

Psychological Trauma: Theory, Research, Practice, and Policy

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Online First Publication, March 18, 2021. <http://dx.doi.org/10.1037/tra0001034>

CITATION

Taft, C. T., Gallagher, M. W., Hoffmann, A., Cole, H. E., & Creech, S. K. (2021, March 18). Does Strength at Home for Couples Prevent Sexual Aggression in Returning Veterans? Examining Randomized Controlled Trial Findings. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. <http://dx.doi.org/10.1037/tra0001034>

Does Strength at Home for Couples Prevent Sexual Aggression in Returning Veterans? Examining Randomized Controlled Trial Findings

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Objective: Sexual aggression between intimate partners is a serious problem. This study examined this problem in returning male veterans and their female partners, and the effectiveness of an intervention for intimate partner violence (IPV) in preventing sexual aggression using data gathered during a randomized controlled trial. Method: Rates of sexual aggression and the effectiveness of the Strength at Home Couples (SAH-C) intervention were examined in a sample of 69 couples with a returning male veteran from Iraq/Afghanistan who participated in a randomized controlled trial for intimate partner violence (IPV) prevention. Couples were assessed at 4 timepoints: immediately prior to the intervention, immediately following the intervention, 6 months postintervention, and 12 months postintervention.

Results: It was found that 57% of couples reported the presence of intimate partner sexual aggression in their relationship across the assessment points, with higher rates reported at baseline than other time points and for veterans relative to their partners. The most commonly endorsed items were “I insisted on sex when my partner didn’t want to” and “I made my partner have sex without a condom.” Overall, couples randomized to SAH-C showed greater declines in sexual aggression than couples who were randomized to Supportive Prevention, with particularly strong differences across conditions from baseline to posttreatment. **Conclusions:** These data suggest that this trauma-informed couples-based intervention based on a social information processing model may assist in reducing intimate partner sexual aggression and builds on prior findings demonstrating the program be associated with the prevention of physical and psychological IPV.

Clinical Impact Statement

This study demonstrates the effectiveness of a trauma-informed couples-based intimate partner violence intervention in reducing sexual aggression in couples.

Keywords: intimate partner violence, sexual aggression, Strength at Home, veterans, military couples

Sexual aggression in returning veterans and their intimate partners has been understudied and underassessed (Teten et al., 2009). Sexual aggression rates among couples range from approximately 9% to 17% in community and college samples (Bagwell-Gray et al., 2015); and 1 study of veterans found a 40% rate (Teten et al., 2009). These data suggest that sexual aggression between intimate partners is a serious problem, though we know relatively little about the scope of the problem in recently returning veterans and

their partners, and perhaps even less about what interventions may be effective in preventing and ending this form of aggression. The aims of the current study were to examine sexual aggression in a sample of couples with a returning veteran from Iraq/Afghanistan who participated in a randomized controlled trial for intimate partner violence (IPV) prevention, and to determine the effectiveness of the Strength at Home Couples (SAH-C) intervention in preventing this form of aggression.

SAH-C is a 10-session couples-based group intervention that incorporates cognitive behavioral strategies to prevent and reduce relationship conflict and violence in trauma-exposed service members and veterans. The intervention was designed to mitigate the impacts of trauma-related problems that increase risk for IPV. In a prior study with the current sample, evidence was provided for the efficacy of SAH-C to prevent physical and psychological IPV

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(Taft et al., 2016a). Specifically, in a sample of 69 heterosexual couples with a recently returning male veteran, couples who were randomized to SAH-C engaged in less physical and psychological IPV at postintervention and follow-up relative to those randomized to a supportive prevention intervention. This was the first published study that we are aware of that demonstrated the efficacy of an IPV prevention intervention in a military or veteran sample.

