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For Psychological Health & Traumatic Brain Injury

Today's Webinar is:

Intimate Partner Violence: What Health Care Providers Need to Know

June 28, 2012

1-2:30 p.m. (EDT)





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Intimate Partner Violence: What Health Care Providers Need to Know

DCoE Monthly Webinar, June 28, 2012

Carole Warshaw, M.D.

Director, National Center on Domestic Violence, Trauma & Mental Health

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Office of the Secretary of Defense Family Advocacy Program, Military Community & Family Policy



Additional Webinar Details

- The following continuing education units (CEUs) and continuing medical education (CME) credits are approved for this activity:
 - 1.5 AMA PRA Category 1 Credits™
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- Webinar pre-registration **required** to receive CEUs or CME credits
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Additional Webinar Details (continued)

- Webinar audio is **not** provided through Adobe Connect or Defense Connect Online
 - Dial: **888-455-4265**
 - Use participant pass code: **9415208#**
- Webinar information
 - Visit dcoe.health.mil/webinars
- Question-and-answer session
 - Submit questions via the Adobe Connect or Defense Connect Online question box

Agenda

- Welcome and Introduction
- Presentations: Intimate Partner Violence
 - Carole Warshaw, M.D.
 - Director, National Center on Domestic Violence, Trauma & Mental Health
 - April Gerlock, Ph.D., ARNP
 - Research Associate, HSRD NW Center of Excellence, VA Puget Sound Health Care System
- Family Advocacy Program Highlight
 - Melvina Thornton, LICSW
 - OSD FAP, Military Community & Family Policy
- Question-and-answer session/discussion

Webinar Overview

Intimate Partner Violence: What Health Care Providers Need to Know

- Intimate partner violence (IPV) is a serious public health problem in the United States. Nearly three of 10 women and one of 10 men have experienced rape, physical violence and/or stalking by a partner ([Black et al., 2011](#)).
- IPV victims are at risk for a variety of psychological health problems, including posttraumatic stress disorder (PTSD), depression and substance misuse.
- Several factors (e.g., being violent or aggressive, alcohol misuse) may increase risk of someone hurting his/her partner. Research has suggested the co-occurrence of IPV and PTSD may be related to combat experiences.
- This webinar will address impact of IPV on victims' psychological health and identify appropriate screening methods for signs of abuse. It also will examine the relationship between IPV and PTSD, emphasizing provider-level strategies for addressing IPV perpetration.



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Intimate Partner Violence: What Health Care Providers Need to Know

Carole Warshaw, M.D.

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Required Disclosure

I have no relevant financial relationships and do not intend to discuss the off-label/investigative (unapproved) use of commercial products/devices.

Why Address IPV in Health and Mental Health Settings?

Intimate Partner Violence Has Significant Health and Mental Health Consequences

- IPV is a **pattern** of assaultive and coercive behaviors used to establish **power and control** over another person with whom an intimate relationship is or has been shared **through fear and intimidation**, often including the threat or use of physical, sexual and psychological violence. Battering happens when one person believes that they are **entitled to control** another.
- Without intervention, the violence often escalates, causing physical and psychological harm and resulting in repeat visits to the health care system.

IPV Survivors Experience Higher Rates of...

- Injuries, headaches and chronic pain
- Asthma, diabetes and irritable bowel syndrome
- Activity limitations and sleep difficulties
- STDs, HIV, unplanned pregnancy and pregnancy complications
- Poor physical and mental health
- Stress-related symptoms, unexplained injuries, repeat visits, delays in seeking care, overly protective or controlling partners

Black et al 2011. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

<http://www.cdc.gov/violenceprevention/nisvs/>

Maternal and Infant Health Assessment, California Department of Health Services, Maternal, Child and Adolescent Health/Office of Family Planning Branch, 2004; Miller et al 2009

IPV Increases Women's Risk for Depression, PTSD and Suicide

Diagnosis

- Depression
- PTSD
- Suicidality

Prevalence*

- 50.0%
- 61.0%
- 20.3% (53.6%)**

* Weighted mean prevalence across studies. Rates differ by setting.

- **In shelters, depression = 63.8%, PTSD = 66.9%, suicidality = 29.6%**
- **For court-involved women, depression = 73.7%**
- **** In mental health settings, suicidality = 53.6%**

Context Also Plays a Role

- **PTSD, depression and substance abuse influenced by length, type and severity of exposure**
 - Traumatic Context: Custody and visitation; other current and previous trauma
- **Cessation of violence and social support reduce depression and PTSD, but for some women they can persist**
- **Treatment and parenting support are effective**

IPV and Childhood Trauma Increase Women's Risk for Substance Abuse

- **Higher rates of substance abuse** among women who have been victimized
- **High rates of victimization** among women in substance abuse treatment
- **Self-medication** common; may be symptom specific
 - Increases risk for coercion
- May be **coerced into using** or dealing; may be **prevented from abstaining**



Women Seen in Mental Health Settings Are at Greater Risk for Abuse

High Rates of Abuse and Violence Among Women Receiving Mental Health Services

Type of Abuse

- Adult physical
- Adult sexual
- Child physical
- Child sexual

OP Prevalence

- 42%-64%
- 21%-41%
- 35%-59%
- 42%-45%

MI

- 87%
- 76%
- 87%
- 65%

Women living with chronic mental illness (MI) experience higher rates of abuse. Women abused in childhood experience higher rates of psychiatric symptoms, homelessness and sexual assault as adults. Women in inpatient settings experience high rates of DV.

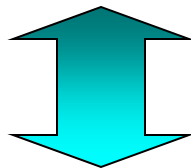
NOTE: Outpatient (OP)

Jacobson 1989, Lipschitz et al 1996, Goodman et al 1995, Friedman 2007, Cluss et al 2010

© DVMHPI 2010

Why is this? Risk versus Vulnerability

Batterers use MH and substance abuse issues to control their partners



Stigma, poverty, discrimination and institutionalization compound these risks

- Control of meds
- Coerced overdose
- Control of supply; coerced use; coerced illegal activities
- Control of treatment
- Undermining sanity, credibility, parenting and recovery
- “She was out of control”

WHY DOES THIS WORK?

- Reports of abuse attributed to delusions
- Symptoms of trauma misdiagnosed as MI
- Assumptions that having a MI precludes good parenting
- Internalized stigma



IPV Survivors Often Experience Multiple Types of Trauma

Trauma and IPV Reduce Access to Resources

- **Trauma can affect access to resources**
 - Avoidance of trauma triggers
 - Responses to law enforcement, testimony and legal case, appearance and demeanor in court
 - Reluctance to reach out when trust has been betrayed
- **Abusers control their partner's ability to utilize resources**
 - Preventing access
 - Threats of retaliatory violence

Trauma and Domestic Violence (DV) Can Affect Our Responses As Well

- Without a trauma framework, services can be retraumatizing
- Without a DV framework services can be endangering
- Understanding and responding appropriately can counter these effects

Trauma Theory: Bridging Clinical and Advocacy Perspectives

- Normalizes human responses to trauma
- Shifts our conceptualization of symptoms
 - Injury model
 - Symptoms as survival strategies
- Integrates multiple domains
 - Developmental, biological, emotional, cognitive, spiritual, relational
- Multidimensional approaches and treatment
- **Impact on providers and organizations**

Trauma in the Context of IPV

- **PTSD**
 - Trauma is not “post”
 - Appropriate response to ongoing danger
 - “Overreaction” to minor stimuli versus acute social awareness
- **Complex trauma**
 - Borderline reframe
- **Insidious trauma**
- **Cultural and historical trauma**

