

Assessment and Documentation of Intimate Partner Violence Perpetration for Veterans with Posttraumatic Stress Disorder

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Overview of Presentation

- Background and scope of problem
- Results from the Phase 1 Data: Relationships and PTSD Study: Detection of Intimate Partner Violence
- IPV-perpetration assessment in medical and mental health settings (missed opportunities to assess)

Scope of the problem: Intimate Partner Violence (IPV) and Military-related PTSD

- War zone deployment and IPV.
- PTSD symptoms and IPV.
- Suicide and IPV homicide.
- Suicide and treatment-seeking veterans.

Intimate Partner Violence & Posttraumatic Stress Disorder... What's the difference?

- Intimate Partner Violence (IPV, also called domestic violence) is a *pattern of behaviors*.
- Posttraumatic Stress Disorder (PTSD) is a *cluster of symptoms*.

Intimate Partner Violence Definition:

- A pattern of coercive and assaultive behaviors in an intimate relationship: some behaviors are physically or sexually assaultive, and others are psychologically abusive; some behaviors are illegal and others are not.

IPV: Salient Features

- When there has been physical and or sexual violence in an intimate relationship, the range of behaviors continually remind victims that violence is always a possibility:
 - Intimidation
 - Coercion and threats
 - Emotional abuse, e.g. name calling, put downs, mind games, public embarrassment
 - Use of children
 - Economic coercion
 - Using minimization, denial, lying and blaming the victim.

Posttraumatic Stress Disorder (PTSD) Defined:

- **Criteria A:**
 - The person experiences, witnessed, or was confronted with an event/s that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, AND
 - Person' response involved intense fear, helplessness or horror.

PTSD:

- **Criteria B: Re-experiencing**
 - Intrusive distressing recollections
 - Distressful dreams/nightmares
 - Acting or feeling as if the traumatic event were recurring (flashbacks, illusions, hallucinations)
 - Intense psychological distress @ exposure to internal or external cues (triggers)
 - Physiological reactivity on exposure to cues.

PTSD:

- **Criteria C: Avoidance**
 - Efforts to avoid thoughts (etc) of the event/s
 - Efforts to avoid activities, places, reminders that arouse recollections
 - Inability to recall an important aspect of the trauma
 - Marked diminished interest in activities
 - Feeling detachment/estrangement
 - Restricted range of affect (& love feelings)
 - Sense of foreshortened future

PTSD:

- **Criteria D: Increased Arousal**
 - Sleep disturbance
 - Irritability or outbursts of anger
 - Difficulty concentrating
 - Hypervigilance
 - Exaggerated startle response

IPV Perpetration & PTSD symptoms

- | | |
|------------------------------|----------------------------|
| ■ PTSD Symptoms | ■ IPV Behaviors |
| ■ Traumatic Event | ■ Physical/sexual assault |
| ■ Re-experiencing that event | ■ Coercion and threats |
| ■ Avoidance | ■ Emotional abuse |
| ■ Increase arousal | ■ Economic coercion |
| ■ Social Isolation | ■ Use of Isolation |
| ■ Irritability | ■ Intimidation and threats |
| ■ Hypervigilance | ■ Stalking & surveillance |

War zone deployment and IPV:

- War zone deployment increases risk of severe intimate partner violence (IPV):
 - Severe aggression significantly greater for soldiers deployed in the past year (compared to those not deployed). The longer the deployment, the more likely the severe spousal aggression (deployment during time-frame of 1990-1994, random sample, n = 26,835, married only). (McCarroll et al., 2000).

War zone deployment and IPV: Bosnia Study

- Active duty recently deployed (313) and non-deployed (712) volunteered for an anonymous questionnaire:
 - Deployment was not a predictor of post deployment violence
 - Some predictors
 - Young soldiers pre-deployment violence
 - Those that lived off post
 - Non-white race
 - Interventions target those with pre-deployment violence not just deployed soldiers (Maccarroll et al., 2003)

PTSD symptoms and IPV

- Veterans and military active duty with PTSD are significantly less likely to have relationship mutuality with their intimate partner ($p = .01$) (Gerlock, 2001).
- PTSD severity is directly related to the severity of IPV in veteran's and active duty military intimate relationships ($p = .000$) (Gerlock, 2004).