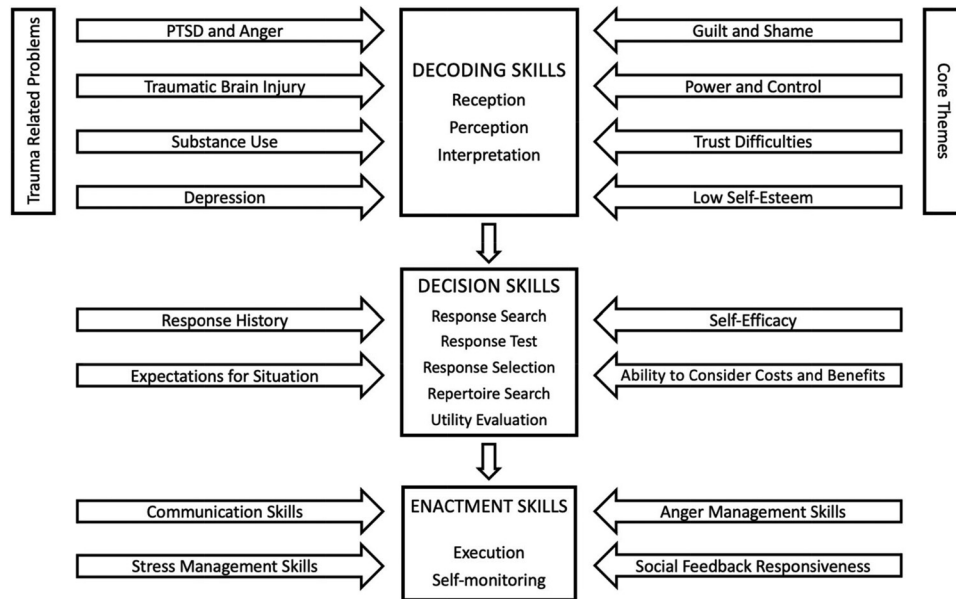
SAH-C is based on a trauma-informed social information processing model that highlights how prior trauma and other negative life events may impact the ways that we interpret and respond to social situations, particularly those involving relationship partners (Taft et al., 2016b). The model, building on the work of McFall (1982) and research on aggression in children and adults (Dodge et al., 2006; Eckhardt et al., 1998); addresses biases and deficits across stages of social information processing from decoding a situation to choosing, enacting, and evaluating a response (see Figure 1). For example, in the decoding stage of social information processing, prior events may lead one to develop biases when they decode the meaning of a relationship situation, and problematic behavior such as aggression may result. These problems may be exacerbated by certain associated underlying themes that may be impacted by trauma, such as difficulties with intimacy, difficulties trusting others, low self-esteem, and conflicts related to power and control. Several studies suggest that trauma-related problems may be associated with physical and psychological IPV at least in part through its influence on these biases or deficits in social information processing (Sippel & Marshall, 2011; Taft et al., 2008; Taft et al., 2015).

Considerable research indicates that cognitive variables related to the social information processing model play a

critical role in men’s sexual offending, such as more distorted and negative beliefs, and distorted expectations about women, sex, and sexual violence (Drieschner & Lange, 1999). Others have argued that men’s sexual violence toward women is a function of how they organize and process information about them (Ward & Hudson, 2000). Those who engage in sexual aggression may evidence deficits at any stage of social information processing, including how the victim’s behavior is perceived and interpreted (decoding stage), what responses are selected (decision-making stage), and what responses are chosen (enactment stage; Treat et al., 2001). Most of the research in this area has focused on the decoding stage in male perpetrators, particularly how they tend to perceive women as more sexually and emotionally interested than they truly are (Abbey & Harnish, 1995); and how they exhibit deficits and insensitivity in recognizing women’s affective and sexual cues (McDonel & McFall, 1991).

