Posttraumatic Stress Disorder and Male-Perpetrated Intimate Partner Violence

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ALTHOUGH THE RELATIONSHIP BETWEEN POSTTRAUMATIC stress disorder (PTSD) and aggression is generally well established within the literature,1-4 research investigating the relationship between PTSD and male-perpetrated intimate partner violence (IPV) has only begun to emerge. Preliminary findings suggest a link between trauma exposure, PTSD symptomatology, and male-perpetrated IPV,5-8 which may have important clinical implications for batterer intervention programs. To the extent that IPV associated with PTSD has an etiology distinct from non–PTSD-related IPV, prevention and intervention programs may need to be tailored to address the potentially unique IPV risk factors among men with PTSD. Because of the lack of research on the association of PTSD and IPV perpetrated by women, this Commentary will focus on male-perpetrated IPV.

Most US studies examining the relationship between PTSD and male-perpetrated IPV have been conducted with male veterans. Findings from these studies indicate that male veterans with greater PTSD symptomatology often self-report higher levels of anger, hostility, aggressiveness, anger reactivity, and IPV perpetration than veterans without significant PTSD symptomatology.4,6,9,10 The association between PTSD and IPV perpetration has also been found among civilian men. Rosenbaum and Leisring7 found that civilian male PTSD and IPV perpetration has also been found among civilians.8,9 Among veterans, other PTSD symptom clusters differentially change over time, influencing other PTSD symptoms, and affect behavior, including aggression.11,12 Although debate exists as to the nature and number of factors, PTSD is currently characterized by 3 distinct symptom clusters consisting of (1) reexperiencing symptoms (eg, nightmares, flashbacks); (2) avoidance symptoms (eg, avoidance of trauma-related stimuli); and (3) hyperarousal symptoms (eg, hypervigilance, exaggerated startle response).

These 3 symptom clusters have been examined as they relate to aggressive behavior. Overall, hyperarousal symptoms appear to play an especially prominent role in the initiation of aggressive behavior.12 For example, in a study examining the association between aggression and each of the 3 PTSD symptom clusters among male Vietnam veterans participating in a larger multisite psychophysiological project on PTSD, Taft et al2 found hyperarousal symptoms to have the strongest positive relationship with aggressive behavior in comparison with the other 2 PTSD symptom clusters. Additionally, the authors found that hyperarousal symptoms were both directly related to aggression and indirectly associated with aggression through alcohol problems, as measured by the CAGE questionnaire for assessing alcoholism. Conversely, findings from the same study show that reexperiencing symptoms may not directly influence aggressive behavior, but may indirectly affect aggression via their positive relationship on physiological reactivity (ie, heart rate and skin conductance) to trauma cues and negative affect on alcohol problems.2

Mixed findings exist regarding the role of PTSD avoidance symptoms and subsequent aggressive behavior. A study comparing male Vietnam veterans seeking inpatient PTSD treatment with a mixed diagnostic group of male inpatient Vietnam veterans without PTSD found a positive relationship between avoidance/numbing symptoms and aggression when assessing PTSD symptom clusters using the brief Mississippi Scale for Combat-Related PTSD. However, additional evidence from the study by Taft et al2 suggests a potential negative association between avoidance/numbing symptoms...
symptoms and aggressive behavior, but the authors caution that the interpretation of this finding due to potential multicollinearity problems with hyperarousal symptoms. Taken together, research examining the relationship between PTSD symptom clusters and aggression suggests that specific PTSD symptom clusters, particularly hyperarousal symptoms, may significantly influence aggressive behavior and further work is needed to elucidate these relationships.

Two recent studies have begun to investigate the influence of specific PTSD symptom clusters on IPV perpetration. Both studies focused primarily on the relationship between hyperarousal and male-perpetrated IPV based on data collected from male Vietnam veteran dyads and their female partners through the National Vietnam Veterans Readjustment Study (NVVRS). The NVVRS was designed to examine PTSD and other psychosocial problems experienced by a nationally representative sample of male Vietnam veterans and their families. Posttraumatic stress disorder symptoms were assessed by using the Mississippi Scale for Combat-Related PTSD and male-perpetrated IPV was measured by the Conflict Tactics Scale. Consistent with findings on hyperarousal symptoms and aggression, initial evidence from the 2 studies indicates a significant positive association between hyperarousal symptoms and male-perpetrated IPV, which may be potentiated by alcohol use. However, a study testing a multifactorial model of male veterans' mental status, including PTSD symptoms, on family functioning and male-perpetrated IPV using NVVRS data did not reveal a significant relationship between avoidance/emotional numbing symptoms and male-perpetrated IPV. The relationship between reexperiencing symptoms and male-perpetrated IPV is yet unknown.

