans, reported a significant improvement in relationship adjustment from baseline to program completion, but no changes in relationship support. Modest improvements of relationship quality are consistent with a previous pilot study suggesting that while the intervention was effective in reducing relational aggression, it was less effective in improving overall relationship quality and well-being.<sup>12</sup> It is possible that participants, by virtue of enhancing communication skills, became more aware of other relationship problems through their participation, which impacted their relationship perceptions.

Veterans and loved ones reported significant decreases in symptoms of depression and PTSD from baseline to treatment completion, and decreases in PTSD symptoms were maintained at follow-up. Given that both depressive and PTSD symptoms are inversely related to social support,<sup>24,25</sup> it may be that the group setting in which SAH-F was delivered helped foster a sense of community with other veterans and loved ones, thereby improving social support. Future studies of the intervention should include measures of social support to formally test this hypothesis.

Study findings must be interpreted in the context of several potential limitations. First, results cannot be evaluated against a comparison group that did not receive SAH-F. Second, though providers of SAH-F received regular weekly supervision and training from program developers, treatment fidelity was not formally assessed. Third, although our analyses accounted for missing data, only 63% completed the program, and only 57% of participants provided data for the final follow-up assessment. Finally, improved measures of relationship quality and social support designed for use with nonintimate friends and family members would facilitate an improved understanding of the intervention's impact on relationship quality and satisfaction.

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