We examined sexual aggression in the same previously described sample of military couples with a returning veteran from Iraq/Afghanistan for which SAH-C was shown to prevent physical and psychological IPV (Taft et al., 2016a). Because trauma and posttraumatic stress disorder (PTSD) have been shown to be only weak correlates of this form of violence in veteran samples (Teten et al., 2009); and historically the development of interventions for sexual aggression and interventions for other forms of IPV have had different trajectories with different areas of emphasis (Marshall & Hollin, 2015); sexual aggression was not examined in this prior study. In addition to examination of rates of sexually aggressive behaviors in the current sample, we compared sexual aggression across baseline, posttreatment, and 2 six-month follow-up assessment points. It was expected that greater reductions in sexual aggression would be found from baseline to posttreatment and

Figure 1
Strength at Home Social Information Processing Model



the 2 follow-up assessment points for those randomized to SAH-C relative to those randomized to supportive prevention.

Method

Participants

Couples were recruited from two major northeastern metropolitan areas between February 2010 and August 2013. Recruitment strategies included the posting of flyers in Department of Veterans Affairs (VA) hospitals, referrals from mental health providers, and presentations at events hosted by servicemember-relevant organizations. Recruitment materials were targeted at male veterans who had deployed to Iraq/Afghanistan as part of Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn, who were involved in cohabiting partner relationships and endorsed some degree of relationship distress or psychological IPV. Exclusion criteria included presence of symptoms that would preclude full participation, such as severe cognitive difficulties, active psychosis, or untreated substance dependence, active suicidal or homicidal ideation, and IPV-related disqualifiers (i.e., report of partner's use of physical violence with injury or use of a weapon in the past 6 months, veteran fearful of partner, report of veteran's use of any physical violence in the past 6 months). Of 97 couples screened, 69 met eligibility criteria and agreed to participate ($N = 138$ research participants).

Participants were primarily White (90% of veterans, 86% of partners) and married (81%), with the majority reporting at least part-time employment (87% of veterans, 70% of partners). M age of veterans was 35.44 ($SD = 9.46$) and mean partner age was 33.60 ($SD = 9.05$). The majority of veterans reported current military status as National Guard (58%), followed by Active Duty and Reserves (both 7% each), with an average of 1.74 deployments ($SD = .89$). Taft et al. (2016a) reported no mean level differences on any demographic (age, race, relationship status, employment), psychological (PTSD symptomatology, depressive symptoms, alcohol problems), or military-related variables (military status, number of deployments, rank) between SAH-C and supportive prevention dyads using data from this same sample. See this earlier study for a more detailed description of the study sample and inclusion/exclusion criteria assessment.

Procedure

This study was approved by an institutional review board in a VA medical center located in the New England area. Following provision of informed consent, couples were randomly assigned to either the SAH-C ($n = 74$, 37 couples) or supportive prevention condition ($n = 64$, 32 couples). Of couples who were randomized to SAH-C, 76% ($n = 28$ couples) completed at least some of the intervention, with 65% ($n = 24$ couples) completing the entire protocol. Among couples receiving supportive prevention, 75% ($n = 24$ couples) completed at least some of the intervention, with 36% ($n = 12$ couples) remaining enrolled for the duration. Couples were assessed at four timepoints: immediately prior to the intervention, immediately following the intervention, 6 months postintervention, and 12 months postintervention. Follow-ups were conducted onsite (or via online survey for hard-to-reach

participants) between October of 2010 and September of 2013. Participants each received \$50 compensation for completed assessments.

Measures

Revised Conflict Tactics Scales

The Sexual Coercion subscale of the revised Conflict Tactics Scales (CTS2; Straus et al., 1996) was used to measure sexual IPV within the sample. The scale consists of seven paired items that ask participants to rate the frequency with which they used a particular sexual coercion tactic against their partner in the past 6 months (e.g., "I insisted on sex when my partner did not want to"), followed by the frequency with which their partner used that tactic against them. Sexual IPV scores were calculated both dichotomously (reported any sexual IPV vs. did not report any sexual IPV) and continuously, using the variety score scoring protocol described by Taft et al. (2016a). More specifically, participant-reported and partner-reported items were compared, and the greater of the two responses was used in the calculation of CTS2 scores. From these ratings, sexual IPV scores were then calculated as variety scores by dichotomously scoring each 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 7. This method of scoring reduces skewness, gives equal weight to each item, and is most defensible with respect to memory limitations regarding behavior frequencies (Moffitt et al., 1997).