Understanding the Context: Coping and Survival Mechanisms

- **Attempts to stop the abuse**
 - Reach out for help
 - Take responsibility
 - Appear passive and compliant
- **Attempts to manage the impact**
 - Dissociation, denial
 - Avoidance
 - Self-medication
 - Self-injury
- **Attempts to escape**
 - Suicide
 - Homicide

Mental Health and Substance Abuse in the Context of DV and Other Trauma: Complex Picture

- Direct effects of perpetrator behavior
- Trauma-related symptoms
 - Mental health and substance abuse effects of DV plus other trauma
- Survival strategies
 - Hypervigilance, passivity/compliance, substance use
- Exacerbation of pre-existing MH and substance abuse conditions
- Active undermining of parenting, recovery and economic independence
- Role of cultural barriers and supports
- Role of stigma and provider, institutional, societal responses and limited overall resources


Importance of Collaboration with DV Programs: Survivors Recommend

Women in DV shelters

- Provide long-term counseling at DV programs
- Train mental health providers to:
 - Understand dynamics of DV
 - Become aware of community resources
 - Not pathologize or blame victims
 - Be wary of abuser control of treatment
 - Recognize dangers of couples counseling
 - Not overemphasize the role of medication

Women in mental health settings

- Want information
- Want access to resources
- Want to be asked but safely and non-judgmentally*
- Want support
- Want gender-specific services
- Want DV and trauma-specific services



Working with Survivors Experiencing the Mental Health or Substance Abuse Effects of DV or Other Trauma

Treatment in the Context of DV: Issues to Keep in Mind

- Recognize safety as a priority
- Respect, collaboration, empowerment and choice are key
- Recognize perpetrator accountability
- Utilize a trauma framework
- Attend to culture and context
- Work in partnership with DV advocates

An Integrated Approach to Safety

- **Mental health context**
 - Self-harm, harm to others
- **Trauma context**
 - Retraumatization
 - Potentially risky coping strategies
- **Domestic violence context**
 - Ongoing danger from partner
 - Revictimization by other people and systems

Creating a Safe Environment: Establishing Physical Safety

- **Ensure privacy and physical safety**
- ***Never ask:***
 - In the presence of someone not identified as safe
 - During couple's therapy; in the presence of children
 - A partner or family member for corroboration
 - An abuser for collateral information
- **Use professional translators**
- **Discuss limits of confidentiality**

Creating Emotional Safety: Attend to Issues of Power in Clinical Interactions

Survivors

- Potential for re-injury
- Attunement to power dynamics
- Importance of respect, choice, control

Clinicians

- Need to tolerate fear and uncertainty; not being able to “fix”
- Need for awareness of our own responses

Creating Emotional Safety: Counteracting the Dynamics of Abuse

- Offer empathy, validation, and respect
- Provide support and consistency
- Share concerns without imposing own point of view
- Attend to power dynamics
- Create opportunity to:
 - Participate in give-and-take relationship and feel free to reflect and make choices
 - Regain sense of connection and hope

Holding Perpetrators Accountable for Their Behavior

- Perpetrator – not the victim – is responsible for abusive behavior and for stopping it
- Do not focus on helping women understand why they unconsciously “chose” to be abused
- Recognize that perpetrators may look psychologically healthier than the partner they’ve been abusing for years
- **Avoid:** Batterer’s intervention programs without protections for victims; anger management; mediation



Routine Inquiry About IPV: Initial Assessment

Trauma-Informed Interviewing: Attend to Process of Assessment

- Impact of assessment on individual
 - May be difficult
 - May trigger painful memories
- May not perceive situation as abusive
- May not have memory of past abuse
- Detailed accounts may be retraumatizing
- Talking may provide relief and enhance sense of control
- Don't dig for information – let person set the pace

Framing Questions

- Because violence is so common in many people's lives I've begun to ask all my patients about it routinely...
- Tell me a little about your relationship... Do you ever argue or fight? Do the fights ever become physical? Do you ever get hurt? Are you ever afraid?
- I don't know if this is happening to you but because so many people have experienced abuse in their lives...
- I'm wondering if some of the way you're feeling might not be related to how you are being treated by your partner...

Direct Questions

- Are you in a relationship with someone who makes you feel unsafe or afraid?
- Has your partner ever physically hurt you? Has he (or she) ever threatened to hurt you or someone you care about?
- Does your partner try to control you or keep you from doing things you want to do?
- Has your partner ever forced or pressured you into engaging in sexual activities that made you uncomfortable or into having sex when you didn't want to? Tried sabotage birth control?

Mental Health and Substance Abuse Coercion

- Has your partner ever used substance abuse or mental health issues against you?
- Has your partner ever tried to control your medication, or access to treatment? Has he/she actively undermined your sobriety/recovery?
- Has your partner threatened to take your children away because you are receiving substance abuse or MH treatment?
- Has your partner blamed you for his/her abusive behavior by saying you're the one who is "crazy" or an "addict?"
- Has your partner deliberately done things to make you feel like you are "going crazy" or "losing your mind?"
- Has he used your substance use or mental health condition as a way to undermine you with other people?
- Has he ever forced you to use substances, take an overdose, or kept you from routines that are healthy for you?

What to Do If a Person Says “No” but You Are Still Concerned

- Accept her/his response
- Let her/him know you are a resource if needed in the future
- Let her/him know where to get more confidential information about DV
- Offer referral sheets
- Survivors take in information but may not disclose until they feel ready and they feel safe

What To Do If a Person Says “Yes” Assessment Phase

- Let her know you're glad she felt comfortable telling you
- Ask if she has any further concerns regarding confidentiality
- Let her know you want to know more about her situation and about her safety

Work with Survivors Assess Their Situations: Key Elements to Discuss

- **Safety** in clinical setting and risk for future harm
- **History and pattern** of abuse
 - Including ways abuser uses health, mental health and substance abuse to control his/her partner
- **Impact** of IPV on health, MH, substance use, TBI and on the children
- **Other trauma:** Are there other things that have happened to you that may be affecting how you are feeling now?
- **Strengths, coping strategies, barriers, concerns, priorities and goals**
- **Access to advocacy, support and resources**

Assess Immediate Safety

- Is your partner here with you? Is he/she likely to return?
- Do you think he/she is dangerous? Does he/she have a weapon? What do you feel would be the safest thing to do?
- What would you like to do? Have us say you've left? Call the police? Go home with him/her?
- Do you have to be home at a certain time?

Assess Safety: Suicide and Homicide Risk

■ **Suicide**

- Assess routinely
- May increase after leaving; may result from abandonment as well as abuse
- Assess perpetrator suicidality: depression, abandonment, pathological jealousy

■ **Homicide**

- Distinguish threats from intention
- Usually potentially lethal self-defense
- Discuss options for safety
- If hospitalized, confidentiality may be protected
- Otherwise Tarasoff applies

Assess for Risk of Future Harm

- Has the **physical violence increased in frequency** or severity over the past six months?
- Has he **ever used a weapon or threatened you with a weapon**?
- Do you **believe he is capable of killing you**?
- Have you **ever been beaten** by him **while** you were **pregnant**?
- Is he **violently and constantly jealous** of you?

