

Intimate Partner Violence, Military Personnel, Veterans, and Their Families

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The United States has been at war for over a decade. Over 2.5 million people have served in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) in Afghanistan. Many military service members have deployed multiple times to war zones over the past decade. Some have returned with visible and invisible injuries that have significantly affected them and their families (RAND Center for Military Health Policy Research, 2008). Communities throughout the country are grappling with the aftermath of war and how to serve military personnel, veterans, and their families effectively with sensitivity to the experiences they have had and the issues they face. This article will focus on the intersection between intimate partner violence (IPV) and combat-related conditions such as posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), substance abuse, and depression and the implications for family court personnel working with military and veteran families.

Terminology

It is important to make a few comments about the terminology used in this article. The authors choose to use the term “intimate partner violence” since it is most descriptive of the nature of the relationship in which the abuse and violence occur. The terms “battering” and “domestic violence” are commonly used to describe the same dynamics that are encompassed in IPV. However, the term “domestic violence” in many jurisdictions now describes any violence that occurs within a household regardless of the familial relationship between the victim and offender. “Battering” is one context in which violence occurs, but all IPV is not battering, as we will discuss later in this article.

We strive to be gender inclusive in our language reflecting victims and offenders, but we acknowledge that it is more common for women to be victims of IPV and their intimate male partners to be offenders. From 1994 to 2010, four out of five victims of IPV were women (Catalano, 2012). We use the term “victim” versus “survivor” because we will generally be talking about someone who remains in the abusive relationship or is in the process of ending the relationship, which often brings them to family court. This article focuses on IPV that occurs within a heterosexual intimate relationship.

IPV occurs when there has been physical and or sexual violence in an intimate relationship and the range of offender behaviors continually remind victims that violence is always a possibility. IPV includes behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, or wound someone. Offenders may use the following tactics (this is not an all-inclusive list):

- Intimidation
- Coercion and threats
- Emotional abuse, e.g., name calling, put downs, mind games, public embarrassment
- Use of children to control the partner
- Economic coercion
- Minimization, denial, lying, and blaming the victim
- Stalking

Context of Violence

It is important to recognize that all IPV is not the same. Each victim has a different experience, and the violence occurs within a larger context. Therefore, a contextual analysis of every incident of IPV is critical to determine the context in which the violence is embedded

whether or not the victim and offender have or have had any connection to the military. The circumstances of the incident are often unclear to first responders and to interveners who may become involved later. More than one involved party may have signs of injury. Both involved parties may have used violence. Participant accounts of the events often conflict. One or more of the participants may have left prior to police arrival. Some injuries may take hours or days to show up. The accounts of those involved may contradict visible injuries and evidence. An individual's demeanor may be misinterpreted. A contextual analysis serves to clarify what happened by determining the offender's INTENT in his/her use of violence, the MEANING of the violence to the victim, and the EFFECT of the violence on the victim and children. Looking at the context of the violence means going deeper than just the incident – to the history in the relationship.

The context in which the violence is embedded affects risk, danger, safety planning, and intervention. The level of risk and danger is associated with the history of the violence and the tactics used by the perpetrator. Safety planning will not be effective unless it takes into account the different forms of coercion or violence present in each situation. Effectiveness of intervention depends upon understanding the context in which the violence was used and ensuring that intervention efforts are focused on the appropriate party. Misunderstandings about the context of the violence can have dangerous or even fatal consequences. This has been shown in analyses of intimate partner homicides (Campbell, et al., 2003).

IPV is embedded in the following four contexts:

- “IPV with coercive control (battering)” includes an ongoing pattern of coercive control in the relationship. Coercive control includes threats of negative consequences for

noncompliance, punishing when necessary, monitoring of the victim's behavior through surveillance, and attempts to wear down resistance (Dutton & Goodman, 2005). There is a patterned set of behaviors with the goal of entrapping the victim or narrowing her/his life so significantly that she/he has little contact with anyone other than the offender. IPV with coercive control affects all aspects of a victim's life – physical injuries, stress-related health problems, and psychological issues. While most victims of IPV with coercive control seek help from resources they perceive as safe, the combination of all of these effects can erode the victim's ability to confront the violence and take action to protect herself and her/his children. However, many IPV victims do everything they can to protect themselves and their children, and many do leave the relationships. Coercion and intimidation distinguish this context from IPV without coercive control.

- “Resistive violence” is generally used by a victim who has been abused, often battered, over time. It is part of a broader strategy to stop the violence perpetrated against her/him. It may be self-defense or it may be more proactive in an effort to get an impending assault over with sooner. It may also be that she/he has decided to stand up to the abuse or is acting out her/his rage in retaliation. According to Johnson (2011, p. 290), “For most women in heterosexual relationships, the size difference between them and their male partner ensures that violent resistance won't help, and may make things worse, so they turn to other means of coping. For a few, eventually it seems that the only way out is to kill their partner.” The effect of resistive violence can be just as dangerous as IPV with coercive control and can result in serious injury or death to either partner particularly if weapons are used. It is, however, qualitatively different from IPV with

coercive control because it is a reaction to, rather than an expression of, coercive controlling violence.