Intervention

SAH-C

SAH-C is a trauma-informed cognitive-behaviorally-based group treatment for couples comprised of 10 weekly two-hour sessions. It is designed to target difficulties in social information processing that may explain connections between trauma and IPV. Group content is largely focused on themes relevant to relationship distress that may be influenced by trauma, such as trust, intimacy, and control. Each group contains a brief didactic overview of various topics as well as interactive activities designed to reinforce skills and build group cohesion. Program content does not explicitly focus on sexual aggression other than psychoeducational material in Session 2 that defines *sexual aggression* as "unwanted sexual contact, pressuring and coercing the other person for sex, using intimidation, threats, or force to make the other person have sex, using intimidation, threats, or force to make the other person perform unwanted sex acts, and so forth." SAH-C is nonconfrontational and collaborative in nature and is designed to foster a supportive environment within the group. Between sessions, group members are encouraged to complete outside practice assignments designed to enhance intimacy, decrease the use of violence, and reinforce skills learned in session.

Supportive Prevention

Supportive prevention is a manualized intervention derived from the work of Jennings (1987) that is designed to provide a supportive group environment with minimal therapist direction

(see Taft et al., 2016a). In supportive prevention, group members work collaboratively to set the agenda, and discuss themes and topics that emerge organically from group processes to provide support for one another.

Both group conditions were delivered in a closed-group format consisting of three to five couples and were facilitated by two doctoral- or predoctoral-level clinicians. High therapist adherence and competence was demonstrated in the prior trial (see Taft et al., 2016a).

Analyses

Sixty-nine couples (37 SAH-C, 32 supportive prevention) were included in intent to treat analyses. First, we examined rates of CTS2 Sexual Coercion scores overall and at the item level. Analyses comparing outcomes across conditions were conducted using Mplus 8.0. Multiple imputation procedures were used to account for missing data. One 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 compared to supportive prevention was conducted using the means, standard deviations, and between and within condition effect sizes. Hedges' g (with the correction for small sample sizes) effect sizes were calculated to examine between condition effects on sexual coercion and victimization. The standardized mean gain (ES_{sg}) was also calculated to quantify within condition changes from baseline to posttreatment. Ninety-five percent confidence intervals are presented for all effect sizes.

Results

Overall, examination of CTS2 data indicated that 57% of couples reported the presence of at least one act of sexual aggression during the study period: 47% at baseline, 29% at posttreatment, 24% at 6-month follow-up, and 15% at 12-month follow-up (see Table 1). Examination of data across couple members indicates

that 50% of veterans and 39% of partners reportedly engaged in sexual aggression at least once across the assessments time points. Veterans were more likely to engage in sexual aggression than partners at each time point, with overall sexual aggression rates of 41% versus 30% at baseline, 24% versus 20% at posttreatment, 22% versus 15% at six-month follow-up, and 13% versus 10% at 12-month follow-up (see Table 1). The most commonly endorsed behaviors across time points for both partners were "I insisted on sex when my partner didn't want to" and "I made my partner have sex without a condom."

Tests of Differences Across Conditions

We next examined differences in the reported rates of sexual aggression by treatment condition. Imputed means, standard deviations, and between condition effect sizes with confidence intervals are presented in Table 2. At baseline, both veterans and their partners randomized to SAH-C engaged in higher rates of sexual aggression than those in the supportive prevention condition, with effect sizes of a small magnitude. However, at the posttreatment assessment this trend was reversed and participants in SAH-C exhibited lower rates of sexual aggression than in the supportive prevention condition, with effect sizes of a small to moderate magnitude. SAH-C maintained slightly superior outcomes for both members of the couple at six-month follow-up, although the between condition effect sizes were smaller than at posttreatment. By the 12-month follow-up point, there were minimal differences between the conditions in partner-perpetrated sexual aggression, but lower reported rates of perpetration for veterans in the supportive prevention condition. None of the between condition effect size comparisons were statistically significant based on the confidence interval of the effect size.

