

The Intersection of Intimate Partner Violence and Co-Occurring Combat- Related Conditions

Ohio Specialized Dockets Conference
Columbus, Ohio
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Agenda

- Introduction
- Magnitude
- Intimate partner violence and combat-related conditions
- Risk, danger, context
- Collaboration
- Q & A



Safety is Paramount



Terminology

- Victim versus survivor
- Gender
- Battering:
 - A term recognized, defined, and brought to public attention in the 1970s
 - Came to describe an ongoing pattern of coercion, intimidation, and emotional abuse, reinforced by use and threat of physical and sexual violence
- Domestic violence:
 - Legally in many states has come to mean all violence involving family members



Definitions



Definition of Intimate Partner Violence (IPV)

- When there has been physical and or sexual violence in an intimate relationship, the range of behaviors continually remind victims that violence is always a possibility:
 - Intimidation
 - Coercion and threats
 - Emotional abuse, e.g., name calling, put downs, mind games, public embarrassment
 - Use of children
 - Economic coercion
 - Using minimization, denial, lying and blaming the victim
 - Stalking
- It is a process, not an event



IPV Statistics

- 1 in 4 women, 1 in 7 men victims of severe IPV
- 1 in 5 women, 1 in 59 men raped during lifetime
- 1.9 women raped in the year preceding the survey
- 1 in 6 women, 1 in 19 men stalked in their lifetime
- Experience short and long-term effects
 - Post-traumatic stress disorder, depression, substance use, etc.
 - Physical health issues – sleep problems, chronic pain, irritable bowel syndrome, etc.

CDC's National Intimate Partner and Sexual Violence Survey, 2011

IPV Statistics

- More than half of female rape victims reported being raped by an intimate partner.
- Three women are murdered by their husbands or boyfriends every day in America.
- IPV is the leading cause of injury requiring serious medical attention for women ages 18-49.
- IPV victims lose nearly 8 million days of paid work each year as a result of the violence.
- 74% of all murder-suicides involved an intimate partner, 96 percent were females killed by their intimate partners.

Lethal IPV

- Surveillance for Violent Deaths - National Violent Death Reporting System (2013)
 - IPV was a precipitating factor in 47.5% of homicides among females, but only 9.3% among males.
 - 44% of males and 39% of females who committed suicide experienced an intimate partner crisis.
 - 21% of homicides committed by or involved a current or former spouse or intimate partner.
 - Relationship problems, specifically intimate partner problems, frequently preceded suicides and homicides.

Lethal IPV

- Firearms were the most common weapon used by males to murder females.
- 70% of female firearm homicide victims were killed with handguns; over 2/3 were murdered by male intimates.
- Sixteen times as many females were murdered by a male they knew than were killed by male strangers.
- Most often, female murders occurred in the course of an argument.

National Coalition Against Domestic Violence Policy Office: *When Men Murder Women: An Analysis of 2010 Homicide Data*

Military Versus Civilian

- 2010 National Intimate and Sexual Violence Survey
 - Collaboration between DoD, DOJ, and CDC
 - First time military sample – active duty women and partners of active duty men (2,800 women, 9,000 civilian)
 - Active duty women significantly less likely to indicate IPV in the 3 years prior to the survey
 - Active duty women less likely to experience stalking
 - Active duty women with a deployment history had higher rates of IPV and sexual violence than women without a deployment history – IPV may develop over time

Military Versus Civilian

- Contact sexual violence
 - Lifetime prevalence was 40 percent for the civilian sample, 36 percent for active duty women, and 33 percent for wives of active duty men.
- IPV
 - Lifetime prevalence of physical violence was 36% for the civilian sample, 28 percent for active duty women, and 27 percent for wives of active duty men .
 - Lifetime prevalence for psychological aggression was 57 percent for the civilian sample, 54 percent for active duty women, and 49 percent for wives of active duty men.

Military Versus Civilian

- Stalking
 - Lifetime prevalence of stalking by any perpetrator was 1 in 5 for the civilian sample, 1 in 9 for active duty women, and 1 in 7 for wives of active duty men.

Black, Michelle C., and Melissa T. Merrick. *Prevalence of Intimate Partner Violence, Sexual Violence, and Stalking among Active Duty Women and Wives of Active Duty Men --- Comparisons with Women in the U.S. General Population, 2010*. Technical report, Division of Violence Prevention, CDC National Center for Injury Prevention and Control, Atlanta: Center for Disease Control and Prevention, 2013,

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Magnitude

- Over 2.7 million served in Iraq and Afghanistan
- Over 600,000 National Guard and Reserves
- Multiple deployments
- Drawdown



Unique Issues

- Deployment
- Reunion and reintegration
- Combat exposure
- “Battlemind” = Survival
- Post-traumatic stress disorder
- Traumatic brain injury



Common Stress Reactions

- Sleep disturbance
- Bad dreams/nightmares
- Anger/short temper
- Agitation, irritation, annoyance
- Jumpy and easily startled
- Avoiding people and places
- Increased drinking, smoking, drug use
- Mistrust
- Over-controlling or overprotective



Co-Occurring Conditions

- Co-occurring conditions and IPV offenders in general
 - PTSD
 - TBI
 - Substance abuse
 - Other mental health issues (depression)
- The same co-occurring conditions are pertinent for military personnel and veterans with combat exposure
- Co-occurring conditions in victims



Screening vs Assessment

Screening

- Quick check to determine if something exists (e.g., high blood pressure)
- Questions routinely asked to determine a problem
- Goal is to identify problem
- Conducted by anyone with some knowledge
- Need protocols for action for positive screen

Assessment

- A more in-depth, focused look at a problem
- Needed to establish a diagnosis
- Needs to be done by qualified people
- Guides intervention once the problem is confirmed



Post-Traumatic Stress

Post-Traumatic Stress Disorder (PTSD)