PTSD Symptoms and IPV:

- 21% of current IPV nation-wide is indirectly attributed to combat (mediated by the development of PTSD) (Prigerson, Maciejewski, & Rosenheck, 2002)

Risk Factors: Suicide and IPV Homicide

- Surveillance for Violent Deaths: National Violent Deaths Reporting System (April 11, 2008)
 - Suicides by former and current military personnel comprised 20% of all suicides.
 - 200 violent incidents involved homicide followed by the suicide of the suspect.
 - 75% of victims were female, 90% of suspects (suicide decedents) were male.

Risk Factors: Suicide and IPV Homicide

- 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.
- 32% of all suicides were precipitated by a problem with an intimate partner.

Risk Factors: Suicide and IPV Homicide

- Washington State Domestic Violence Fatality Review “..health care providers did not recognize the risk when someone is both suicidal and intimately violent..”:
 - 35% of the fatalities overall (including cases where homicide was averted), perpetrators were suicidal; 31% where homicide was committed (Hobart, 2000).
 - 30% of the homicides the IPV perpetrator was suicidal; 25% of the cases were suicide/homicide (Hobart, 2002).
 - 27% single homicide + suicide; additional 5% multiple homicides + suicide (Starr & Fawcett, 2006).

Risk Factors: Suicide and treatment seeking veterans

- James B. Peake, MD (Issues Related to Collecting Suicide Data, 2008: testimony before Congress)
 - Suicide rates for both male and female veterans—particularly those receiving VA care—surpass their non-veteran community counterparts.

Risk Factors: Suicide and Military Veterans

- Veterans who have served in Iraq or Afghanistan, who have used VHA health care services, and who have a mental health condition are at increased risk of suicide.
- OIF/OEF Veterans with Major Depression, receiving VHA services, have a 9.1-fold increase risk of suicide, compared to those w/o MDD.
- PTSD alone (without co-existing mental health conditions) does not account for a significant risk in suicide.

Serious Mental Health Treatment,
Research, & Evaluation Center
(9/09)

The controversy: Screening for IPV in health care settings

- Mandatory screening for IPV victimization in primary care and emergency room settings.
- No such mandate for screening for IPV perpetration...is it important?

The Relationships and PTSD Study: Detection of Intimate Partner Violence (Phase 1)

1. Is IPV perpetration being assessed and documented in the veteran's record?
2. If so: Who is assessing? Where are the assessments taking place? When does the assessment occur? And, How is IPV perpetration determined?

The Relationships and PTSD Study: Detection of Intimate Partner Violence (Phase 1)

3. How does health care access differ when IPV perpetration is present and identified?
4. How do health care providers document IPV perpetration?

The Relationships and PTSD Study: Detection of Intimate Partner Violence (Phase 1)

- 10% of male veterans enrolled in treatment at the VA Puget Sound Health Care System (PTSD outpatient clinics, Deployment Health Clinics, Intensive PTSD inpatient, PTSD Domiciliary, and the Tacoma Vets Center)
- n = 507
- 5 – year look-back, reviewing EVERY progress note, from every health care setting (11/1/02 – 11/1/07).

Exemplars

- The following exemplars are based on real-life charting. However, these examples do not reflect any individual veteran or health care provider. Any semblance to an actual chart note reflects the frequency of the life-problem themes that veterans present with in treatment.

Definition of terms:

- No Documentation: No mention of physical violence perpetration towards partner in any of the notes reviewed.
- No IPV: Note clearly states that NO intimate partner violence (IPV) exists (“no DV, admits to yelling, but no hitting”).
- Yes IPV: Note clearly states that IPV perpetration exists (defined as: presence of PO, DV charges, or physical violence or use of object/force with intent to cause bodily harm)

Definition of terms: High Relationship Conflict

- Vague documentation: There were a number of records where ‘high relationship conflict’ was noted, however:
 - Vague re: the details e.g. use of physical force, target of physical force, chain of events
 - Likely IPV was discussed, (based on content of note), but was not documented.