Impact of Abuse: Substance Use in Context

- ***Survivor's assessment of:***
 - Relationship of substance use to current and past abuse
 - Role of abuser in maintaining substance use
 - Function substance abuse serves (how it helps)
 - Impact and other risks (how it hurts)
 - Attempts to stop, goals, barriers, options and strategies

Ask About the Children

- Woman's perception of impact on children
- Concerns
- Efforts to protect and care for children
- Observations of attachment and parenting

Coping Mechanisms and Survival Strategies

- **Sources of strength and support**
 - Spiritual beliefs, practices, community
 - Friends and family, love for children, work
 - Internal resources, surviving abuse
 - Strengths and resources used in the past
- **Coping mechanisms that may cause harm**
 - Substance abuse
 - Avoidance, numbing, dissociation, high-risk behaviors

Current Concerns and Long-Term Goals

- **What are her/his most pressing concerns?**
- **What are her/his long-term goals?**
 - How does she/he prioritize them?
 - How does she/he envision addressing or meeting them?
 - What obstacles does she/he face?
 - What resources and assistance does she/he need?

Analyzing Risks: Staying vs. Leaving

Batterer-generated

- Physical risks
- Psychological risks
- Children
- Financial
- Family and friends
- Relationship (loss)
- Legal (arrest, residency status)

Life-generated

- Financial
- Home location
- Physical and mental health
- Institution response
- Discrimination
- Batterer manipulation
- Perception of resources



Intervention for Domestic Violence

Integrating Advocacy and Treatment

Mental Health Treatment in the Context of IPV

- Safety and stability:
 - Treat acute symptoms; safety planning
- Decrease fear and isolation:
 - Information, options, referrals to DV programs, support networks, National DV Hotline: 1-800-799-SAFE (7233)
- Skills: Problem solving, economic independence
- Coping with impact of victimization:
 - Contextualized trauma treatment: Build on strengths and supports
- Build alliances around parenting
- Medication: Safety and choice
- Documentation

DV Safety Planning: Issues Specific to MH Treatment

- Physical, emotional, sexual safety
 - Withholding medication, sleep deprivation
 - Coerced treatment, custody threats
 - Control of finances, guardianship; advance directives
 - Medication: Control, choice, impact on safety
 - Anticipate trauma triggers; distinguish from necessary vigilance
- Adapt to cognitive abilities and ability to process information during crisis

Safety Planning

- Review episodes
- Anticipate and reduce danger if possible
- Locate safe place to go in emergency
- Make provisions for leaving quickly
- Remove important items
- Develop and rehearse escape plan
- Develop plan for getting help when can't escape
- Process not a product*

Principles of Documentation

- Observations of client's physical condition and demeanor
 - Factual descriptors: e.g., upset and crying; black eye and bruises on arms
- Statements about specific acts of abuse
 - Include as many facts as possible: describe physical acts of abuse; note day, time and place abuse occurred
- Identify abuser by name and relationship to client.
- Take photographs, with permission
- Include info on: History of abuse, causal relationship, referral source

What to Exclude

- Anything that raises doubt (e.g., alleges, claims, denies, hallucinations)
- Neutral language about DV (e.g., domestic dispute, relationship problem)
- Legal terminology
- Any irrelevant information that could hurt client (e.g., was a sex worker in past)
- Passive voice regarding abuse; instead, put abuser in picture (“abuser pushed client,” not “client hit her head”)
- Anything that could be interpreted as blaming client for abuse suffered

Documentation

- Document relationship of symptoms to abuse
- Discuss potential to subside when safe
- Carefully frame diagnoses and medication
- Recognize appropriateness of anger
- Describe strengths, coping strategies, and ability to care for and protect children
- Describe engagement in treatment; make sure treatment plan is acceptable and doable
- Observations about abuser
- Be alert to abuser who seems “healthier” than victim

DV-specific Trauma Treatment Differs from PTSD Treatment

- PTSD treatment targets specific symptoms
- Complex trauma treatment addresses multiple domains
- Most trauma treatment models focus on past abuse
- Some evidence-based treatments for PTSD can be harmful in context of affect dysregulation and/or ongoing abuse
- Several CBT RCTs and other promising practices for DV survivors; two for women experiencing recent abuse
- People experiencing current DV often excluded from trials

In Sum: What You Can Do

- Create a safe environment; assure confidentiality
- Ask routinely
- Attend to physical and emotional safety
- Incorporate into health and MH history
- Assess for risk of future harm
- Strategize around safety risks
- Empathize, validate and provide information, safety cards and warm referrals to DV advocacy programs
- Document appropriately
- Incorporate into ongoing treatment

Resources

- [Nelson HD, Bougatsos C, Blazina I. Screening women for intimate partner violence: a systematic review to update the U.S. Preventive services task force recommendation.](#) Ann Intern Med. 2012 Jun 5;156(11):796-808.
- [ACOG Committee Opinion No. 518: Intimate partner violence.](#) Obstet Gynecol. 2012 Feb;119(2 Pt 1):412-7.
- [Cerulli C, Talbot NL, Tang W, Chaudron LH. Co-occurring intimate partner violence and mental health diagnoses in perinatal women.](#) J Womens Health (Larchmt). 2011 Dec;20(12):1797-803.
- [Moore AM, Frohwirth L, Miller E. Male reproductive control of women who have experienced intimate partner violence in the United States.](#) Soc Sci Med. 2010 Jun;70(11):1737-44.
- Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, Schoenwald P, Silverman JG. [A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion.](#) Contraception. 2011 Mar;83(3):274-80.
- [O'Campo P, Kirst M, Tsamis C, Chambers C, Ahmad F. Implementing successful intimate partner violence screening programs in health care settings: evidence generated from a realist-informed systematic review.](#) Soc Sci Med. 2011 Mar;72(6):855-66.

Resources

- Warshaw C. Changing Theory, Changing Practice in E. Morrison (ed.) *Health Care Ethics: Critical Issues for the 21st Century*. 2nd Edition. Jones and Bartlett. Sudbury, MA. 2008. pp. 365-381.
- Warshaw, C., Brashler, P., and Gill, J. Mental health consequences of intimate partner violence. In C. Mitchell and D. Anglin (Eds.), *Intimate partner violence: A health based perspective*. New York: Oxford University Press (2009)
- Warshaw, C., Brashler P. Mental Health Treatment for Survivors of Domestic Violence. In C. Mitchell and D. Anglin (Eds.), *Intimate partner violence: A health based perspective*. New York: Oxford University Press (2009)
- National Center on Domestic Violence, Trauma & Mental Health
<http://www.nationalcenterdvtraumamh.org/publications-products/responding-to-domestic-violence-tools-and-forms-for-mental-health-providers/>
- Futures Without Violence: National Health Resource Center:
http://www.futureswithoutviolence.org/section/our_work/health
- National Resource Center on Domestic Violence & Domestic Violence Resource Network:
<http://www.vawnet.org/links/networks.php>



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US Department of Health and Human Services

Thank You

- Throughout the webinar, you are welcome to submit questions via the Adobe Connect or Defense Connect Online question box located on the screen.
- The question box is monitored during the webinar, and questions will be forwarded to our presenters for response during the question-and-answer session during the last half hour of the webinar.
- Our presenters will respond to as many questions as time permits.

First Polling Question

Do you/your organization regularly screen patients for intimate partner violence perpetration?

Please select “YES” or “NO”



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Focus on IPV Perpetrators



NOTE: This is a copy of an actual note left by an IPV perpetrator on the victim's vehicle parked outside the shelter.

Health Care and IPV Perpetrators

- Perpetrators are there but mostly overlooked.
- Perpetrators are seen by health care providers for injuries secondary to their perpetration of IPV. (Gerlock, 1999; Coben & Friedman, 2002)
- The consequences of IPV are stressful and impact perpetrators. (Gerlock, 1999; Coben & Friedman, 2002)
- If asked directly by their provider, perpetrators will report. (Jaeger, et al 2008; Jaeger, 2004)

Why Do Health Care Providers Need To Know About Combat-related Conditions and IPV Perpetration?