- **Criterion A:** Traumatic event [exposure to actual or threatened death, serious injury, or sexual violence]
- **Criterion B:** Intrusive symptoms [intrusive memories, physiological reactivity on exposure to cues, nightmares, dissociative reactions/flashbacks]
- **Criterion C:** Persistent avoidance [efforts to avoid reminders & withdrawal]
- **Criterion D:** Negative alterations in cognitions and mood [inability to remember, negative beliefs about self and others, fear/horror/anger/guilt/shame, detachment, inability to experience positive emotions]
- **Criterion E:** Marked alterations in arousal [hypervigilance, paranoia, anger, irritability, verbal or physical aggression with little or no provocation, startle, concentration problems, sleep]
- **Criterion F,G,H:** > month, distress & impairment, not due to medication, substance use, or other illness

Rates of PTSD

- Estimates vary from 18% (VA) of OIF/OEF veterans to as high as 35%
- Close to 25% of Army soldiers, with deployment to Iraq, met definition of PTSD at long-term follow-up (*Vasterling, et al., 2016*)
- PTSD is an enduring, consequence of warzone participation

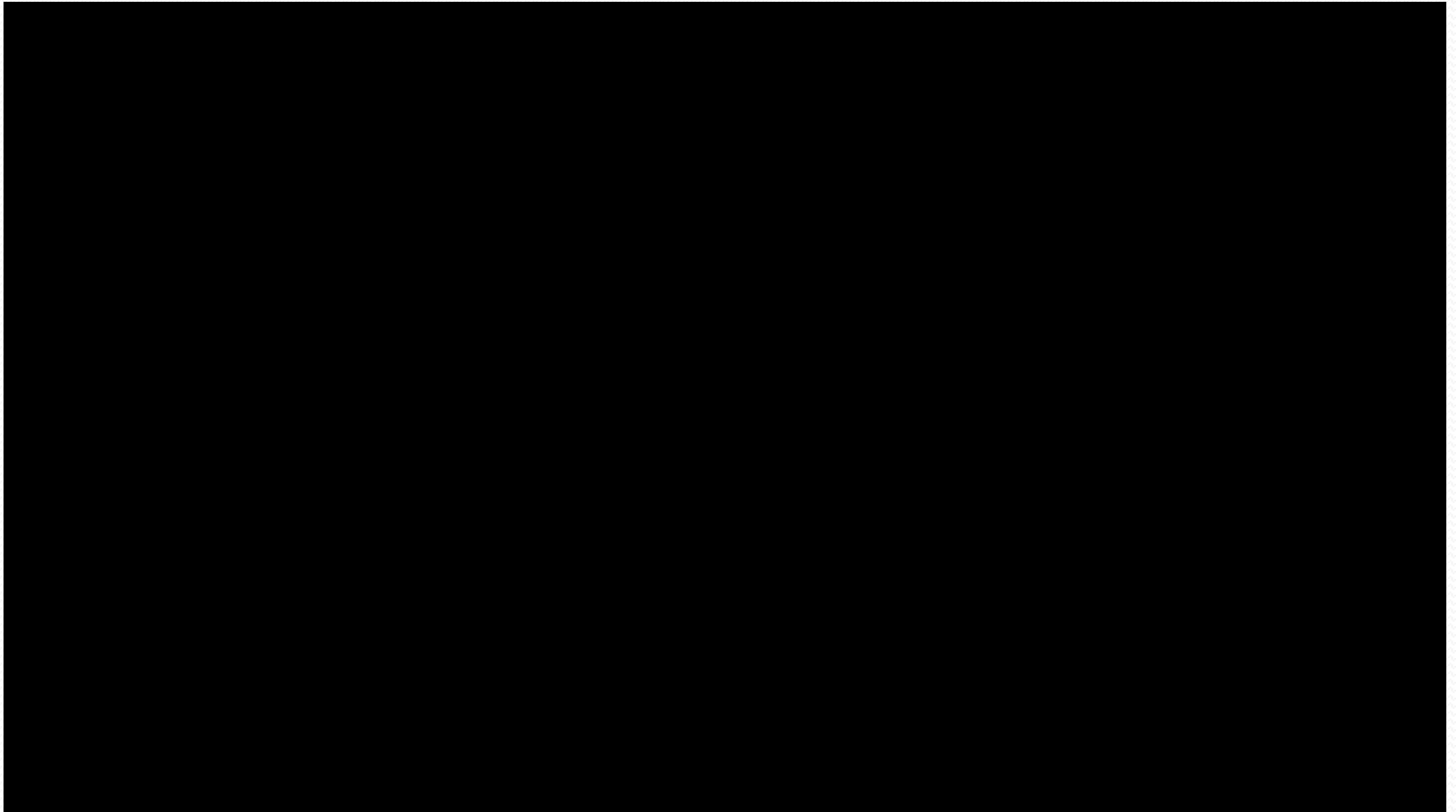
Screening for PTSD

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that you...

- Had nightmares about it or thought about it when you did not want to?
No=0 Yes=1
- Tried hard not to think about it or went our of your way to avoid the situation that reminded you of it? No=0 Yes=1
- Have been constantly on guard, watchful, or easily startled?
No=0 Yes=1
- Felt numb or detached from others, activities, or your surroundings?
No=0 Yes=1
- Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? No=0 Yes= 1