- “IPV without coercive control” is NOT part of an attempt to establish an ongoing position of dominance in a relationship or in response to being battered. The victim often reports the violence is not typical in the relationship. One or both parties in the relationship may be violent. It is often in response to ongoing conflict in the relationship over issues such as infidelity, childrearing, finances, etc. Persistent, unresolved issues in a relationship may escalate into violence. The violence may occur only upon separation or divorce. Some researchers call this “common couple” or “situational” violence (Johnson, 2008, p. 60). While severe violence occurs at a lower rate in situational IPV than it does in IPV with coercive control, it can still be dangerous and potentially lethal.
- “Pathological violence” may be influenced by psychological problems, brain injury, substance abuse, etc. However, the reality is that most people with mental illness do not commit acts of violence, including IPV. More commonly, mental illness, substance abuse, or brain injuries can be co-occurring conditions in perpetrators of IPV in any context. This reinforces the importance of thorough screening and assessment to include not only the presence of co-occurring conditions but also a history of violence in the relationship. Violence that occurs within this context may be battering.

It is important to be clear that violence embedded within any of these contexts can be dangerous and lethal. Determining context is not an attempt to minimize the level of risk and danger of IPV. It is not meant to excuse criminal behavior. It can assist in making more informed decisions regarding offender dispositions and victim safety. Context helps to determine appropriate interventions and safety planning.

There appears to be a common belief that IPV involving a military service member or veteran who has been deployed to a combat zone always occurs within the context of pathological violence and is caused by their combat experiences and/or co-occurring combat conditions such as PTSD, TBI, substance abuse, or depression. It is true that a relationship between combat-related PTSD and IPV perpetration has been found consistently in research studies (Gerlock, 2004; Orcutt, King, & King, 2003; Sayers, Farrow, Ross, & Oslin, 2009). It is also true that there are service members who never perpetrated IPV prior to deployment to a combat zone. However, there are also those who perpetrated IPV, including battering, prior to deployment (McCarroll, Ursano, Fan, & Newby, 2004). Unfortunately, there has been very little formal research to determine how many had already perpetrated IPV prior to deployment, so there is little hard data available at this time. It is critical to remember that IPV involving military personnel and veterans can be embedded in any of the four contexts, whether or not co-occurring combat-related conditions are present.

It is very common these days for victims of IPV (including those who have or have had a connection to the military) who also engage in resistive violence to be arrested as IPV perpetrators in many jurisdictions across the country. This arrest affects how they are viewed and treated by law enforcement, criminal justice, child protective service, and family court personnel. We would like to elaborate a bit on women's use of violence. Interveners need to recognize the choices IPV victims have when confronted with violence. They can leave, submit, or fight back, and it is often even more dangerous when they try to leave the situation or the relationship. We acknowledge that women use violence in intimate heterosexual and same-sex relationships, and they can be batterers. However, the reality is that women are generally not batterers, especially in heterosexual relationships. There is rarely an ongoing pattern of coercive

control. Often women's violence is minor and ineffective. The intent of the violence is not to dominate, and the violence often has little impact on the partner's behavior. The partner usually does not feel afraid or intimidated – they can generally leave with little risk. Women often experience severe consequences for their violence either at the hands of the partner or by the system response. Escalation can lead to lethal violence (Johnson, 2011). This reinforces the importance of looking beyond one IPV incident to the history in the relationship and determining the context in which the violence is embedded.

Intersection of IPV and Combat-Related Co-Occurring Conditions

In this section, we address how to differentiate IPV behaviors from symptoms of common co-occurring conditions for military service members and veterans who have deployed to a combat or conflict area. Combat deployments are times of increased stress for military couples. The period for the service member to reintegrate into family life after a combat deployment is also stressful and may be further complicated by injuries, anxiety, and attempts to cope with symptoms of posttraumatic stress and depression through the use of alcohol or illegal drugs. Lower marital satisfaction in general has been observed in active duty couples both before and after deployments when compared to similar civilian couples (McLeland, Sutton, & Schumm, 2008). For this reason, it is important to understand the differences between IPV perpetration tactics and symptoms of PTSD, TBI, substance use disorder (SUD), and depression and how these may overlap with and impact IPV when also present.

Posttraumatic Stress Disorder

Most service members who have deployed to a combat zone will not develop PTSD. However, many will return home with expected combat stress reactions, which may include

problems with sleep and nightmares, being easily startled, becoming easily irritated with non-life threatening civilian-related stressful situations, feeling uncomfortable in crowds or around people they do not know, and withdrawing from friends and family. While couples may experience some increase in conflict as they readjust to each other and as they re-establish their roles within the relationship and family, this conflict does not usually become physically violent or threatening. It may take up to two years or longer for service members to reintegrate when the service member is no longer deploying. However, when combat-related PTSD is present, the question of “what is a PTSD symptom?” versus “what is an IPV tactic?” becomes more critical as spouses, treatment providers, and family courts attempt to understand what is happening, set intervention priorities, and implement safeguards to enhance safety.