- Veterans with PTSD have consistently been found to have a higher incidence of IPV perpetration and also report significantly higher rates of generally violent behaviors and aggression than veterans without PTSD

Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar, Weiss, 1988; Taft, King, L.A., King, D.W., Leskin, & Riggs, 1999; Bryne & Riggs, 1996; Jordan, Marmar, Fairbank, Schlenger, Kulka, Hough, 1992; Freeman & Roca, 2001; Beckham, Feldman, Kirby, Hertzberg, & Moore, 1997

Scared & Beaten Woman: Image by kenfotos / FreeDigitalPhotos.net



Why Do Health Care Providers Need To Know About Combat-related Conditions and IPV Perpetration?

- Over one half (53.2%) OEF/OIF 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 four months (Jakupcak, et al, 2007).
- Co-occurring conditions like mental health conditions, TBI, substance misuse/abuse can impact the frequency and severity of IPV perpetration.
- The risk of an IPV-related homicide is greater when depression and suicidal thinking/intent are also present.
- With the increasing number of National Guard and Reservists returning from deployments, many return to their civilian jobs and civilian health plans.

Why Do Health Care Providers Need To Know About Combat-related Conditions and IPV Perpetration?

- At VA Puget Sound Health Care System and the Tacoma Vet Center, PTSD treatment-seeking veterans with documented IPV perpetration were accessing all VA health care at twice the rate of those identified as not perpetrating IPV.
- Documentation of IPV screening/assessment significantly increased the likelihood that these men would be rescreened again in other clinics, thus increasing the detection of IPV perpetration. (Gerlock et al, 2011)

Why Do Health Care Providers Need To Know About Combat-related Conditions and IPV Perpetration?

- Understanding how IPV differs from combat-related co-occurring conditions is important because what we identify as the problem drives how we respond.
- Understanding that when IPV perpetration is present, the caregiver of a disabled veteran is also an IPV victim.

The Relationships and PTSD Study: Detection of Intimate Partner Violence (NRI-04-040)

Research Study Team:

Principle Investigator: April Gerlock Ph.D., ARNP

Project Director: Jackie Grimesey, Ph.D.

Study Team: George Sayre, PsyD, LMFT; Ofer Harel, Ph.D.;
Lynne Berthiaume, MN; Elaine Nevins, BA; Christina Cho, BA;
Koriann Brousseau, BA; Alisa Pisciotta, MSW

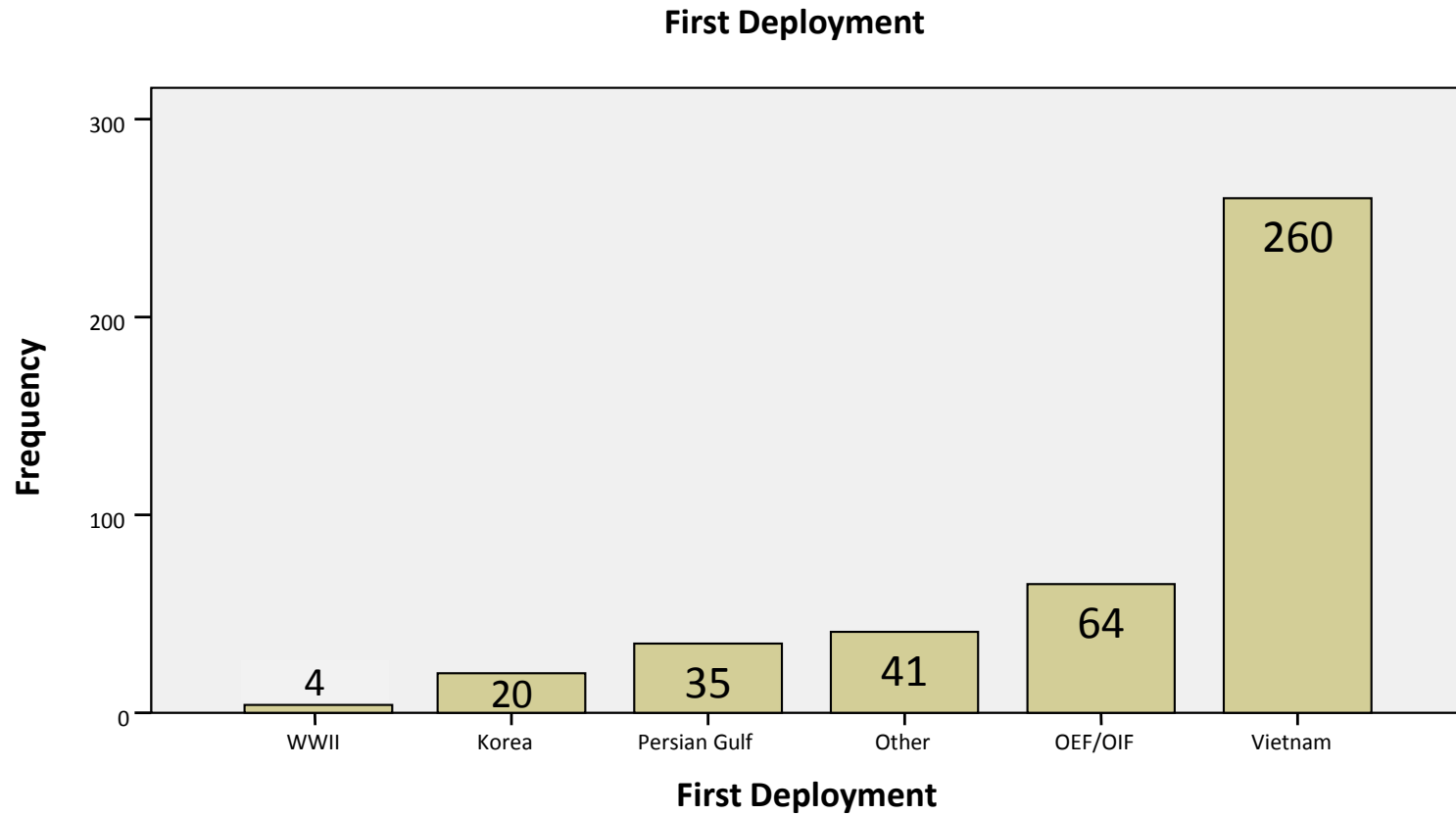


This material is based upon work supported by the US Department of Veterans Affairs, Office of Research and Development, Nursing Research Initiative. This research does not reflect VA policy and opinions expressed do not necessarily reflect those of the VA.