3 or more a positive screen for PTSD

Hector Talks About PTSD



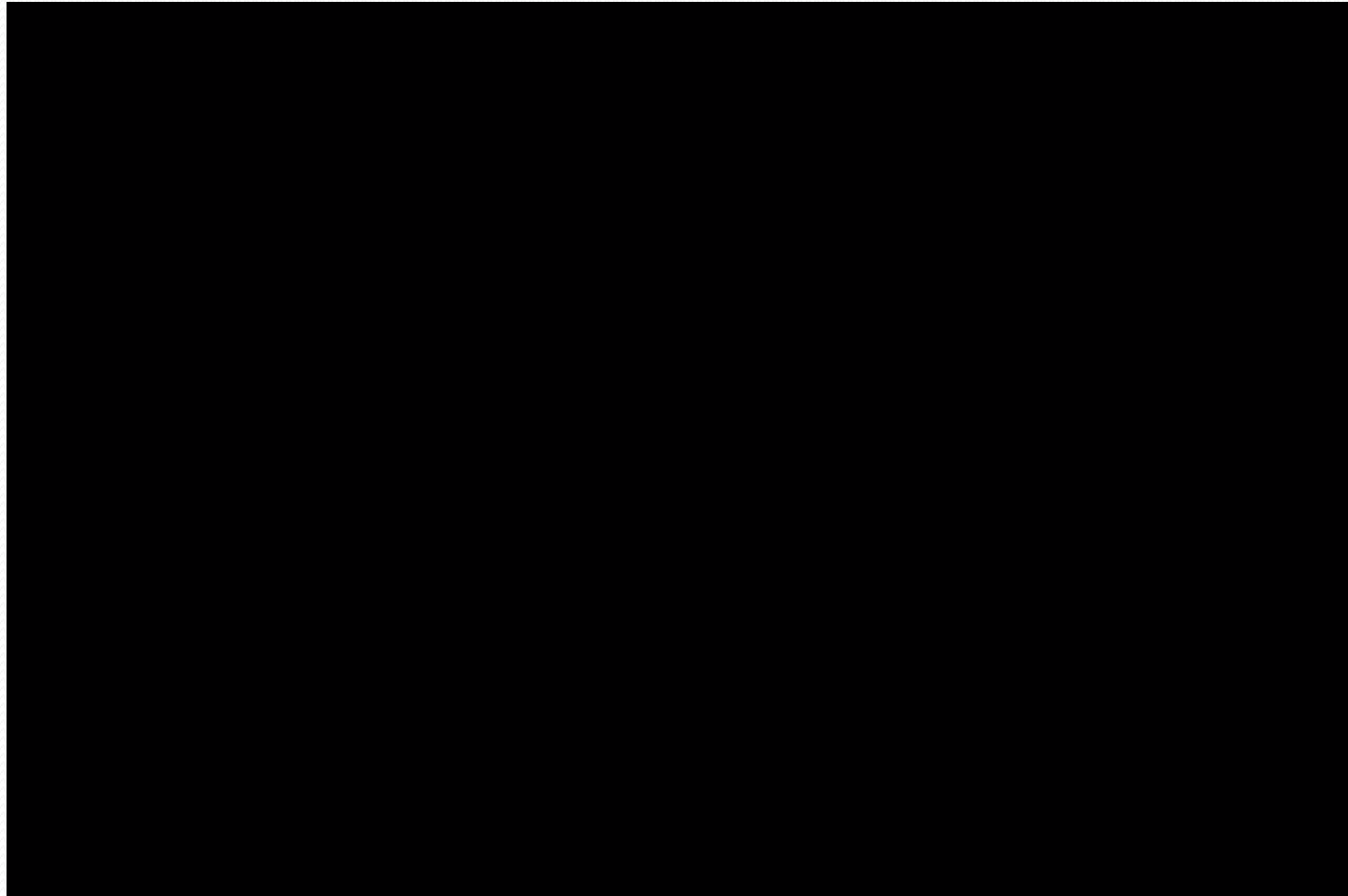
PTSD and IPV

- Most returning military **do not become abusive**
- Veterans with PTSD consistently found in research studies to have higher incidence of IPV perpetration than veterans without PTSD
- Veterans with PTSD report significantly higher rates of generally violent behaviors and aggression than veterans without PTSD
- Over one half (53.2%) OIF/OEF veterans presenting for care at a VA Deployment Health Clinic endorsed at least one act of physical aggression against an intimate partner in the past 4 months (Jakupcak, et al., 2007)

The Intersection of PTSD and IPV

- There is a lot of research about war zone deployment, the development of PTSD symptoms, and the connection to aggression and perpetration of IPV
- In reading this research, do not jump to the conclusion that war zone deployment and the development of PTSD symptoms cause IPV

Hector Talks About Arrest for IPV



PTSD Symptoms and IPV Tactics Can Look Similar

PTSD SYMPTOMS	IPV TACTICS
<ul style="list-style-type: none">• Traumatic event• Re-experiencing the event• Avoidance• Increased arousal• Social isolation• Irritability• Hypervigilance	<ul style="list-style-type: none">• Physical or sexual assault• Coercion and threats• Emotional abuse• Economic coercion• Use of isolation• Intimidation and threats• Righteous rage• Stalking & surveillance

PTSD vs IPV

PTSD Symptoms

- **Re-experiencing:** Nightmare-related aggression; aggression during a dissociative flashback
- **Avoidance:** Self-imposed social withdrawal; avoiding family/friends, and social activities
- **Negative cognitions and mood:** Negative beliefs about self and others; negative emotions e.g., anger; inability to experience happiness and loving feelings
- **Arousal:** Irritable/angry outbursts (little to no provocation); hypervigilance; reckless/self-destructive behavior

IPV Tactics

- **Physical/sexual assault:** Occurs outside of nightmares and/or dissociative flashbacks
- **Social isolation:** Cuts victim off from family/friends; isolates victim from support network
- **Emotional abuse:** Suspicious and jealous of victim; accuses victim of unfounded actions (e.g., having an affair); alternates between angry, threatening behavior and demonstrations of love
- **Intimidation and threats:** Threatens victim through displays of anger and aggression; exposes victim to reckless behaviors (e.g., reckless driving); uses tactics of stalking and surveillance of victim; justifies anger

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• Increase arousal	• Economic coercion
• Social isolation	• Use of isolation
• Irritability	• Intimidation and threats
• Hypervigilance	• Righteous rage
	• Stalking & surveillance

There are certain PTSD symptoms that may or may not be related to IPV perpetration.