The frequency of sexual aggression by both members of the couple decreased by more than 50% from baseline to posttreatment in the SAH-C condition, whereas rates for veterans declined only slightly in the supportive prevention condition and rates for

Table 1
Revised Conflict Tactics Scales' Item-Level Endorsement of Sexual Aggression Perpetration

Item endorsed	Baseline, <i>n</i> (%)	Posttreatment, <i>n</i> (%)	6-month follow-up, <i>n</i> (%)	12-month follow-up, <i>n</i> (%)
Veterans				
"I made my partner have sex without a condom"	16 (20.5%)	8 (13.3%)	4 (8.0%)	5 (9.4%)
"I used force to make partner have sex"	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
"I used force to make partner have oral or anal sex"	0 (0.0%)	0 (0.0%)	1 (2.0%)	0 (0.0%)
"I insisted on sex when my partner didn't want to"	23 (29.5%)	7 (11.7%)	6 (11.8%)	4 (7.5%)
"I insisted on oral or anal sex when my partner didn't want to"	10 (12.8%)	3 (5.0%)	1 (2.0%)	1 (1.9%)
"I used threats to make my partner have sex"	1 (1.3%)	1 (1.7%)	0 (0.0%)	0 (0.0%)
"I used threats to make my partner have oral or anal sex"	0 (0.0%)	1 (1.7%)	0 (0.0%)	0 (0.0%)
Overall	29 (41.4%)	13 (23.6%)	10 (21.7%)	6 (12.5%)
Partners				
"I made my partner have sex without a condom"	14 (17.9%)	5 (8.3%)	4 (8.0%)	4 (7.5%)
"I used force to make partner have sex"	0 (0.0%)	1 (1.7%)	0 (0.0%)	0 (0.0%)
"I used force to make partner have oral or anal sex"	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
"I insisted on sex when my partner didn't want to"	11 (14.1%)	8 (13.3%)	4 (8.0%)	1 (1.9%)
"I insisted on oral or anal sex when my partner didn't want to"	1 (1.3%)	1 (1.7%)	0 (0.0%)	0 (0.0%)
"I used threats to make my partner have sex"	0 (0.0%)	2 (3.4%)	0 (0.0%)	0 (0.0%)
"I used threats to make my partner have oral or anal sex"	0 (0.0%)	1 (1.7%)	0 (0.0%)	0 (0.0%)
Overall	21 (30.0%)	11 (20.0%)	7 (15.2%)	5 (10.4%)

Table 2
Tests of Sexual Aggression Differences Across Conditions

Outcome and time	Supportive prevention <i>M (SD)</i>	Strength at home-couples <i>M (SD)</i>	Hedges' <i>g</i>	95% CI
Veteran sexual coercion				
Baseline	0.56 (0.86)	0.74 (0.94)	0.19	-0.28:0.66
Posttreatment	0.49 (0.95)	0.27 (0.62)	-0.27	-0.74:0.20
6-month follow-up	0.29 (0.55)	0.21 (0.44)	-0.14	-0.62:0.33
12-month follow-up	0.11 (0.35)	0.24 (0.75)	0.22	-0.25:0.69
Partner sexual coercion				
Baseline	0.28 (0.51)	0.37 (0.53)	0.16	-0.31:0.63
Posttreatment	0.36 (0.85)	0.18 (0.40)	-0.28	-0.75:0.19
6-month follow-up	0.29 (0.60)	0.16 (0.36)	-0.27	-0.74:0.20
12-month follow-up	0.09 (0.29)	0.10 (0.30)	0.03	-0.44:0.50