Phase 2: Veteran's Sample

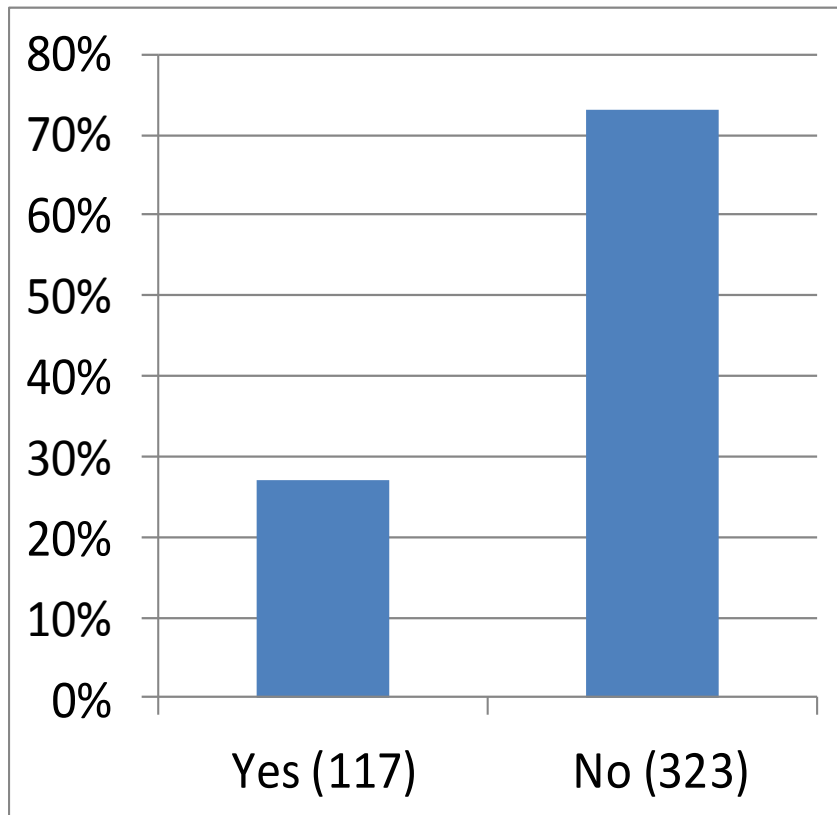
- Sample size: 441 couples
 - Yes IPV 190 (44%) No IPV 251 (56%)
 - Within IPV NO group: 3 women primary aggressors
 - Within IPV YES group: 2 mutual violence couples
- Veteran's age range
 - 22 years old - 88 years old
- Served in war zone
 - 423 (96%) Yes 17 (4%) No

The Sample

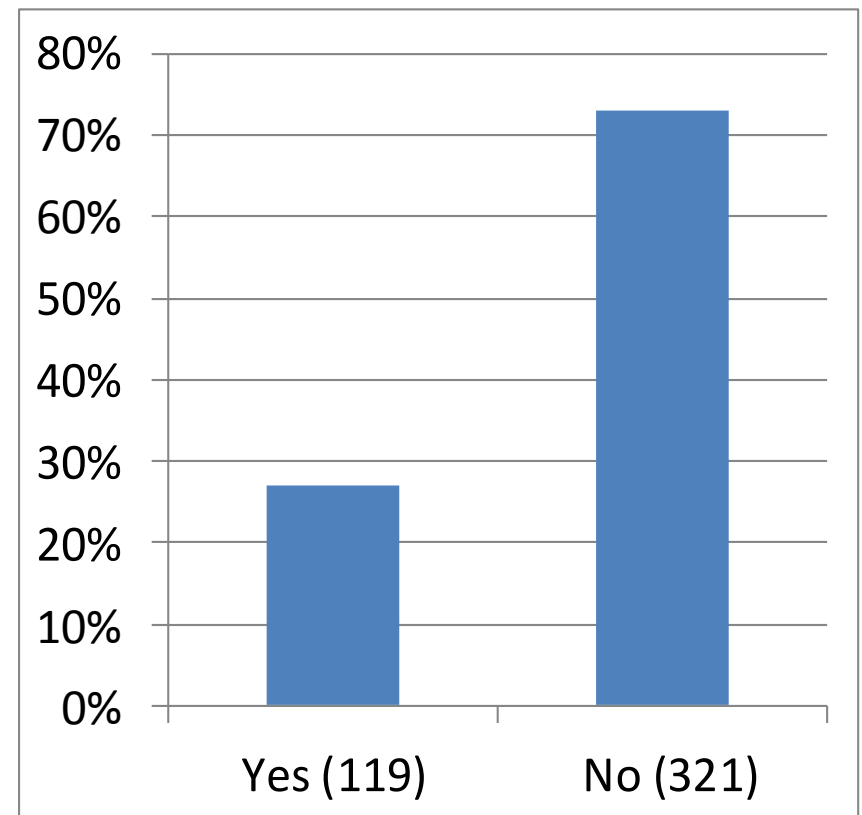


Veteran Currently Violent in Intimate Relationship?

Veteran Report

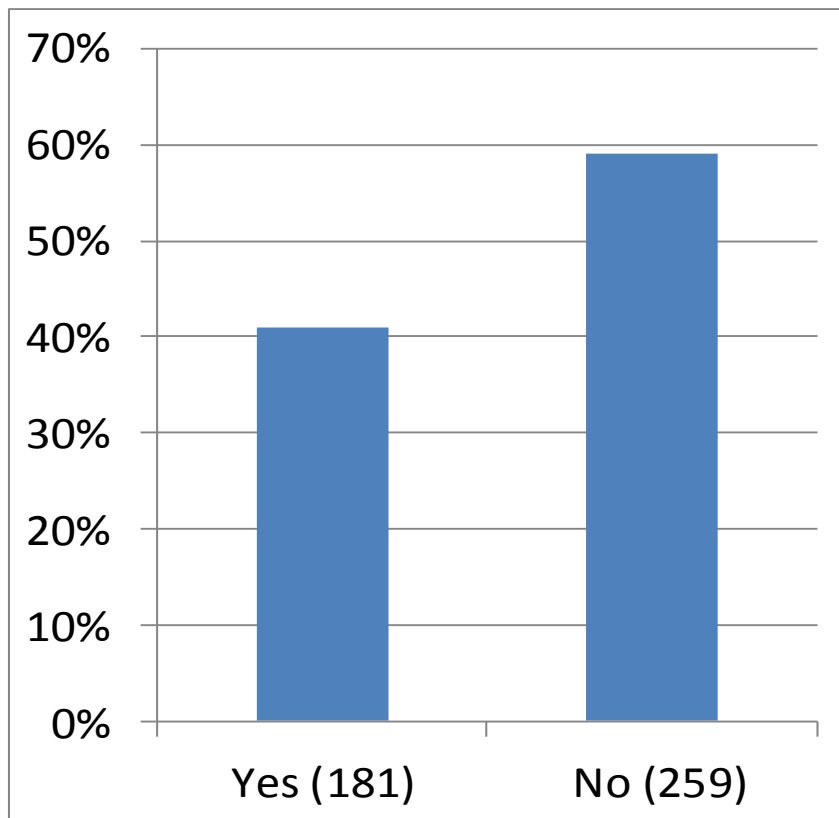


Partner Report

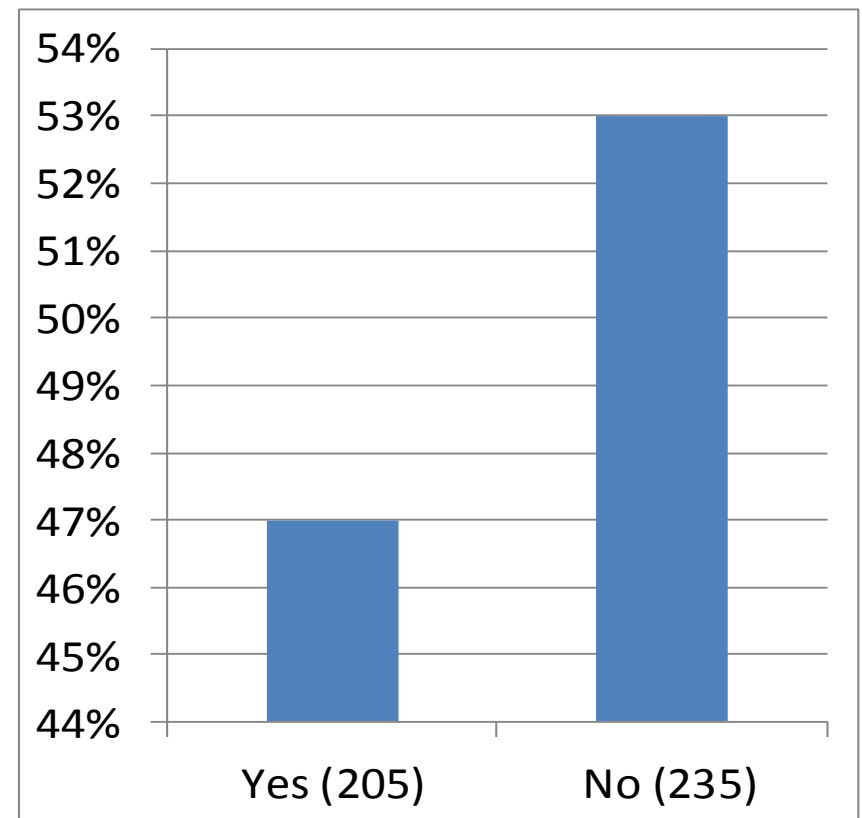


Veteran Previously Violent in This Relationship?