Each of the symptom criterion has elements where the two may intersect.

The challenge here is to determine if these behaviors are stand-alone symptoms of PTSD or are part of a pattern of coercion and assault.

Let's take a closer look at how to tell the difference.

Criterion B: Re-Experiencing

Re-Experiencing: Nightmares

Unfortunately, nightmares are very common for those service members and veterans who have developed PTSD secondary to war zone deployments.

It is not uncommon to strangle or hit a partner in response to a nightmare.

These couples work together to put safety first, often sleeping separately until the nightmares calm down on their own or are quieted through PTSD-specific treatment.

In couples where there is no pattern of coercive or assaultive behaviors, this is a stand-alone PTSD symptom and not an IPV perpetration tactic.

Criterion B: Re-Experiencing

Let's Look at a Case Example:

The wife of a Marine back from a tour in Afghanistan tells you that her husband strangled her while she was sleeping. She thought it was because he was having a nightmare.

More of the story...

The first time she was strangled she woke up with a start and yelled at him. He immediately woke up, and acted confused. He was sweating and he told her he was having a bad dream.

His behavior during the day is also different. He wants to know where she is all the time and yells at her for minor things like having dishes in the sink. He calls her awful names like whore and bitch. She realizes that he has had a hard time, and he's only been home for a couple of months from a deployment to Afghanistan.

However, the other night he strangled her again while she was sleeping. She woke up with a start and screamed, but he was already awake. He didn't let loose right away. He told her he was having a bad dream, but he wasn't asleep, and didn't seem to "wake-up" when she screamed. She tells you that it seemed like he was practicing strangling her.

Criterion B: Re-Experiencing

The wife of a Marine back from a tour in Afghanistan tells you that her husband strangled her while she was sleeping. She thought it was because he was having a nightmare.

Re-Experiencing



Physical Assault

It's important to ask additional questions to determine if the situation was a symptom of PTSD or a tactic of IPV or both.

Some important questions to ask include the following:

1. Describe any physical or sexual assaults whether or not they seem related to a nightmare.
2. Are there other behaviors that make you feel afraid or ashamed? Describe those.
3. Have these behaviors changed in any way? How? When?
4. Are there behaviors that are more dangerous or lethal (e.g., strangulation, threatening with guns, kicking any part of the body, etc.)?

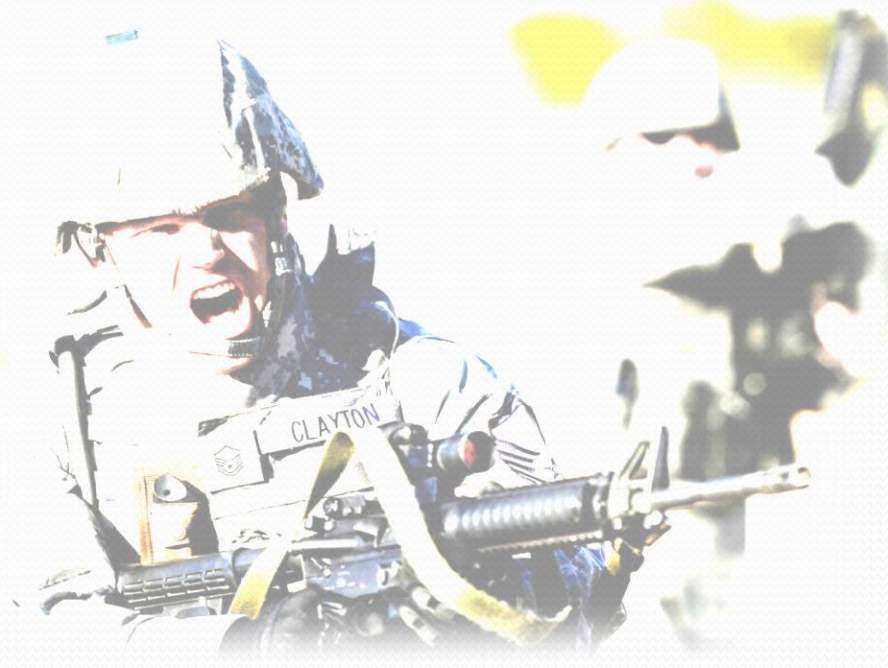
Criterion B: Re-Experiencing

This example shows both symptoms of PTSD and IPV tactics.

In this case, it does appear that he has nightmares that may possibly be related to his tour in Afghanistan.

However, his behavior during the day indicates that he is also engaging in psychologically abusive behaviors.

The recent strangulation is different from the first. It doesn't appear to be related to a nightmare, and he kept strangling her despite her resistance and screams. Rather than "waking up," he appears to have reconsidered and let go of her.



Criterion B: Re-Experiencing

Re-experiencing: Flashbacks

A full flashback, meaning fully re-experiencing a traumatic event, as if it were happening all over again, is not as common as nightmares.

However, they are equally distressing when they occur. A flashback may be triggered by an external cue (a smell, sight, sound, temperature, etc.).

In the flashback, the person may be responding to what he/she believes is happening to him/her and may respond aggressively.

This aggression is **not specific to any one person**, but anyone standing nearby may inadvertently be assaulted. When this occurs in a couple's relationship, where there is no other pattern of coercive or assaultive behaviors, it is a stand-alone PTSD symptom and not an IPV perpetration tactic.

Criterion C: Avoidance

Avoidance:

It is common for people with PTSD symptoms to withdraw from family and friends and avoid engaging in activities that they once enjoyed.

For example, the person with PTSD may no longer want to participate in a sports league or go to gatherings where there are crowds of people.

Avoiding intimacy, not wanting to talk, and withdrawing from family all have a significant impact on wives/partners, family, and friends.

Criterion E: Increased Arousal

Increased Arousal: Hypervigilance

This area has received the greatest focus in linking it with IPV perpetration. People with PTSD may be super aware of their surroundings and those around them. This is called *hypervigilance*.