No Documentation Examples

- “HISTORY OF VIOLENCE/ASSAULTING OTHERS/LEGAL PROBLEMS: Denied”

Documentation: No IPV Examples

- “Pt lives with his girlfriend. Reports that he and his girlfriend frequently argue, but denies any DV.”
- “He identifies his mood as depressed, and angry, sometimes anxious. He prefers to be alone and says that he acts in ways to push his family away. He denies any violence towards family members (no physical hands on violence towards his wife or children).”

IPV Documented: Yes IPV Examples

- "History of violence/assaulting others/legal problems: recently arrested for DV and he spent the night in jail. States he cannot remember the incident."
- "Veteran said he hit his last wife when he was drinking..."
- "He is concerned about his recent aggressive behavior with wife....pushed her against the wall with his hands...raised fist as if he were going to hit her...."

High relationship conflict: vague documentation Examples

- "...the first 10 years of my married life I was just brutal to my wife. I see now how badly I treated my kids..."
- "Scheduled to return in two weeks. He is to tell his partner it is not okay for her to hit him or him to hit her."

Phase 1 Findings: Was IPV perpetration assessed and documented? n = 507 (single coding)

NO Documentation	■ n = 363	■% of 507=71%
Vague doc	■ n = 24	■% of 507=5%
YES (n = 120) Documentation	24% of total: % of Yes doc	
■No IPV = 47	■ 10 % No IPV	■39 %
■Yes IPV = 73	■ 14% Yes IPV	■61 %

Phase 1 Findings: If yes, how determined? n = 120

How Determined?	Total	%
■ Provider inquiry	■ 54	■ 45%
■ Self disclosed <small>(due to legal reasons)</small>	■ 16	■ 13%
■ Third party <small>(from PES & victim)</small>	■ 9	■ 8%
■ Unclear	■ 41	■ 34%

Phase 1 Findings: If yes, When was it assessed? n = 120

When Determined?	Total	%
■ Initial appointment	■ 85	■ 71%
■ Ongoing appointment	■ 35	■ 29%

Phase 1 Findings: Who assessed and documented? n = 120

Who assessed and documented?	Total	%
■ MH Counselors	■ 46	■ 38%
■ MD	■ 22	■ 18%
■ APNs & PAs	■ 18	■ 15%
■ RN	■ 16	■ 13%
■ PhD	■ 14	■ 12%
■ Health Tech	■ 3	■ 2%
■ Other	■ 1	■ 1%

Phase 1 Findings: Where was the assessment conducted?

n = 120

Where determined?	Total	%
■ Outpatient Mental Health	■ 87	■ 72%
■ Inpatient Mental Health	■ 22	■ 18%
■ Other (dental, specialty clinics)	■ 8	■ 7%
■ Outpatient medical (primary care, urgent care)	■ 2	■ 2%
■ Inpatient medical	■ 1	■ 1%

Phase 1 Findings: Does health care access differ when IPV perpetration has been identified?

- YES:
 - There is a significant difference in health care access between the “no documentation group” compared to the “yes IPV perpetration and high relationship conflict (vague doc)” groups (ANOVA, $F = 8.529$, $p = .000$, $n = 408$).
 - Veterans where IPV had been documented, and veterans where high relationship conflict had been documented were accessing the health care system at twice the rate compared to veterans with no doc.

Phase 1 Findings: Multiple IPV entries

- n = 213
- Compares to single entries:
 - “Self-disclosure” of IPV perpetration increased ($n = 59$, 28%), compared to 13%.
 - Identification of IPV on a “follow up” appointment increased ($n = 85$, 40%), compared to 29%.
 - Over-all identification in both inpatient and outpatient MH settings increased. Inpatient MH increased ($n = 56$, 26%), compared to 18%.
 - Documentation by physicians increased ($n = 51$, 24%), compared to 18%.

Phase 1 Findings: “Vague” and IPV documentation

- n = 254
- The general picture of documentation across settings and providers has little variation when comparing IPV documentation to IPV documentation AND the vague documentation.
 - That is: everyone in every setting was just as likely to have “vague” documentation as well as documenting the presence of IPV perpetration.

How do multiple screens impact IPV documentation?

- By examining the records of veterans where multiple assessments were documented, it was clear that once an IPV assessment had been documented, it created a ripple effect across the medical center (all health care settings), resulting in multiple assessments, and increasing the likelihood of IPV perpetration being identified and documented (Spearman’s $\rho = .611$, $p = .000$)

How do multiple screens impact IPV documentation?