Veteran Report

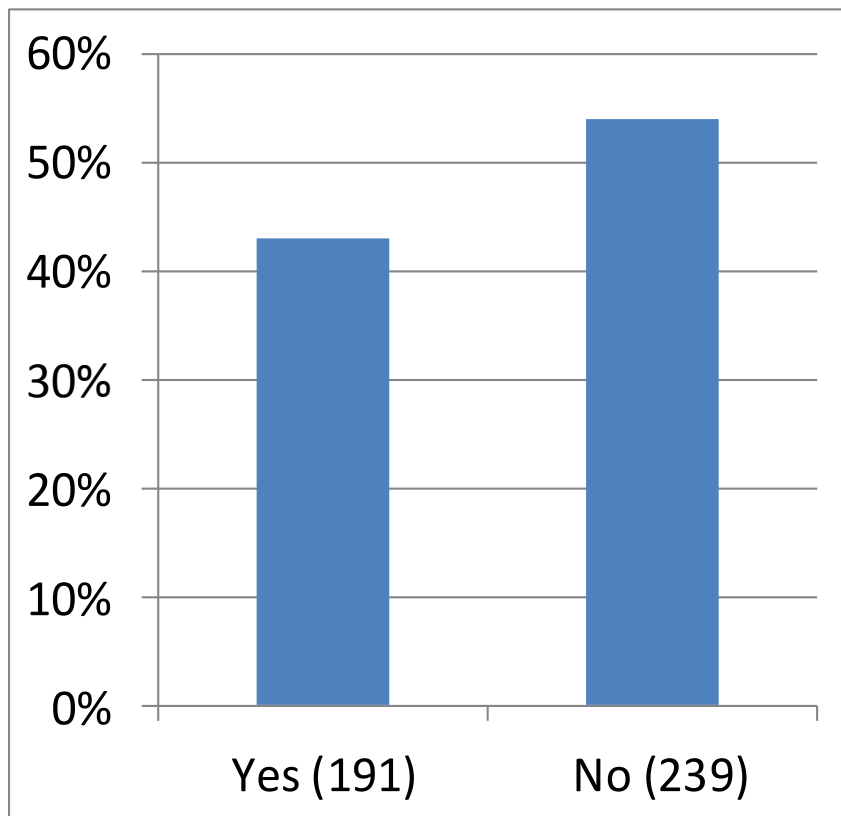


Partner Report

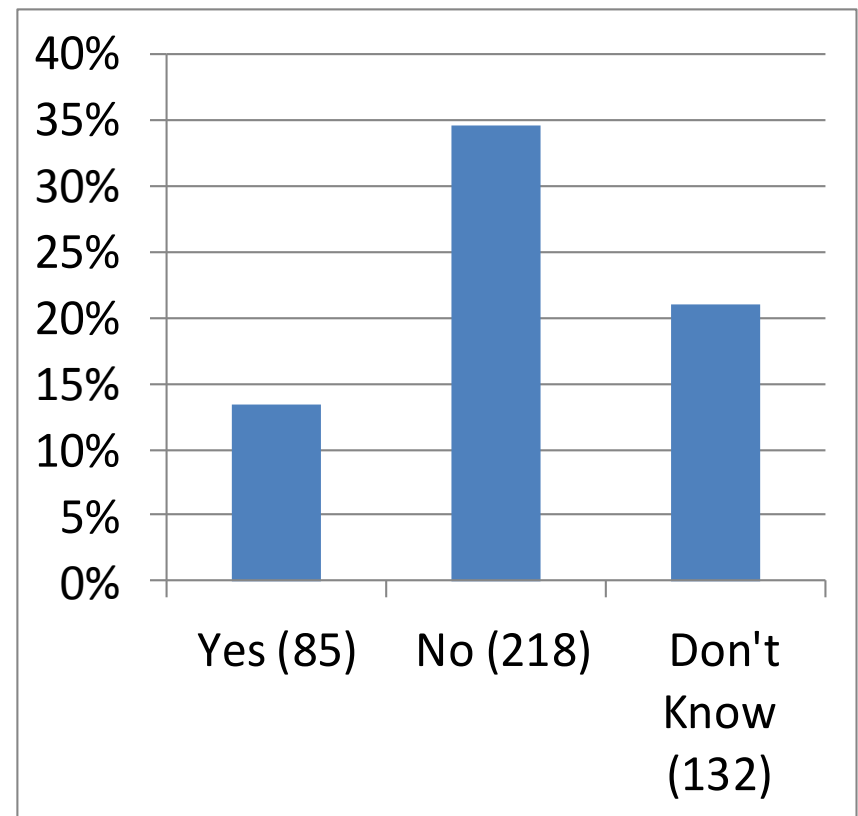


Veteran Physically Violent in Past Relationship?

Veteran Report



Partner Report



Partner's Use of Physical Force (Discussion)

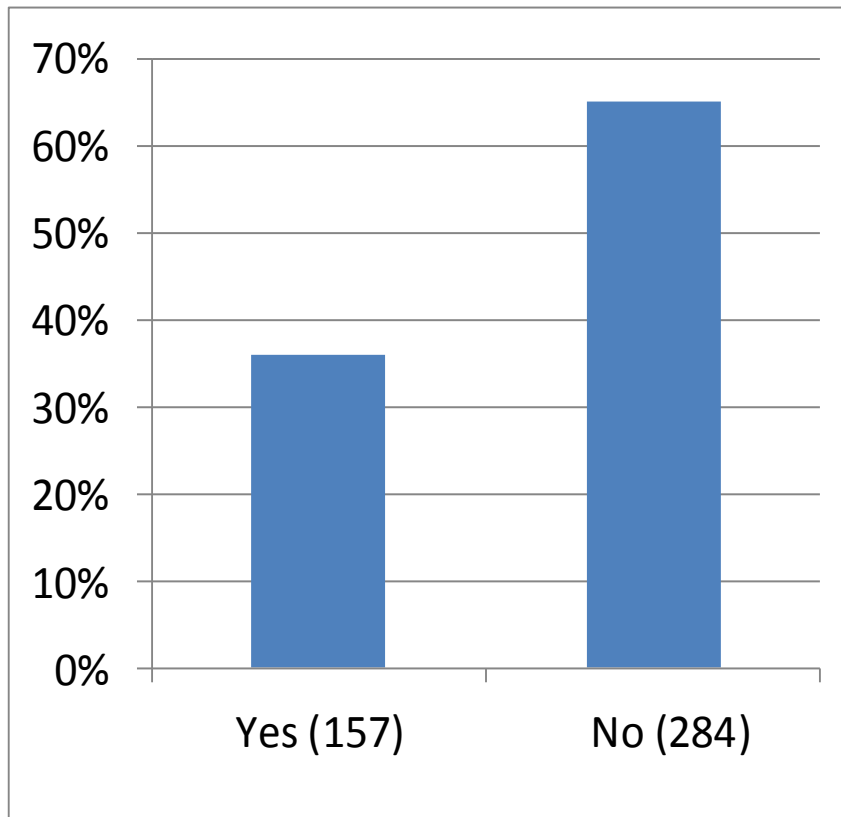
Women's use of physical force is significantly related to the veteran's current* and past** physical violence (or credible threat) in this relationship.