partners slightly increased from baseline to posttreatment. When examining within condition effect sizes from prepost there were moderate to large and statistically significant decreases in veteran sexual aggression (ES_g = $-.56$; 95% CI [$-.88, -.24$]) and partner sexual aggression (ES_g = $-.41$; 95% CI [$-.77, -.05$]) in SAH-C, but only small and nonsignificant changes for veterans (ES_g = $-.10$; 95% CI [$-.59, .39$]) and partners (ES_g = $.09$; 95% CI [$-.40, .58$]) in the supportive prevention condition.

Discussion

Rates of sexual aggression reported in this study were generally comparable to prior studies of veteran samples (Teten et al., 2009), with 57% of couples reporting the presence of sexual aggression in their relationship during at least one assessment point. The most commonly endorsed items for both members of the couple were "I insisted on sex when my partner didn't want to" and "I made my partner have sex without a condom." These data speak to the importance of examining sexual aggression in military and veteran couples in addition to physical and psychological forms of IPV. To date, most of the attention for the problem of sexual aggression in service members and veterans has focused on nonintimate sexual assault. These data suggest that this scope should be broadened to include intimate partners.

Findings regarding the efficacy of SAH-C for intimate partner sexual aggression were consistent with expectations and are promising, albeit preliminary. Overall, couples who were randomized to SAH-C showed greater declines in sexual aggression relative to couples who were randomized to supportive prevention. Reductions in sexual aggression rates by more than 50% from pretreatment to posttreatment in SAH-C are particularly notable, especially considering that rates for partners in the supportive prevention comparison intervention actually increased during the same time period and rates for veterans only slightly decreased. These data suggest that a trauma-informed couples-based intervention that focuses on enhancing social information processing not only contributes to reductions in physical and psychological IPV (Taft et al., 2016a), but sexual aggression as well.

Given the study design that did not isolate components of the intervention, it is not possible to determine the specific mechanisms that accounted for differences across conditions for reductions in sexual aggression. However, since the two interventions used in this study were developed to be comparable on the nonspecific elements of the

group, it is likely that the cognitive-behavioral elements of SAH-C, which were heavily informed by the trauma-informed social information processing model, was primary in promoting reductions in sexual aggression. These findings support social information processing-based models for sexual aggression (McDonel & McFall, 1991) and are consistent with prior research showing interventions based on this model to be effective in preventing various forms of aggression (see Taft et al., 2016b). Because prior research has not examined the role of social information processing with respect to sexual IPV among couples, current findings point to a need for additional research in this area of investigation.

It is important to note that at the final assessment time point, approximately one year after the completion of the groups, no significant difference in reductions in sexual aggression was found. These findings were unexpected, and examination of the scores suggests that they were more a function of reductions in sexual aggression from the first to the second follow-up among those in the Supportive Prevention condition than to a lack of retention of treatment gains in SAH-C. Future research should be conducted to see if this pattern is replicated and if there may be some long-term benefit to supportive prevention in preventing sexual aggression. Conclusions regarding within and between condition effects are limited by the sample size limiting power for significance tests, but results suggest that SAH-C may be associated with a greater initial reduction in sexual aggression by both members of the dyad, and both intervention approaches may eventually lead to clinically significant reductions in sexual aggression, although more research is needed with larger samples to strengthen these conclusions.