Hypervigilance means they are particularly alert to any potential sign of danger. They may think there is danger when no true threat really exists. They may easily startle with a loud noise or sudden, unexpected movement. They are often irritable and easily angered. Small, daily stressors may upset or anger them.

While family members are most often witness to these events, they are not always the targets. If no other pattern of coercive control or assaultive behavior exists, then it is a stand-alone PTSD symptom.

Criterion E: Increased Arousal

Case Example:

A sailor's partner reported that when he came back from deployment, he followed her everywhere...to the grocery store etc. He called her 107 times in one day. If she didn't answer the phone or turned it off, there would be a big fight waiting at home. He told her that if she ever left him, he would be able to find her.

What do you think? (select the best answer)

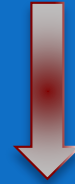
- This is a symptom of PTSD
- This is a tactic of IPV
- Both PTSD and IPV
- Not enough information to decide

Criterion E: Increased Arousal

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Hypervigilance



Stalking

Behaviors such as stalking or monitoring an intimate partner's coming and going may be confused with the PTSD symptom of hypervigilance.

The stalking tactics seen in this case were used in the context of a larger pattern of coercive control in a relationship where there had also been physical violence.

This is an example of IPV tactic.

Criterion E: Increased Arousal

Increased Arousal: Outbursts of Anger

Outbursts of anger is a common symptom of PTSD.

Once again, while family members are most often witness to these events and are greatly impacted by them, they are not singled out as targets. If no other pattern of coercive control or assaultive behavior exists, then it is a stand-alone PTSD symptom.

Criterion E: Increased Arousal

Case
Example:

A sailor's wife reported that whenever she and her husband had an argument he would just snap and get super angry.

He would scream at her that he had guns and knives all over the house that she would never find, and he could kill her whenever he wanted to.

What do you think? (select the best answer)

- This is a symptom of PTSD
- This is a tactic of IPV
- Both PTSD and IPV
- Not enough information to decide

Criterion E: Increased Arousal

Case Example:

A veteran's wife reported that whenever she and her husband had an argument he would just snap and get super angry.

He would scream at her that he had guns and knives all over the house that she would never find and he, could kill her whenever he wanted to.

Outbursts of Anger



Threats and Intimidation

In this example, the man blamed his outbursts of anger on his PTSD diagnosis and used that diagnosis to justify his rage. His rage was fueled by his belief that he had a right to direct his rage at her, and she had to take it.

This is another example of an IPV tactic of intimidation.



Traumatic Brain Injury (TBI)

TBI



- A traumatically induced disruption of brain function/disturbance of consciousness, resulting in impairment of cognitive, emotional, and physical functioning
 - Cognitive: problems with memory and concentration
 - Emotional: anger, anxiety, poor impulse control, misinterpret communication of others
 - Physical: headaches, fatigue, insomnia
- Blasts **leading cause** of TBI in OIF/OEF
 - Account for 69% of TBI in current conflicts
 - Effects of concussion from blast injury not always immediately apparent

Definitions, TBI Symptoms

Traumatic brain injury is a disruption of brain function and disturbance of consciousness caused by an external injury to the head. A TBI may also occur when there is loss of consciousness and brain hypoxia secondary to strangulation.



TBI

- TBIs, not unique to military...and not a new war zone related injury. Considered “signature injury” for conflict in Iraq and Afghanistan (22% of combat casualties are from brain injuries, compared to 12% in Vietnam)
- Estimated 30% of those returned from deployments have experienced a TBI, most common symptom headache
 - Of those 30%, MOST have experienced a mild TBI (concussion)...high 70 to mid-80%
 - See: Department of Veterans Affairs, National Center for PTSD website

TBI

Impairments Include the following:

- **Cognitive Functioning:** loss of consciousness, working memory problems, impaired attention, slowed thinking and reasoning processing, and communication problems
- **Emotional Functioning:** depression, anxiety, irritability/rage, and mood swings
- **Behavioral Functioning:** agitation, aggression, acting on impulse, not caring about things, and sleep disturbance
- **Physical Functioning:** headaches, pain, visual problems, dizziness/vertigo, and seizures



TBI

- Current research on the intersection of TBI and IPV includes findings on TBI secondary to victimization (Hunnicuttt, et al., 2017: doi:10.1007/s10896-016-9854-7), includes TBI secondary to strangulation.
- Strangulation (just once) is related to a significant increase in risk of homicide (Gwinn, March 2015).
- Common pathway for the experience and expression of anger: 1. impaired self-awareness; 2. limitations in problem-solving (Hart, et al., 2017).

TBI

- Exhibiting aggressive behavior after a moderate to severe TBI is common and generally seen within the first year after the injury. However, this aggression may also be associated with a major depression and pre-injury substance abuse.
- TBI can also cause subtle changes in how a person interacts with other people. They may have difficulty reading and interpreting social cues. A harmless remark may be misinterpreted and responded to with aggression.
- Both TBI and PTSD may include an element of paranoia:
 - Misreading behavioral cues of others and suspiciousness
 - With TBI, tendency to perceive a range of situations as annoying, frustrating, or just and respond with anger (to include verbal and physical aggression) (*Hart, et al., 2017*)

TBI Symptoms and IPV Tactics

TBI SYMPTOMS	IPV TACTICS
<ul style="list-style-type: none">• Aggression• Depression• Memory problems• Rage, mood swings• Pain, headaches• Sleep disturbance• Irritability• Impulsiveness	<ul style="list-style-type: none">• Physical or sexual assault• Coercion & threats• Emotional abuse• Economic coercion• Use of isolation• Intimidation and threats• Stalking & surveillance

As with PTSD, it may be difficult to distinguish a TBI-related symptom or behavior from an IPV perpetration tactic.

The challenge here is to determine if these behaviors are stand-alone TBI symptoms or if they are part of a pattern of coercion and assault.