* [r = .465, p = .000]

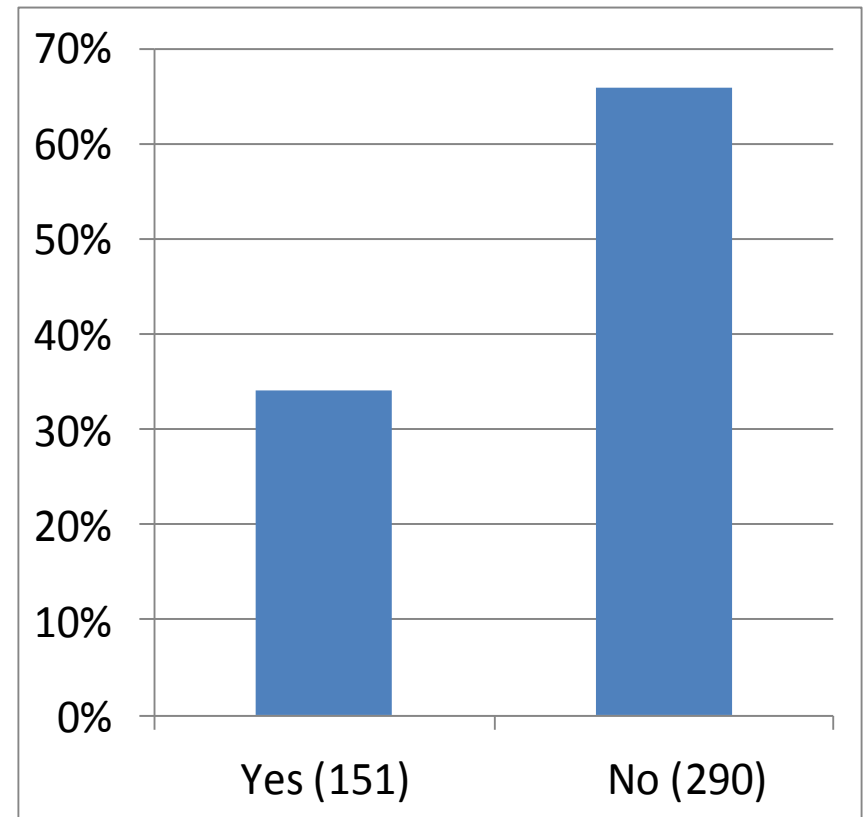
** [r = .500, p = .000]

Partner's Use of Physical Force

Veteran Report

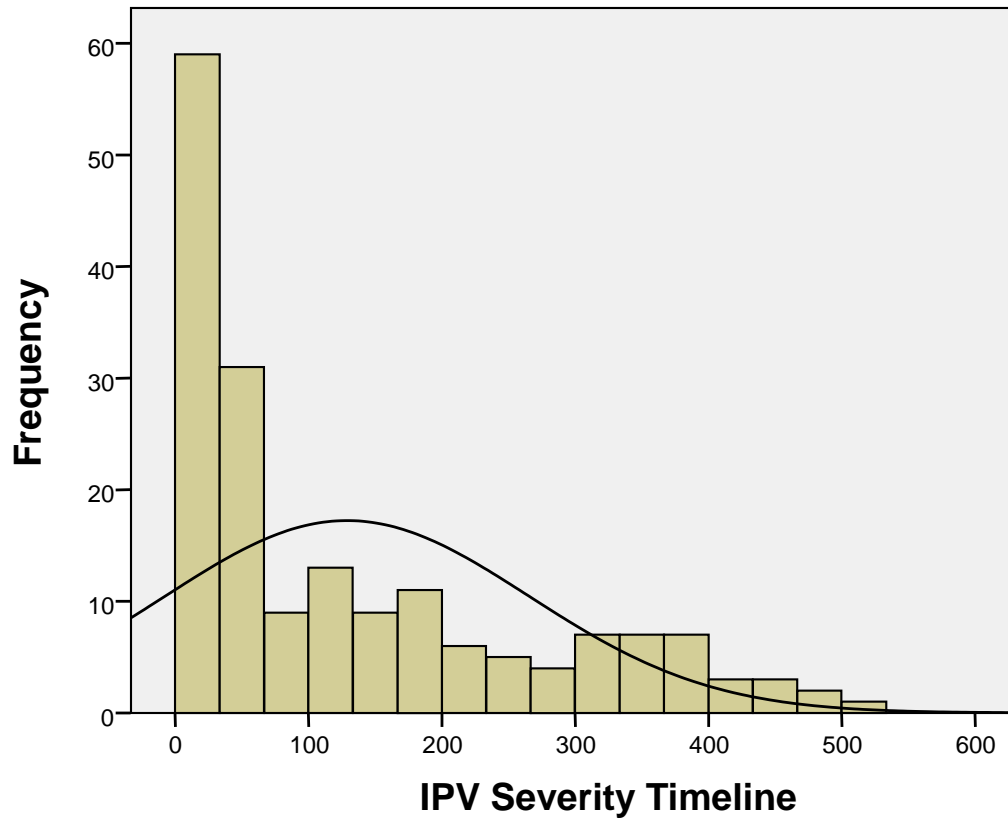


Partner Report



Deployments and IPV Severity

Histogram



Mean = 128.79
Std. Dev. = 136.598
N = 177

The Intersection of PTSD and IPV Perpetration

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.

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 and surveillance

PTSD Symptoms and IPV Tactics

Criterion A: Traumatic experience

Criterion B: Re-experiencing

Criterion C: Avoidance

Criterion D: Increased Arousal

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.

PTSD Symptoms and IPV Tactics

Criterion A: Original Experience

Criterion B: Re-experiencing

Criterion C: Avoidance

Criterion D: Increased Arousal

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, withdrawing from family all have a significant impact on wives/partners, family, and friends.

PTSD Symptoms and IPV Tactics

Criterion A: Original Experience

Criterion B: Re-experiencing

Criterion C: Avoidance

Criterion D: 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 the targets. If no other pattern of coercive control or assaultive behavior exists, then it is a stand-alone PTSD symptom.

PTSD Symptoms and IPV Tactics

Criterion A: Original Experience

Criterion B: Re-experiencing

Criterion C: Avoidance

Criterion D: Increased Arousal

Increased Arousal: Outbursts of Anger

Outbursts of anger are 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.

The Difference in Treatment Approaches for PTSD and IPV

PTSD Treatment:



The goal of PTSD treatment is to quiet the PTSD symptoms and facilitate re-integration into the full range of social experiences.

The work is done with the survivor of traumatic experiences.

Therapists accept what is offered by the client at face value and approach with empathy and compassion.

Photo provided by: Battered Women's Justice Project; supported by Grant No. 2011-TA-AX-K110 awarded by the Office on Violence Against Women, US Department of Justice

The Difference in Treatment Approaches for PTSD and IPV

IPV Treatment:

The goal of IPV treatment is to stop all forms of abuse of intimate partners by holding the abuser responsible for the violence and accountable for stopping the abusive behavior.