PTSD is a mental health disorder. It falls within the “Trauma- and Stressor-Related Disorders” within the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) (American Psychiatric Association, 2013, p. 271). Both military and non-military alike are susceptible to developing PTSD after either directly experiencing or witnessing an extremely stressful event happening to a close friend or loved-one; or a person may be repeatedly exposed to adverse details of trauma in the course of his/her work. These experiences are referred to as traumatic events. If a person then develops a cluster of symptoms related to that experience (or to multiple exposures to those experiences), and these symptoms persist more than a month, cause clinically significant impairment in social, occupational, or other important areas of functioning, are not attributable to the physiological effect of a substance or medical condition, the individual may be experiencing PTSD.

Responses to traumatic events can be quite variable and can include a range of symptoms and psychological manifestations. PTSD symptoms present as four symptom clusters associated

with the traumatic event/s: 1. Re-experiencing (e.g., intrusive/involuntary memories, distressing dreams or nightmares, dissociative reactions/flashbacks); 2. Avoidance (e.g., persistent avoidance of stimuli associated with the traumatic event); 3. Negative alterations in cognitions and mood (e.g., problems with memory associated with the trauma, negative beliefs, distorted cognitions, negative emotional states, feeling detached from others, and inability to experience positive emotions); and 4. Marked alterations in arousal (e.g., sleep disturbance, outbursts of anger expressed as aggression toward people or objects, recklessness, difficulty concentrating, constantly tense and on guard, and startles easily).

A relationship between PTSD and IPV perpetration has been found consistently in research studies (Gerlock, 2004; Kulka, et al., 1988; Taft, Watkins, Stafford, Street, & Monson, 2011).¹ Researchers have reported that the association between PTSD to both general and partner aggression is linked to dysphoria (anxiety, depression or unease) and the PTSD (hyper) arousal symptom cluster (Bell & Orcutt, 2009; Savarese, Suvak, King, & King, 2001; Taft, Vogt, Marshall, Panuzio, & Niles, 2007). Researchers have also looked at the types of aggressive acts to better understand the nature of male-to-female sexual and non-sexual aggression (Teten, Schumacher, Bailey, & Kent, 2009). An impulsive/reactive aggression (unplanned response to a threat) is considered to be consistent with the PTSD hyper-arousal understanding of aggression while a premeditated/proactive (planned and purposeful) aggression is more consistent with an IPV understanding of aggression. However, both types of aggression may be present when a person is experiencing PTSD symptoms AND engaging in IPV perpetration tactics.

¹ Referenced here are just a few of many studies over the past several decades that have found this positive correlation between partner violence and PTSD.

For example, a service member or military veteran may be experiencing severe nightmares (re-experiencing symptom cluster). During these nightmares he/she may strike out, kick, or even strangle their partner. If these acts of physical aggression occur only during a nightmare and there are no coercive or threatening behaviors during wakeful hours, these may be stand-alone PTSD re-experiencing symptoms. However, if these happen and there are other psychologically abusive and threatening behaviors associated with IPV, these nighttime acts of aggression serve as a credible threat that violence is always a possibility. In most cases, these are PTSD symptoms and the couple take steps to stay safe (e.g., sleeping separately), however, at other times PTSD-related aggression overlaps with IPV aggression.

Irritability and anger receive a great deal of attention when trying to differentiate between PTSD symptoms and IPV tactics. According to the arousal criteria for a PTSD diagnosis, a person may exhibit "...irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects" (American Psychiatric Association, 2013, p. 272). To adequately assess for IPV, it is important to determine if these behaviors are targeted towards a spouse or partner, are coercive and controlling, result in injury (psychological or physical) to a spouse or partner, and result in fear. By asking about targeted patterned behaviors that result in injury and fear, a clearer distinction between PTSD symptoms and IPV tactics becomes possible. A person may be both intimately violent as well as suffering from PTSD. The following table is a guide to help differentiate the areas of overlap.

Table 1. PTSD Symptoms vs. IPV Tactics.²

PTSD Symptoms	IPV Tactics
<i>Re-experiencing:</i> Nightmare-related aggression; aggression during a dissociative flashback.	<i>Physical/sexual assault:</i> Occurs outside of nightmares and/or dissociative flashbacks.
<i>Avoidance:</i> Self-imposed social withdrawal; avoiding family/friends, and social activities.	<i>Social isolation:</i> Cuts victim off from family/friends; isolates victim from support network.
<i>Negative cognitions and mood:</i> Negative beliefs about self and others; negative emotions (e.g., anger; inability to experience happiness and loving feelings).	<i>Emotional abuse:</i> Suspicious and jealous of victim; accuses victim of unfounded actions (e.g., having an affair); alternates between angry, threatening behavior and demonstrations of love.
<i>Arousal:</i> Irritable/angry outbursts (little to no provocation); hyper-vigilance; reckless/self-destructive behavior.	<i>Intimidation and threats:</i> 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 through righteous rage (e.g., “you owe me”). ³

Traumatic Brain Injury

A traumatic brain injury is a disruption of brain function and disturbance of consciousness caused by an external injury to the head. Combat deployments may expose service members to blast injuries, shrapnel or bullets above the shoulders or falls or other injuries that may result in a head injury. Head trauma is common, and service members have been experiencing TBIs as long as there have been wars and conflicts. TBIs are not exclusive to service members. Head trauma can occur from non-military-related injuries as well, such as falls during construction work, motor vehicle accidents, certain sports activities, and secondary to assaults as in the case of IPV victims.