Let's take a closer look at how to tell the difference

TBI Symptoms and IPV Tactics

Case Example

Wife of a Vietnam veteran:

“I know he got blown up in Vietnam. I can understand him forgetting things. I even understand him getting angry. I just don’t understand...anytime when I take a weekend to work at the arts and crafts fairs he calls me all day long. He calls me awful names. He accuses me of having affairs and sleeping with other men. Now just when am I supposed to do that...In between selling a bracelet and an earring?”

TBI Symptoms and IPV Tactics

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In this example, she identifies the general problems with memory and anger that can be associated with a TBI.

But, she correctly points out how a TBI doesn’t seem to explain his ongoing name-calling, accusations, and constant monitoring of her through the phone calls. This is an example of IPV.

Screening for TBI

Screening helps determine if brain trauma occurred and if a referral needs to be made

Four sections

- Section 1 establishes a trauma to the head
- Section 2 establishes symptoms and injury immediately at the time of the event
- Section 3 establishes the symptoms after the event
- Section 4 establishes ongoing symptoms and problems that are connected to the injury

Further assessment is needed to diagnose a TBI

Department of Veterans Affairs Website

Brief Screening for TBI

H.E.A.D.S.

Have you experienced:

- a. Headaches*
- b. Ears ringing*
- c. Altered consciousness*
- d. Dizziness*
- e. Something isn't right*



Substance Use Disorders

From Intoxication to Withdrawal

Substance Abuse and IPV

- Some combat veterans with substance abuse problems may be violent and some may not.
- Some combat veterans self-medicate to numb out the difficult thoughts, feelings, and memories.
- Research indicates that chronic substance abuse by the IPV perpetrator poses an increased risk for dangerous/lethal violence.
- When IPV is present, the substance abuse may aggravate the IPV behaviors and vice versa.

Substance Abuse Disorders

- We commonly see service members increase their alcohol and drug use during and after a war zone deployment.
- Drugs and alcohol may be used to relax...forget about the war zone...fall to sleep...avoid thinking about the war....



Triple Jeopardy

- *IPV perpetrators 2-3 times more likely to use illicit drugs and abuse or be dependent on alcohol or other drugs, or have serious mental illness [Lipsky et al., 2011]*
- *Combat experience indirectly related to aggression through the development of PTSD and dysphoric symptoms—particularly depressive symptoms [Taft, et al., 2007]*
- *More alcohol consumption before violent IPV incidents among military veterans and service members [Marshall et al., 2005]*
- *General aggression significantly related to the hyper-arousal symptom cluster & feeling a lack of control [Taft, et al., 2009]*

SUD and IPV Perpetration

Both IPV perpetration and victimization is often identified as a co-occurring problem for people seeking alcohol and drug treatment

- Rates of both are higher for treatment-seeking individuals than the general population

The question of *whether drinking causes IPV perpetration* has been controversial. While NOT considered causal, alcohol consumption (particularly binge drinking) has been linked to the severity of the IPV perpetration (see Fals-Steward, 2003; Gerlock, et al., 2012).

SUD and IPV Perpetration

Substance abuse treatment programs are an important point of entry into the mental health system and a critical element in the coordinated community response to IPV.

- While offender intervention programs typically routinely assess for SUD, substance abuse programs do not typically assess for IPV. (Timko, et al. 2012)
- Because hazardous drinking, drug abuse/dependence, and serious mental illness are common among IPV perpetrators, these co-occurring problems are important to assess. (Lipsky, et al. 2011)

Screening for Alcohol Misuse

Alcohol Use Disorders Identification Test (AUDIT-C)

- How often did you have a drink containing alcohol in the past year? (0 – 4)
- How many drinks containing alcohol did you have on a typical day when you were drinking in the past year? (0 – 4)
- How often did you have six or more drinks on one occasion in the past year? (0 – 4)

A positive score of >4 for men, >3 for women indicates probably unhealthy drinking levels.

Screening for Drug Misuse

Drug Abuse Screening Test (DAST) (yes/no)

- Have you used drugs other than those required for medical reasons?
- Do you abuse more than one drug at a time?
- Are you unable to stop using drugs when you want to?
- Have you ever had blackouts or flashbacks as a result of drug abuse?
- Does your spouse/partner (or parents) ever complain about your involvement with drugs?

Score of 2 or more indicates a need for further assessment and possible intervention.

Depression



Depression, Suicide, and IPV

- War experiences and combat stress reactions can lead a depressed person to think about hurting or killing themselves.
- Combat exposure, PTSD, depression, substance abuse, and/or TBI increase the risk of suicide.
- Combat-related guilt is strongly related to suicidal behavior.
- Male combat veterans are twice as likely to die from suicide.
- Suicidal thinking and behaviors is one of the risk factors for lethal IPV.

Depression

- Depressed mood (most of the day, nearly every day)
- *Diminished interest or pleasure*
- Significant weight change
- *Sleep disturbance*
- Slowed response or *agitated behavior*
- Fatigue or loss of energy.
- *Feelings of worthlessness; inappropriate guilt*
- *Impaired concentration*
- *Recurrent thoughts of death* or killing themselves
- Cause significant distress and impairment

Depression and PTSD

Depression

- Lack of interest and stop participating in activities
- Trouble getting to and staying asleep or may wake up early and be unable to go back to sleep
- Thoughts of death or actually make plans to kill him/herself (sometimes following through on the plan)

PTSD

- Avoid participating in activities to avoid symptom triggers
- Disturbed sleep with nightmares or night terrors – fatigue during the day
- Wish to be dead because of survival guilt
- Feel something bad is going to happen or not long to live

Veterans and Suicide

- 30,000 - 32,000 US suicide deaths per year among the population overall (CDC)
- 20% are veterans
- 18 deaths from suicide per day are veterans
- 5 suicide-related deaths/day among veterans receiving VA care
- 950 suicide attempts per month among Veterans receiving care as reported by VA suicide prevention coordinators (October 1, 2008 – December 31, 2010)
- Veterans are more likely than the general population to use firearms as a means for suicide