IPV perpetrators often minimize, lie, and blame the victim for the violence.



Photo provided by: Battered Women's Justice Project; supported by Grant No. 2011-TA-AX-K110 awarded by the Office on Violence Against Women, US Department of Justice

The Difference in Treatment Approaches for PTSD and IPV

Other important points to consider:

When the victim is in a care-giving role to the person with PTSD, the impact of co-occurring IPV perpetration is even greater. There is the strain of providing care to the abusive person and the added pressure to stay in the relationship to care for the service member or veteran.

IPV perpetrators may also be victims of trauma (e.g., childhood abuse, witnessing violence, etc.).

Dealing with Disability

“Relationships and PTSD Study”

- He felt I was intruding. He felt that I was treating him like a child. He felt I was asking of him things that were unreasonable. And, really, what I was concerned about was making sure that he was safe and that he was going to get home OK and on time. (Partner)

Care Giving

“Relationship and PTSD Study”

- ...depends on a trigger. If she hits a trigger, like she's, sometimes - let's see, when, when I have the feeling that she's nagging, when you get the feeling that she, she's nagging, and, then, all of a sudden, it's, like, bam, bam, bam. ...- I can't be speci-, I can't be specific, but that's pretty much what happens. (Veteran)
- ...you know, I was secondary. And, that's another thing that I would like it known is that the family and the spouse become secondary to everything. And, you, kind of, get lost in the shuffle. Everything is focused on it, everything. And, in some ways, rightfully so, but, also, the - my emotions, my feelings, my medical care, my physical care, my sexual desires, my life desires, you know, work, everything falls to the wayside. And, it all is about them. (Partner)

Trauma

“Relationship and PTSD Study”

- Entitlement “you owe me” because of what I’ve been through, actions as well as impotence justified in this way, weakness and vulnerability turned back so others have to deal with me.
- “Triggering” (being activated by environment) used as excuse for IPV.
- Veterans’ significant need for control and the level of aggression was described as inducing neither empathy nor concern, but fear and anxiety.
- An awareness of the veteran’s capacity to harm, noted in reference to his size, strength, or past history, military or previous IPV, created significant partner fear and anxiety.
- Assaults during sleep added to the knowledge that the veteran has killed/could harm actively or passively.
- Possession of weapons was common with the veterans and a recurrent theme among the more distressed and violent couples, becoming the focal point of the veteran’s capacity to harm.

Months in PTSD Treatment x Age of Men x IPV Severity

- Significant relationship between months in PTSD treatment and physical abuse:
 - More time in treatment is positively related to higher levels of physical abuse (per veteran report): [t = 2.167, p = .031]; and overall abusiveness [t = 1.944, p = .05].
 - This is not a factor of age: [t = -.706, p = .480].
- Significant relationship between months in PTSD treatment and provider awareness of physical violence.
 - Logistic regression, Wald = 14.424, df = 1, p = .000, Exp B

Screening for IPV Perpetrators

- Screening for IPV will likely identify both IPV victims and perpetrators.
- Always in a private setting without family members present.
- Script varies on the health care setting and purpose of the screen.
- Emphasize the 'routine' nature of the screen.
- Draw on your therapeutic relationship and health care issues.

Interventions

- Resources on responding to perpetrators:
www.futureswithoutviolence.org
- Assess risk elements:
 - When IPV is present, ask about symptoms of depression and thoughts of suicide
 - When depression and suicidal thinking are present, ask about IPV perpetration and victimization
 - Determine if immediate intervention is needed (e.g., hospitalization)
- Recommend treatment that will decrease symptom-related impulsivity:
 - Substance abuse treatment
 - Screening/assessment/treatment for TBI
 - Treatment for depression or other mental health disorders

Interventions

- Ask that all guns be removed from the home:
 - Ask the IPV perpetrator to remove guns and request permission (release of information depending on the setting) to verify they are in safe keeping.
 - Ask the IPV victim to secure guns.
- Document behavioral descriptions of patient, assessment and interventions.
- Follow-up at the next visit: “At the last visit we talked about..., how did that go?”
 - Assess for any change in IPV behaviors or risk elements.

Questions/Discussion



Presentation References

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Thank You

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Second Polling Question

Are you familiar with the Defense Department Family Advocacy Program?

Please select “YES” or “NO”



DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Family Advocacy Program

Melvina Thornton, LICSW

Office of the Secretary of Defense Family Advocacy Program,
Military Community & Family Policy



Required Disclaimer

I have no relevant financial relationships and do not intend to discuss the off-label/investigative (unapproved) use of commercial products/devices.



Family Advocacy Program (FAP)

Scope:

- Congressionally authorized Defense Department program
 - Addresses child and domestic abuse among those eligible for treatment in a military medical treatment facility
- ** FAP is located at every installation where families are also sponsored and present



Family Advocacy Program (FAP)

Goals:

- Promote prevention, early identification, reporting, and treatment of child and *intimate partner* and spouse abuse
- Strengthen family functioning in a manner that increases the competency and self-efficacy of military families
- Preserve families in which abuse has occurred if possible without compromising the health, welfare and safety of victims
- Provide effective treatment for all family members when appropriate
- Collaborate with state and local civilian social service and law enforcement agencies



FAP Services

- Public Awareness and Primary Prevention
- Secondary Prevention (**at risk)
- Clinical Treatment and Rehabilitation
- Collaboration with other family support activities: financial management, spouse employment, EFMP, Military OneSource, MFLCs, chaplains
- Collaborate with non-federal partners



Safe Helpline Overview

- ▶ Crisis support service for adult service members of the DoD community who are victims of sexual assault
- ▶ Features
 - Available 24/7 worldwide, users can “click, call, or text” for anonymous and confidential support
 - CLICK:** www.SafeHelpline.org
 - CALL:** **877-995-5247**
 - TEXT:** **55-247 (Inside the U.S.) / 202-470-5546 (Outside of the U.S.)**
 - Provide “warm hand-off” transfers to Sexual Assault Response Coordinators (SARC), Military OneSource, National Suicide Prevention Lifeline and civilian sexual assault service providers
 - Provide a military and veteran-specific resource dashboard available 24/7 and information on benefits, resources and referrals
 - Easily accessible smart-phone application and mobile format
 - Administered by the DoD via a contract with the non-profit Rape, Abuse & Incest National Network (RAINN), the nation’s largest anti-sexual violence organization

Thank You

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Question-and-Answer Session

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We want your feedback!

- Please take the [Interactive Customer Evaluation](#) found on the Monthly Webinar section of the DCoE website
- Or send comments to DCoE.MonthlyWebinar@tma.osd.mil

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If you pre-registered for this webinar and want to obtain a continuing education certificate, you must complete the online CEU/CME evaluation.

- Did you pre-register on or before Monday, **June 25**, 2012?
 - If yes, please visit conf.swankhealth.com/dcoe to complete the online CEU/CME evaluation and download your continuing education certificate.
- Did you pre-register between Tuesday, **June 26**, 2012, and now?
 - If yes, your online CEU/CME evaluation and continuing education certificate will not be available until Monday, **July 2**.
- The Swank Health website will be open until **July 23**, 2012.
 - If you did not pre-register, you will not be able to receive CE credit for this event.

Save the Date

DCoE Monthly Webinar:

***Military Acute Concussion
Evaluation (MACE)
Training: Administration,
Use and Interpretation of
the MACE***

July 26, 2012
1-2:30 p.m. (EDT)

JULY						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

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