² Table first presented on October 10, 2013: Battered Women’s Justice Project (BWJP) Webinar, “Intimate Partner Violence: Risk, Danger, Military Personnel, and Veterans” (G. Tinney, C. Sponsler-Garcia, & A. Gerlock).

³ See: Gerlock, Grimesey, & Sayre (in press) for a discussion and examples of entitlement based anger.

Most TBIs are mild (mTBI), and symptoms resolve quickly within weeks to a few months. Some TBIs are more serious ranging from moderate to severe, and full recovery could take as long as a year or longer. Aggressive behavior is typically seen with more serious head injuries but may also be associated with other co-occurring mental health disorders such as depression and pre-injury substance abuse (Carlson, et al., 2011; Hoge, et al., 2008). A TBI may also cause subtle changes in how a person interacts with other people. For example, a harmless remark may be misinterpreted and responded to with aggression.

The number of service members who have experienced injuries to the head and neck during their deployments to Iraq and Afghanistan is estimated at 30%, with most (between 70% - 80%) considered mTBI (Taber & Hurley, 2010). People with TBIs experience the following symptoms (Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) and the Defense and Veterans Brain Injury Center (DVBIC), 2010; Defense and Veterans Brain Injury Center, n.d.; U.S. Department of Veterans Affairs, n.d.):

- 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.

As with PTSD, it may be difficult to differentiate between a TBI-related symptom or behavior and an IPV perpetration tactic. Some TBI symptoms also overlap with PTSD symptoms, for example, working memory problems, irritability/rage (anger), agitation,

aggression, and sleep disturbance. When a person suffering from a TBI exhibits these symptoms and behaviors, family members, healthcare professionals, and family court personnel are likely to attribute all behaviors to TBI. However, when IPV is also present, the irritability, rage, agitation, aggression, and acting on impulse take on an additional dimension that endangers spouses/partners and children. As with PTSD, it is important to determine if there is a pattern of behaviors that include the physically/sexually aggressive acts (or credible threat), in addition to threatening and coercive behaviors that result in injury and/or fear. Also, as with PTSD, veterans may be experiencing both TBI symptoms as well engaging in IPV tactics. In many ways justice system involved veterans resemble their civilian counterparts when it comes to increased risk of engaging in criminal behaviors. For example, veterans with deployments to Iraq and Afghanistan with “probable” PTSD or TBI were considered more likely to be arrested than other veterans (Elbogen, et al., 2012a). However, in the final analysis, only younger male veterans, who had witnessed family violence, had a prior arrest history, engaged in alcohol/drug misuse, and had PTSD with high anger/irritability were more likely to have criminal justice system involvement. Neither combat exposure nor TBI met the statistical associations necessary to be represented in the final model representing increased risk in criminal behaviors (Elbogen, et al., 2012a).

Substance Use Disorder

Substance use disorder (SUD) reflects a range of substance-related and addictive disorders that vary along a continuum from intoxication, withdrawal, abuse, and dependence with a wide range of substances to include alcohol, cocaine, marijuana, and more. With SUDs cognitive, behavioral, and physiological symptoms persist when the individual continues to use.

A critical characteristic in diagnosing an SUD is that the person continues to use despite these significant problems (American Psychiatric Association, 2013, p. 483).

The relationship between substance abuse and misuse and IPV perpetration has been controversial in the IPV literature. While numerous studies show a link between substance abuse and misuse and IPV, in an examination of the literature for both alcohol and drug abuse, Capaldi and colleagues summarized that the evidence for the association among alcohol and drug use indicators and IPV perpetration was not strong. The authors found that other risk factors were also important, and it was the combination of substance and these other risk factors (e.g., age, relationship status, race, employment, *partner's* substance use, and combined alcohol and cannabis and hard drugs) that explained the association with IPV perpetration (Capaldi, Knoble, Shortt, & Kim, 2012).

It is not uncommon for service members and veterans to increase their alcohol and drug use during and after combat zone deployments to help them relax, get to sleep, and reduce the hyper-arousal. However, these co-occurring problems of PTSD symptoms, other risk factors like age and unemployment and substance abuse/misuse present a stronger association with IPV perpetration. The interplay between hyper-arousal and drinking frequency and quantity has been associated with higher levels of physical violence, and partners' reports of both physical and psychological abuse among a sample of military veterans (Savarese, Suvak, King, & King, 2001). Similar findings have been found in samples of active duty service members, as this complex association between drinking and other psychosocial or behavioral variables have been associated with IPV perpetration (Bell, Harford, Fuchs, McCarroll, & Schwartz, 2006; Marshall, Panuzio, & Taft, 2005).

The link between IPV perpetration and substance abuse/misuse cannot be overlooked for service members and veterans because of other risk factors, to include major mental health disorders (e.g., PTSD and depression), young age, predominantly male gender, and combat exposure (Elbogen, et al., 2012b). These added risk elements highlight the importance of recognizing how co-occurring problems overlap and increase the complexity of the family court response when IPV is also present.