Dr. Jan Kemp, VA, January 2012 Webinar, *Military Personnel, Veterans, Suicide, and Intimate Partner Violence*

Service Members and Suicide

- Rates of suicide death more than doubled for soldiers from 2001 through 2009
- Surpassed adjusted civilian rate in 2008 (*Black, et al., 2011*)
- Soldiers with a combat arms occupation at a high risk for PTSD reactions, suicidality, other mental health problems, relative to other military occupations. (*Sundin, et al., 2010; Trofimovich, et al., 2013*)
- Among suicide attempters, soldiers with a combat occupation had a higher risk than other soldiers, with exception of Special Forces. (*Ursano, et al., 2017*)

Military Suicide

- Department of Defense: 275 in 2016
 - Army: 127
 - Air Force: 61
 - Navy: 50
 - Marine Corps: 37
- 1263 attempts
- Reserve Component: 80
- National Guard: 123

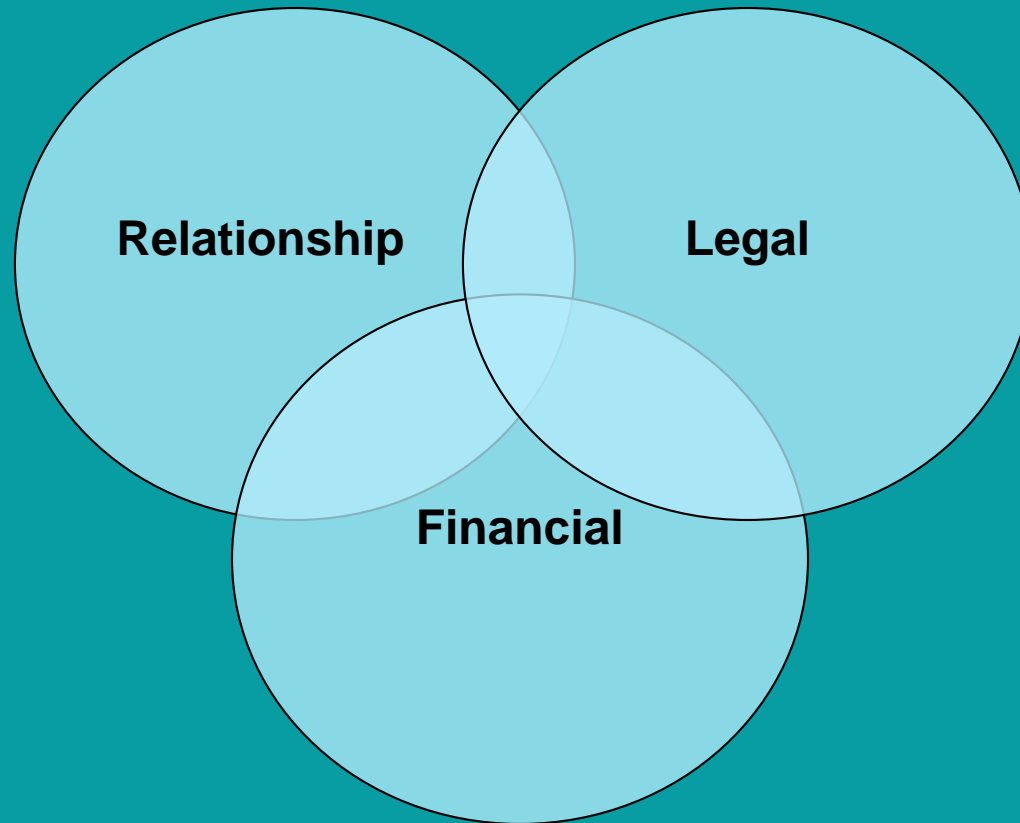


DoD Suicide Event Report, Calendar Year 2016 Annual Report

Demographics

- Male
- Caucasian
- E1 – E4 pay grade
- Age younger than 25
- High school graduate
- Married and never married highest groups
- Active duty
- Less than half had a history of deployment to OEF, OIF, OND

What Are Key Risk Factors?



Context

- Intimate partner relationship problems
- Other non-intimate relationship problems
- Relationship problems within 30 days
- Over half no known behavioral health history
- Healthcare visit within 90 days of suicide
- Legal problems (administrative/financial/criminal)
- History of self-harm
- Alleged abuse victimization or perpetration
- Substance abuse/misuse Use of *non-military* firearms

Depression and IPV

- A major depressive disorder interferes with an offenders focus and concentration; impairing their ability to respond adequately to offender intervention.
- When IPV is also present, suicidal thinking and intent takes on an additional risk. An IPV offender who is jealous, suspicious, and possessive may kill their partner first.
- Screening for depression usually involves screening for suicide, but not usually for homicide.
- When all behaviors are attributed to depression, IPV not be identified, missing the potential risk to victims.

Screening for Depression

Patient Health Care Questionnaire -2 (0 – 3)

- Over the past 2 weeks, how often have you been bothered by any of the following problems?
 - Little interest or pleasure in doing things
 - Feeling down, depressed or hopeless

A score of 3 or more is a positive screen for depression.

A negative screen does not mean a person is not depressed, a positive screen does not mean he/she is.

If a person appears depressed, refer for a full assessment regardless of score on screening.

Risk and Danger



Risk, Danger, and Context

- Most police reports and court documents have insufficient information to determine the context of the violence or the level of risk.
- Talk with the victim:
 - Find out the history of violence and other abusive behaviors in the relationship.
 - Listen to her perceptions of the situation.
 - Get the details of the current incident.
- Regardless of the context, all IPV can be dangerous.
- Risk assessment is the beginning of an ongoing process of risk management – the goal is to prevent the violence not predict it.