This study has a number of limitations. The relatively small sample size necessitates replication of current findings with larger sample studies that also allow for examining factors that may moderate intervention outcome such as trauma and PTSD, relationship characteristics, or acquisition of specific skills. Further, because the majority of participants were National Guard members, the degree to which current study findings generalize to active duty military personnel is unknown. There may also be an advantage to working with at risk couples earlier following a deployment on a military installation to mitigate the early impacts of potential risk factors for biased social information processing and increased risk for all forms of IPV, such as trauma, PTSD, traumatic brain injury, substance use problems, and underlying relationship issues/themes such as those relating to mistrust and power and control. Additional research is needed to examine the effectiveness of SAH-C in preventing sexual IPV on a military installation with active-duty service members and their

partners. Future research is also needed to determine whether the program is effective for women veterans and those in same-gender relationships, and more research is needed to determine the necessary level and type of training and background for those delivering SAH-C, given that the intervention was delivered by professionally trained staff under close supervision by the intervention developers.

Despite these study limitations, this study may have some important clinical implications. Enhancement of couples' ability to actively listen to and interpret the intentions of one another, generate assertive responses, and enact them skillfully while being mindful of the role of trauma and negative life events on these processes may be helpful in preventing various forms of aggression including sexual IPV. This may suggest potential benefits of enhancing social information processing specific to sexual cues to prevent sexual IPV and to facilitate more direct communication around the issue of expectations about sex and use of sexual aggression (Drieschner & Lange, 1999; McDonel & McFall, 1991). The use of couples intervention to prevent and end IPV has been relatively understudied but has some advantages over individually focused interventions in that this modality may better address underlying relationship issues, core themes underlying trauma and distress, and bidirectional aggression (Stith & McCollum, 2011). Moreover, because intimate relationship distress is a strong predictor of IPV, effectively addressing this distress in the couples context may have particular benefits in preventing IPV (Stith et al., 2008).

Current findings speak to the importance of including intimate partner sexual aggression assessment in IPV program evaluation efforts. Most research in the area of IPV, including our own prior work (Taft et al., 2016a), has neglected to examine sexual aggression while focusing on physical and psychological IPV as these have historically been considered distinct forms of IPV that require different forms of intervention (Marshall & Hollin, 2015). As current findings suggest, there may be critical mechanisms that must be targeted across all of these forms of intimate aggression, such as social information processing biases and deficits and core themes related to power and control and self-esteem. It is critically important that future research attempts to better delineate the common mechanisms across these different forms of partner aggression so that we can better develop interventions that prevent violence more broadly.