Depression

Depression frequently co-occurs with PTSD and SUD (Institute of Medicine of the National Academies, 2008; Seal, et al., 2009). Veterans returning from deployments to Iraq and Afghanistan have reported rates of depression around 20% with symptom rates even higher when both PTSD and depression are co-occurring (RAND Center for Military Health Policy Research, 2008). According to the National Survey on Drug Use and Health Report from November 6, 2008, (Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, 2008) an estimated 9.3% of veterans aged 21 to 39 experienced at least one major depressive episode in the past year and more than half received treatment for depression. Over half had severe impairment in at least one of four areas (to include close relationships with others and social life).

As with PTSD and SUD, depression is diagnosed when a person is experiencing a set of symptoms for a period of time (American Psychiatric Association, 2013, p. 155). Depression differs from moodiness. Depression is a pervasive sad mood that a person experiences nearly every day, for most of the day. The person may lose interest in activities they once enjoyed. As with PTSD, a person may also have a disturbance in sleep (either insomnia or hypersomnia) and

express feeling fatigued and a loss of energy. Also, like PTSD and TBI, a person may have agitated behavior or he/she may have a slowed response to questions or slowed movements. Either significant weight gain or loss is possible. The person may describe feeling worthless, and, like PTSD may have excessive inappropriate feelings of guilt. Overlap with PTSD and TBI is apparent in impaired concentration. With depression, a person may have thoughts of death while a person with PTSD may wish he/she were dead because of survival guilt over living when friends and comrades did not. With depression, a person may make plans to kill him/herself, where someone with PTSD may feel as if something bad is about to happen and he/she will not live long enough to have a future. Not everyone experiences every symptom, but a major depression is characterized by a period of at least two weeks during which there is either a depressed mood or the loss of interest or pleasure in nearly all activities. Having five symptoms or more meets the criteria for depression.

Sometimes IPV perpetrators are depressed because of their IPV behaviors (Gerlock, 1999). Irrespective of the cause of the depression, it is extremely important to identify depression, especially when IPV is also present. Depression interferes with focus and concentration, making it difficult for an IPV offender to adequately respond to offender intervention or other interventions. Hopelessness and helplessness are two key emotional states seen with depression. When an IPV perpetrator expresses a belief that there is nothing else to lose, and he/she is jealous and dependent on the victim, there is a potential increased risk for an IPV-related homicide (Campbell, 1992).

Suicide

One risk factor associated with suicide and suicide attempts is a known failure in a spousal or intimate relationship. According to the Army Suicide Event Report (2008), as many as 50% of soldiers who completed suicide had a recent failed intimate relationship (Suicide Risk Management & Surveillance Office, 2008). In the Department of Defense (DoD) Suicide Event Calendar Year 2011 Report (Luxton, et al., 2012, p. 16), half of the suicides had a failed spousal or intimate relationship, with many experiencing the failure within a month of the suicide. The risk of suicide for military veterans in general and service members returning from tours in Iraq and Afghanistan in particular has received a great deal of attention from media, DoD as well as the Department of Veterans' Affairs (VA). The rates of mental health disorders (e.g., depression, PTSD, anxiety disorders, personality and psychotic disorders, and SUDs) and suicide among Army service members have been increasing since 2004 (Bachynski, et al., 2012).

The relationship between suicide, IPV, and homicide has also received attention and has been reviewed in violent death reviews and domestic violence fatality reviews across the nation (National Domestic Violence Fatality Review Initiative, 2012). The 2008 Surveillance for Violent Deaths report identified the following data for military service members and veterans (Karch, Logan, & Patel, 2011):

- Suicides by former and current military personnel comprised 20% of all suicides;
- Two hundred violent incidents involved homicide followed by the suicide of the suspect;
- 75% of victims were female, and 90% of suspects (suicide decedents) were male;
- Relationship problems or IPV were precipitating factors for many forms of violence;
- 19% of all homicides were precipitated by IPV;

- 52% of all female homicides were precipitated by IPV compared with 9% of all male homicides; and
- 32% of all suicides were precipitated by a problem with an intimate partner.

The link between suicidal intent and homicide when IPV is present makes suicidal intent an obvious risk factor for lethal IPV (covered in the next section). Suicidal intent, as one of the risk factors for lethal IPV, should be evaluated when people present with any of the co-occurring conditions addressed above.

Risk and Danger

Many people think that IPV cases involving military personnel and veterans are more dangerous than cases involving perpetrators who never served in the military. However, there has been no research comparing IPV risk factors and level of danger for military personnel and veterans to the civilian population, so there is no data to prove this belief is true. This belief seems to be based on the assumption that everybody in the military is trained to kill and that they all carry weapons all the time. These assumptions are not correct. Everybody in the military is not trained to kill. It is dependent on their role in the military. Everybody in the military has not deployed to a war zone. Many have deployed to a war zone over the past decade, and many have deployed multiple times, especially in the Army and Marine Corps, but there are also people who have never deployed. Military personnel and veterans have personal weapons just like many people in the civilian community. They are perhaps better trained than many civilians to use them. However, contrary to popular belief, they do not bring their military-issued weapons home with them at the end of the day. These weapons are kept in an armory on the military installation and are closely monitored.