Risk Factors

- There is consensus in the research literature identifying the most important factors to consider when assessing risk for IPV. Most risk factor lists include:
 - A history of violent behavior toward family members (including children), acquaintances, and strangers
 - A history of physical, sexual, or emotional abuse toward intimate partners
 - Access to lethal weapons
 - Threats to kill partner

Risk Factors

- Threats of suicide
- Antisocial attitudes and behaviors and affiliation with antisocial peers
- Relationship instability, especially if there has been a recent separation or divorce
- Presence of other life stressors, including employment/financial problems or recent loss
- A history of being a witness or victim of family violence in childhood
- Evidence of mental health problems and/or substance abuse

Risk Factors

- Resistance to change and lack of motivation for treatment
- Attitudes that support violence toward women
- A pattern of coercive control
- Stalking
- Strangulation
- Forced sex

Military Personnel & Veterans

- Majority of servicemembers are in the ages at highest risk for IPV (18-29).
- Constant mobility and geographic separation isolate victims, sometimes creating physical distance from family and support.
- Deployments and reunification create unique stressors.
- Many have extensive firearms and hand-to-hand combat training; some have combat experience.
- Medical and psychological sequelae from war zone deployments are contributing factors.

Risk and Danger Assessment

- Risk assessment an ongoing process – not a one-time event
- Continuous process of risk management
- Victims best source of information relative to risk and danger
- Victim perception + danger assessment
- Risk of lethal IPV
- Tools for risk of re-assault

Risk and Danger Assessment

- Some victims' perceptions vastly different than the advocate's or the danger assessment.
- Some victims downplay risk and signs of danger.
- The goal is to identify life-threatening violence and serious risk to victim and children.
- Some of most dangerous cases are where there has been no intervention.
- Intervention can compromise safety – unintended consequences.
- Separation can be dangerous.

Benefits of Risk Assessment

- Develops more realistic safety plans with victims
- Educates criminal justice practitioners about risk
- Provides a shared language about risk, lethality, and recidivism
- Helps the criminal justice system identify appropriate interventions
- Informs bail, conditions of release, supervision strategies, and other types of court-ordered treatment decisions

Risk Assessment Tools

- DVSI (Domestic Violence Screening Instrument)
 - Predictive of recidivism
 - Most questions rely on available information; a few are asked of victim
 - Commonly used by pre-trial for bail recommendations and Probation for case management

SARA (Spouse Abuse Risk Assessment)

- Predictive of recidivism
- Longer and includes clinical factors; includes victim questions
- Commonly used by Probation to inform recommendations to court, case management strategies and level of supervision

Assessment Tools

- Danger Assessment (DA)
 - Predictive of lethality and recidivism
 - Information gathered solely from the victim
 - Used by victim advocates with survivors in safety planning
 - www.dangerassessment.org

Cost, training, and access issues for assessment tools

Risk/Danger Assessment

- Pattern of escalating abuse and violence
- Access to lethal weapons, particularly firearms
- Active substance abuse/misuse on the part of either the perpetrator (↑frequency & severity) or the victim (diminished ability to self-protect)
- Mental health disorders, particularly depression, for either perpetrator or victim
- Suicidal thinking on the part of either the perpetrator or victim

Risk/Danger Assessment

- Homecoming (perpetrator has access to the victim) and family reuniting
- Relationship instability, especially if victim is attempting to leave (separation or divorce)
- Adult victim or children using resistive violence
- Past failures of systems to respond appropriately
- Any condition that increases impulsivity (e.g., alcohol abuse/misuse, TBI)

Risk/Danger Assessment

- Risk factors
 - Carries, has access to or threatens with a weapon
 - Pattern of estrangements, separations, and reunions
 - Obsessive jealousy
 - Mental health issues
 - PTSD
 - Depression
 - Suicide threats
 - TBI
- Daily impairment by alcohol or drugs



Safety Planning

- Not a static, one-time event
- A dynamic, evolving process
- Adjusts to changing risks and circumstances of each victim
- Different for active duty victims than for civilian victims
- Different depending on if staying or leaving
 - Some victims not ready to leave
 - Provide referral information for offender and how to safely approach the abuser

Safety Planning

- Pay attention to:
 - Victim's fears and concerns, i.e., deployments and returns, new duty stations, etc.
 - Personal weapons in the home
 - Key contact information on and off installation
 - Collection of key documents, i.e., ID cards, passports, etc.
 - Military and civilian protection orders

Intervention

- Victim safety and autonomy
- Eliminating offender's opportunities and inclination to abuse
- System accountability and responsibility
- Changing the climate of tolerance to violence in intimate relationships
- Done by qualified providers – one provider not qualified for all co-occurring conditions
- Concurrent intervention

Collaboration





Offenders CRAWL Through Them
Victim/Survivors FALL Through Them

**Where are the GAPS
in your interagency
response?**



How we can help military personnel and veterans in crisis...

Many ways....

Don't look the other way...give them options and resources before there is no going back... (suicide, homicide, DUI, IPV, etc.)

Contact Information

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Questions and Answers



Resources

- BWJP Website, Military Page

<http://www.bwjp.org/military.aspx>

- Screening, Assessment, and Intervention Model for Intimate Partner Violence Perpetration and Co-Occurring Combat-Related Conditions
- Intimate Partner Violence: Insights into Military Personnel and Veterans
- Safety at Home – Intimate Partner Violence, Military Personnel, and Veterans E-Learning Course
- Webinar recordings

Resources

- Additional Resources
 - *Understanding the Military Response to Domestic Violence, Tools for Civilian Advocates*
 - *Collaborating for Safety: Coordinating the Military and Civilian Response to Domestic Violence, Elements and Tools*
 - *Victim Advocate Guide: IPV and Combat Experience*
 - *Representing Victims of Intimate Partner Violence Connected with the Military*
- National Center on Domestic and Sexual Violence
http://www.ncdsv.org/ncd_militaryresponse.html