References

- Abbey, A., & Hamish, R. J. (1995). Perception of sexual intent: The role of gender, alcohol consumption, and rape supportive attitudes. *Sex Roles, 32*(5–6), 297–313. <https://doi.org/10.1007/BF01544599>
- Bagwell-Gray, M. E., Messing, J. T., & Baldwin-White, A. (2015). Intimate partner sexual violence: A review of terms, definitions, and prevalence. *Trauma, Violence & Abuse, 16*(3), 316–335. <https://doi.org/10.1177/1524838014557290>
- Dodge, K. A., Coie, J. D., & Lynam, D. (2006). *Handbook of child psychology: Aggression and antisocial behavior in youth*. Wiley. <https://doi.org/10.1002/9780470147658.chps0312>
- Drieschner, K., & Lange, A. (1999). A review of cognitive factors in the etiology of rape: Theories, empirical studies, and implications. *Clinical Psychology Review, 19*(1), 57–77. [https://doi.org/10.1016/S0272-7358\(98\)00016-6](https://doi.org/10.1016/S0272-7358(98)00016-6)
- Eckhardt, C. I., Barbour, K. A., & Davison, G. C. (1998). Articulated thoughts of maritally violent and nonviolent men during anger arousal. *Journal of Consulting and Clinical Psychology, 66*(2), 259–269. <https://doi.org/10.1037/0022-006X.66.2.259>
- Jennings, J. L. (1987). History and issues in the treatment of battering men: A case for unstructured group therapy. *Journal of Family Violence, 2*(3), 193–213. <https://doi.org/10.1007/BF00976539>
- Marshall, W. L., & Hollin, C. (2015). Historical developments in sex offender treatment. *Journal of Sexual Aggression, 21*(2), 125–135. <https://doi.org/10.1080/13552600.2014.980339>
- McDonel, E. C., & McFall, R. M. (1991). Construct validity of two heterosocial perception skill measures for assessing rape proclivity. *Violence and Victims, 6*(1), 17–30. <https://doi.org/10.1891/0886-6708.6.1.17>
- McFall, R. M. (1982). A review and reformulation of the concept of social skills. *Behavioral Assessment, 4*(1), 1–33. <https://doi.org/10.1007/BF01321377>
- Moffitt, T. E., Caspi, A., Krueger, R. F., Magdol, L., Margolin, G., Silva, P. A., & Sydney, R. (1997). Do partners agree about abuse in their relationship? A psychometric evaluation of interpartner agreement. *Psychological Assessment, 9*(1), 47–56. <https://doi.org/10.1037/1040-3590.9.1.47>
- Sippel, L. M., & Marshall, A. D. (2011). Posttraumatic stress disorder symptoms, intimate partner violence perpetration, and the mediating role of shame processing bias. *Journal of Anxiety Disorders, 25*(7), 903–910. <https://doi.org/10.1016/j.janxdis.2011.05.002>
- Stith, S. M., Green, N. M., Smith, D. B., & Ward, D. B. (2008). Marital satisfaction and marital discord as risk markers for intimate partner violence: A meta-analytic review. *Journal of Family Violence, 23*(3), 149–160. <https://doi.org/10.1007/s10896-007-9137-4>
- Stith, S. M., & McCollum, E. E. (2011). Conjoint treatment of couples who have experienced intimate partner violence. *Aggression and Violent Behavior, 16*(4), 312–318. <https://doi.org/10.1016/j.avb.2011.04.012>
- Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised conflict tactics scales (CTS2) development and preliminary psychometric data. *Journal of Family Issues, 17*(3), 283–316. <https://doi.org/10.1177/019251396017003001>
- Taft, C. T., Creech, S. K., Gallagher, M. W., Macdonald, A., Murphy, C. M., & Monson, C. M. (2016a). Strength at Home Couples program to prevent military partner violence: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 84*(11), 935–945. <https://doi.org/10.1037/ccp0000129>
- Taft, C. T., Weatherill, R. P., Scott, J. P., Thomas, S. A., Kang, H. K., & Eckhardt, C. I. (2015). Social information processing in anger expression and partner violence in returning U.S. Veterans. *Journal of Traumatic Stress, 28*(4), 314–321. <https://doi.org/10.1002/jts.22017>
- Taft, C. T., Murphy, C. M., & Creech, S. K. (2016b). Trauma-informed treatment and prevention of intimate partner violence. *American Psychological Association*. <https://doi.org/10.1037/14918-000>
- Taft, C. T., Schumm, J. A., Marshall, A. D., Panuzio, J., & Holtzworth-Munroe, A. (2008). Family-of-origin maltreatment, posttraumatic stress disorder symptoms, social information processing deficits, and relationship abuse perpetration. *Journal of Abnormal Psychology, 117*(3), 637–646. <https://doi.org/10.1037/0021-843X.117.3.637>
- Teten, A. L., Schumacher, J. A., Bailey, S. D., & Kent, T. A. (2009). Male-to-female sexual aggression among Iraq, Afghanistan, and Vietnam veterans: Co-occurring substance abuse and intimate partner aggression. *Journal of Traumatic Stress, 22*(4), 307–311. <https://doi.org/10.1002/jts.20422>
- Treat, T. A., McFall, R. M., Viken, R. J., & Kruschke, J. K. (2001). Using cognitive science methods to assess the role of social information processing in sexually coercive behavior. *Psychological Assessment, 13*(4), 549–565. <https://doi.org/10.1037/1040-3590.13.4.549>
- Ward, T., & Hudson, S. M. (2000). Sexual offenders' implicit planning: A conceptual model. *Sexual Abuse, 12*(3), 189–202. <https://doi.org/10.1177/107906320001200303>