There is general consensus in research literature identifying risk factors that help predict continuing and escalating violence (Dutton & Kropp, 2000; Goodman, Dutton, & Bennett, 2000; Kropp, 2008; Weisz, Tolman, & Saunders, 2000). The truth is that the risk factors for IPV identified in research studies for the general population also apply to cases involving military and veteran offenders as well. Most lists include the following risk factors (Hotaling & Sugarman, 1986; Kropp & Hart, 2000; Pence & Lizdas, 1998; Roehl & Guertin, 2000; Sonkin, 1997; Straus, 1992):

- A history of violent behavior toward family members (including children), acquaintances, and strangers
- A history of physical, sexual, or emotional abuse toward intimate partners
- Use of or threats with a weapon
- Threats of suicide
- Estrangement, recent separation, or divorce
- Use of drugs or alcohol daily
- Antisocial attitudes and behaviors and affiliation with antisocial peers
- 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 a personality disorder (i.e., antisocial, dependent, borderline traits)
- Resistance to change and lack of motivation for treatment
- Attitudes that support violence toward women

The Campbell Danger Assessment (DAS) was developed using known risk markers for lethal violence and is meant solely for use with the victim (Campbell, 1995). Studies have also shown the DAS to be predictive of re-assault in the short-term (Goodman, Dutton, & Bennett, 2000; Weisz, Tolman, & Saunders, 2000). In addition to the risk markers listed above, the DAS includes:

- Access to gun in the house
- Choking or attempted choking
- Survivor beaten during pregnancy
- Forced sex
- Stepchild in the home
- Partner is obsessively jealous and controlling
- Partner is unemployed

As discussed previously in this article, it is true that military personnel and veterans who have deployed to a war zone may have co-occurring conditions such as PTSD, TBI, substance abuse, and depression. However, many in the general population of IPV offenders also have these co-occurring conditions. They may not have deployed to a war zone, but they have often experienced various kinds of trauma in their lives. There are some military-specific risk factors to consider as well. Constant mobility and geographic separation isolate victims, sometimes creating physical distance from family and support. Deployments and reunification create unique stressors. Medical and psychological effects from war zone deployment must be taken into account as well.

Most police reports and court documents have insufficient information to determine the context of the violence or the level of risk and danger. Risk assessment is the beginning of an ongoing process of risk management – the goal is to prevent the violence not predict it. Risk assessment is not something you do one time, and it is done. Risk and danger must be assessed on an ongoing basis since the situation is constantly changing. It is important to talk with the victim, military or civilian, to find out the history of violence and other abusive behaviors in the relationship and to determine the context in which the violence is embedded. It is critical to listen to her/his perceptions of the situation. Combining the victim's perception of risk, along with available defendant criminal records, judgment and expertise of practitioners, and the use of a formal danger assessment tool (e.g., Campbell's DAS) improves the predictive power of risk and danger more than any of these in isolation (Heckert & Gondolf, 2004, p. 778). Victims' predictions and perceptions of risk need to be included in risk assessments.

Implications for Family Court Decisions

Screening/Assessment

Given the considerable overlap in symptoms and behaviors of the conditions addressed above, and the complex interplay of these symptoms/behaviors with IPV and, at times lethal IPV, the need to conduct initial screening followed by thorough assessments is apparent. It is important that family court personnel have a system in place to screen for these co-occurring issues, or refer out for screening, and have individuals within the professional community identified to conduct thorough assessments for IPV and co-occurring conditions.

Screening

A screen is a quick check to determine if something exists. Most people are familiar with a blood pressure check to screen for high blood pressure. A screen is a quick snapshot, often taking the form of a few routine questions. There are many screens that have been developed to help identify the co-occurring conditions previously addressed. Many of these screens have undergone scientific review to test for trustworthiness (called reliability and validity). While screens vary in timing, questions, and methods of gathering information across settings, certain screens have become a stable and routine part of the encounter (e.g., a blood pressure check, or routine screening for IPV victimization in healthcare settings). In general, almost anyone can conduct a screen if they have information on the problem they are asking about and are willing to ask the questions in a private setting, verbatim, and in a non-judgmental manner. The caution arises, however, that without some knowledge of IPV dynamics, an IPV victim who has used resistive violence or who has been fighting back may be inaccurately identified as an IPV perpetrator. This unintended consequence has implications for family court as decisions about intervention, visitation, and custody come into play.

There are additional cautions for family court personnel to consider when IPV and the co-occurring conditions of PTSD, TBI, SUD, and depression are present. By not recognizing IPV, the risk to victims is potentially increased. When all behaviors are attributed to the co-occurring conditions, IPV victims do not receive needed resource information or victim advocacy. Appropriate services to address the IPV perpetration are not recommended, thus failing to hold the perpetrator accountable for the violence and abuse and for stopping it. Mental health interventions for the co-occurring conditions do not have safeguards in place to address victim safety. A caregiver for a disabled service member or veteran may also be an IPV victim, thus

further decreasing their autonomy with the expectation that they need to remain in the relationship. Lastly, when IPV is present, suicidal intent could result in more than one death. For these reasons, it is important that professionals across systems have some basic tools to screen for IPV and these co-occurring conditions and understand their role in making a determination of the need for further assessment and intervention.