Models of information processing and anger regulation deficits may shed light on the association between PTSD and aggression, including male-perpetrated IPV, and help explain findings linking hyperarousal to aggressive behavior. For example, Chemtob et al proposed a theoretical model of PTSD and aggression, based on their clinical observations, suggesting that trauma-exposed individuals who exhibit PTSD symptoms may be prone to engage in “survival mode” functioning when confronted with a perceived threat within their environment. This “survival mode,” which may have been an adaptive way of functioning during the traumatic event and may be subsequently triggered by trauma-related reminders, is thought to activate cognitive, behavioral, and physiological processes that prepare the individual to respond in potentially threatening conditions. During this activation, anger structures are stimulated resulting in increased hostile appraisal and heightened arousal that may prevent cognitive reappraisal of threat and consideration of alternative ways of behaviorally responding. Furthermore, increased physiological arousal following onset of “survival mode” may serve to confirm the initial threat appraisal and result in a positive feedback loop, strengthening both the hyperarousal and cognitive processes in response to the perceived threat. The combination of the heightened arousal and active threat schema are believed to jointly inhibit the individual’s ability to control aggressive responding and may increase risk for aggressive behavior to occur. Thus, further research is needed to determine the viability of this model in explaining the association between PTSD and aggression.

The theoretical model of PTSD and aggression described above by Chemtob et al may be particularly relevant in accounting for the relationship between PTSD and male-perpetrated IPV. Men exhibiting heightened levels of PTSD symptoms may experience greater hypervigilance to ambiguous social and environmental cues, making it more likely for them to misperceive threat in their partners’ behaviors, particularly during times of relationship conflict. Misperception of a partner’s action as threatening may result in an activation of anger structures, leading to increased arousal, hostile attributional biases, diminished ability to engage in decision making processes to identify nonaggressive ways of responding, and strengthened impulses to act aggressively in response to the perceived threat.

Preliminary research offers some support for the application of this model in understanding the relationship between PTSD and male-perpetrated IPV. For example, the study by Orcutt et al used a structural equation modeling framework in a national sample of Vietnam veteran couples (NVVRS) to model the sequential relationships of childhood experiences, war-zone trauma exposure, and PTSD symptomatology in predicting male-perpetrated IPV. Structural equation modeling involves specifying a model a priori, based on theory, previous research, or both, and testing the degree to which the proposed structure fits the observed data. Structural equation modeling is particularly well suited for examining complex associations between multiple constructs; such constructs are often represented as latent constructs and are assumed to be free of measurement error. As predicted, PTSD symptoms were significantly positively associated with increased reports of male-perpetrated IPV. After partialling out the effect of dysfunctional family of origin, childhood antisocial behavior, and severity of combat exposure, perceived threat in the Vietnam war zone had a significant positive direct effect on male-perpetrated IPV as well as a significant positive indirect effect via PTSD symptoms. Thus, perceived threat functioning as a direct risk factor for male-perpetrated IPV, even after controlling for the relationship between perceived threat and PTSD symptoms, suggesting that men with PTSD may also be more likely to misperceive threat during interactions with their partners.

More recently, Taft et al used structural equation modeling to examine the interrelations between family-of-origin variables, PTSD symptomatology, social information processing deficits, and male-perpetrated IPV within a community sample of 164 men and their female partners. The authors discovered both a direct relationship between PTSD and male-perpetrated IPV and an indirect relationship between PTSD symptoms and IPV perpetration via so-
cial information processing deficits, including misattribution of partner's negative intentions and deficits in decision making processes in response to potentially negative marital interactions.\(^8\)

Clearly, initial findings establishing an association between PTSD and male-perpetrated IPV offer evidence supporting the need for batterer intervention programs to be tailored to address the individual treatment needs of male batterers with PTSD. If trauma exposure leads some men to develop certain information processing and anger regulation deficits that increase risk for IPV perpetration, these deficits may need to be more directly targeted as part of treatment. Likewise, future treatment outcome studies may demonstrate that in cases involving male batterers with PTSD, treatment that directly addresses PTSD symptomatology may be successful in reducing both PTSD symptoms and IPV perpetration.

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REFERENCES