Screening can also help identify behaviors that may or may not be related to community re-entry (as in the case of recent deployments), the level and type of services needed (e.g., specialized treatment for mental health disorders, drug testing, etc.), and services specific to improving family and community stability. A positive screen does not necessarily mean that a problem or condition exists, just as a negative screen does not necessarily mean that it does not exist. For this reason, it is important to have individuals or programs identified that have the training and expertise to conduct more thorough assessments when needed.

Assessment

An assessment may be needed to establish a diagnosis. It may also be needed to determine if a problem exists, such as IPV. If IPV is present, further assessment may be needed to determine who is the predominant perpetrator and predominant victim, or the context in which violence has been used in the relationship. An assessment will guide the response once screening identifies an issue. An assessment is a more in-depth and focused look at the problem, and may include accessing multiple sources of information (e.g., medical, legal, and/or military records) in addition to obtaining new information through interviews and possibly tests. Additional assessment elements are often needed that further address the level and type of intervention needed, disability, or functional impairments of the parent/s, strengths and supports,

response/s to prior treatments or interventions (if applicable), and the level of motivation and readiness for treatment/change (if indicated). An assessment will also help determine what risk factors are present and what to do next.

Factors that may affect the accuracy of the information obtained during an assessment include inadequately trained staff (i.e., staff who are unfamiliar with the condition or situation for which they are assessing), time constraints, inadequate access of available collateral information (e.g., police reports, previous arrests or convictions, medical or mental health information, etc.), missing information on issues of substance abuse/misuse, reluctance on the part of the person being assessed to provide information needed, and reluctance to share information out of fear of negative consequences (e.g., an IPV perpetrator's retaliation).

Most VA facilities, military installations, and community health settings have mental health professionals who have the training and experience to assess and diagnose PTSD, SUD, and depression. Because suicidal thinking can change very quickly (especially when there is co-occurring PTSD, TBI, SUD and depression), most mental health settings frequently assess for suicidality. These same settings can screen for TBI, but a trained health professional is needed to make a thorough assessment and address the question of whether a TBI impacts decisions around visitation and custody. Most mental health providers at VAs, military installations, and community health settings DO NOT have the training or expertise to fully assess for IPV. In general, they do not have an understanding of the dynamics of IPV and how behaviors of co-occurring conditions can overlap with and impact IPV. Family court personnel and custody evaluators will need input from victim advocates (military or community-based) and professionals with the expertise in IPV to address the question of whether IPV is present and how that affects decisions about visitation and custody.

Tips for Family Court:

- Prioritize routine screening for the conditions identified and frontload the legal process with good, thorough assessments conducted by individuals who have the training and experience to address them if they exist. A custody evaluator can assist the court by pooling all the available information, in addition to their evaluation, in making recommendations on visitation and custody questions. However, they may not have the expertise to conduct assessments for IPV and co-occurring conditions often seen in military personnel and veterans.
- While VAs, Vet Centers, military installations, and most community health settings have personnel with the expertise to assess, diagnose, and treat PTSD, TBI, SUD, and depression, they do not generally do stand-alone assessments for legal or custody purposes. If the service member or veteran is already in treatment and willing to have an existing assessment shared (through a release of information to talk with the provider or provide a copy of the assessment), this information is available without requesting a separate assessment. These types of evaluations may also be available if the veteran is already involved in specialty courts where such evaluations have been conducted.
- When IPV is not a factor, most health and mental health providers are willing and able (with a release of information) to provide the court with information regarding the service member's or veteran's response to treatment, stability, risk of relapse (in the case of a SUD), and how these may or may not impact questions around visitation and custody decisions.

- When IPV is a factor, DO NOT rely on general mental health or healthcare professionals' opinions about how co-occurring conditions impact questions around visitation and custody decisions unless that professional also has expertise in IPV.
- Custody evaluators may or may not have the expertise and understanding of IPV dynamics or co-occurring conditions so may have to rely on assessments from those who do. The providers who have expertise in IPV are usually found in community-based domestic violence programs. Remember it is critical to determine if IPV is present, the context in which it is embedded, and the level of risk and danger in order to make informed decisions.
- Remember that the co-occurring conditions of PTSD, TBI, SUD, and depression have behavioral presentations that overlap with IPV and may have complex interactions that increase the frequency and severity of IPV perpetration.
- When depression and suicidal thinking are present, determine if IPV is also present, assess for homicidal thinking, and reassess often as intent to harm self or others may change quickly as circumstances change. This is especially important for family court when couples are separating and divorcing and having custody disputes.
- When IPV is present, determine if depression and suicidal thinking are also present and ask about homicidal thinking (on the part of either the perpetrator or victim). Reassess often.
- Remember to ask the victim about her/his perception of risk and danger. It is important to ensure that someone is assessing risk and danger and doing safety planning with the victim.

Treatment Recommendations

An assessment guides treatment recommendations. When several co-occurring conditions exist, it is difficult to prioritize interventions. Having a mental health diagnosis is often embarrassing and shameful, but being arrested for IPV is also shameful. IPV perpetrators may have trauma histories and may also have been the victim of violence in the past. IPV perpetrators and victims alike may want to attribute all the problems they are having to the co-occurring conditions. While embarrassing and shameful, service members and veterans may prefer a diagnosis of PTSD to being identified as an IPV perpetrator. IPV victims may put pressure on the court to implement court sanctions that address the co-occurring problems with the belief that treatment for PTSD or substance abuse, for example, will solve the problem, while ignoring the IPV altogether.

When IPV is present, other dynamics emerge. IPV perpetrators may use a victim's mental health and/or SUD as way to discredit them. They may purposely sabotage a victim's help-seeking behaviors by destroying medications, taking the car (or other behaviors to prevent them from getting treatment), controlling the finances so the victim is unable to afford treatment, or by making threats to hurt or kill family, friends, or pets if they try to seek help.

It is also important to remember that specialized treatment programs have different priorities. For example, PTSD treatment focuses on working with a trauma victim/survivor. To build rapport and create a safe environment, information provided by the client is generally accepted at face value. There is an expectation that family members attempt to understand the symptoms and help create a healing environment. The goal is to stabilize symptoms and support re-integration back into the full range of family and community living. With TBI, the focus is

again on the client/patient. Behaviors are viewed as secondary to the TBI. Family members (particularly the spouse) are expected to assist the patient/client in a range of caregiving activities. Treatment for depression also focuses on the patient/client first with expectations of family members to assist in providing a supportive environment.

Substance abuse treatment diverges in some ways in that information provided by the client is not necessarily accepted at face value. The onus is on supporting the client to stop the abuse of substances and incorporates a wide-range of behavioral changes to support sobriety. Expectations of family members are to desist behaviors that would support substance use on the part of the client.

Offender interventions programs (commonly known as batterers' intervention programs or BIPs) also diverge from general mental health treatment in a number of ways. Collateral information from police reports, probation, the victim, etc., is a key part of the assessment. The offender is held accountable for their violence and abusive behavior and for stopping it. A wide-range of protocols is in place to address victim safety.

These differences in program approaches and expectations are important to keep in mind. While there is a complex interplay between symptoms and IPV tactics, these co-occurring conditions do not cause IPV. Treatment for the co-occurring conditions may help reduce the severity and frequency of physical violence (as in the case of substance abuse treatment) but do not address the pattern of coercive behaviors present with IPV. Male veterans and spouses have reported that specific PTSD and substance abuse treatment helped reduce the intensity and frequency of physical violence but had no impact on other IPV tactics (Gerlock, Grimesey, &

Sayre, in press). Therefore, there must be intervention for IPV perpetration as well as for any co-occurring conditions that exist.

Tips for Family Court:

- Be familiar with military and veteran-specific services in your community. Some VAs, Vet Centers, military installations, and community health centers have programs specifically designed to address co-occurring mental health disorders, making it possible for a service member or veteran to attend one program for several co-occurring conditions.
- Be aware that most VAs and Vet Centers do not have standardized protocol for screening and assessing for IPV victimization or perpetration. In addition, they do not have IPV offender intervention programs. These are very specific treatment programs available in many community settings and on some military installations.
- Court sanctions may include confiscating all firearms, issuing protection orders, and regular court or probation monitoring (for compliance).
- Resources and information should be provided to IPV victims, such as referrals for victim advocacy and information about shelters, etc.
- Be aware there may be actions pending for military and veteran families in other courts (criminal, civil, etc.).
- Leverage resources and interventions available through specialized treatment courts (e.g., mental health, drug, and veteran's) when applicable.

Conclusion

After over a decade of war and multiple deployments to war zones for many, it is clear that military families have experienced a great deal of stress over a long period. This stress has taken its toll on military personnel, veterans, and their families. We see the effects of this stress played out in criminal and family courts across the country. It is important for family court personnel to understand the experiences of military families and the unique issues they face. Family court decisions should be based on the facts of the case and not on assumptions and biases about military personnel and veterans and their families. A person can be both a war hero and an IPV perpetrator. An IPV victim can engage in violent behavior toward the person who has been abusing her/him and still be a good mother/father. The facts of the case should include information obtained from screening and assessment for IPV and co-occurring conditions such as PTSD, TBI, substance abuse, and depression, whether the case is military or veteran-related or not. It is important to remember that the non-military population of IPV offenders often has trauma histories and co-occurring conditions as well. IPV victims may also have co-occurring conditions as the result of the abuse they have experienced.

IPV is not caused by military or combat experience or the co-occurring conditions discussed in this article. However, they may be contributing factors, and they all need to be addressed by people who have the expertise to do so. Those people may or may not be connected to family court. The dynamics of IPV and the risk factors for IPV are the same for military personnel and veterans as they are for the general civilian population. The military is a microcosm of our larger society. People enter the military from all walks of life and from communities throughout the United States. They have all of the same problems and issues

experienced by people everywhere but also have the additional stressors that accompany the military lifestyle.

Military personnel and their families have made huge sacrifices to serve their country. Some have made the ultimate sacrifice. We have a responsibility to them to make sure that we are there to support them as they make their way through the aftermath of war and attempt to move forward with their lives. Therefore, we must be ever vigilant in ensuring we know the whole story before making decisions that will affect their families forever.

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