- 61 records had multiple lines of coding:
 - 10 veterans: at re-assessment their documentation went from “vague” (high relationship conflict) to “yes IPV perpetration.”
 - 5 veterans, records had been coded both “vague” (high relationship conflict) and “no IPV”.
 - 7 veterans, records had been coded both “no IPV” and “yes IPV.”

Implications for interventions:

- Do you know if there is intimate partner violence in the relationship?
- Do you know if your patient is a victim or a perpetrator of IPV?
- Do you know if your patient has suicidal thoughts and intent?
- Do you know if your patient has thoughts or intent to harm his/her partner?

Missed opportunities to assess:

- Do you know if there is intimate partner violence in the relationship?
 - "He states that he lost his first wife due to his violence and anger and irritability and by pushing them away."
 - "His stormy marriage has again resulted in a separation with his wife. He is concerned it may end in divorce as the previous marriages."
 - "Veteran's wife called today and reported that she does not want him to come home from the hospital, ...and is afraid of him."

Do you know if there is intimate partner violence in the relationship?

- ASK:
 - "You mentioned that your stormy marriage has resulted in a separation from your wife..."
 - "Has the fighting ever become physical between you and your wife?..." "Have you ever physically fought with her...any "hands on" fighting?..." "Or have you acted in a way that made her feel ashamed or afraid?"

Missed opportunities to assess:

- Do you know if your patient is a victim or a perpetrator of IPV?
 - "The veteran described how symptoms were particularly bad during his marriage to his first wife. He recounted an event in which his wife physically attacked him with a broken bottle during a heated argument."

Do you know if your patient is a victim or a perpetrator of IPV?

- ASK:
 - "You've told me that your wife attacked you with a broken bottle...Have you ever physically fought with her...any "hands on" fighting?..." "Or have you acted in a way that made her feel ashamed or afraid?"
 - Go for examples/details: most recent, most violent (any injuries of either parties), any others that stand out.

Missed opportunities to assess:

- Do you know if your patient is a victim or a perpetrator of IPV?
 - History of violence (intake template): DV—states he is the recipient of physical abuse, but he is verbally abusive, history of throwing things and fights."

Do you know if your patient is a victim or a perpetrator of IPV?

- ASK:
 - "You've told me that you and your wife fight, and sometimes it has gotten physical....Can you describe one of your worse fights for me?"
 - Listen for both victimization and perpetration.
 - "You've told me that you have become verbally abusive to your wife. Have you ever physically assaulted her?"

Missed opportunities to assess:

- Do you know if your patient has suicidal thoughts and intent?
 - "Veteran reports that he is over-whelmed with everything...Can't pay his bills, his wife is "nagging at him", he wishes everyone would "just shut up"...and he would "like to go away."

Do you know if your patient has suicidal thoughts and intent?

- ASK:
 - "You talk about being over-whelmed...do you ever think about hurting or killing yourself?"
 - "How?"
 - "Do you have a _____?" (gun, knife, pills, etc)
 - "Have you ever tried before?"
 - "Do you intend to do so?" (now or in the future)

Missed opportunities to assess:

- Do you know if your patient has thoughts or intent to harm his/her partner?
 - "...thoughts of harming wife, visual hallucinations or "waking nightmare" of harming wife."
 - "Patient reports that he has command hallucinations of bashing her head in."

Do you know if your patient has thoughts or intent to harm his/her partner?

- ASK:
 - "You mentioned that you have thoughts about harming your wife..."
 - "...in what way have you thought of harming her?"
 - "...do you have the _____ to do so?"
 - "...when did you last think of doing so?"
 - "...have you ever done this in the past?"
 - "...do you intend to do _____?" (now or in the future)

When the Situation is Dangerous:

INTERVENE



- When the patient is suicidal:
 - Assess further for homicidal thinking (see previous slides)
 - May require Tarosoff if homicidal
 - May require detaining the patient
 - May require hospitalization of the patient (voluntary or involuntary)

Determine Motivation for Changing Behaviors: ASK

- Sample script:
 - *"I'm concerned about the health and safety of your family and you..."*
 - *"You don't have to treat your partner like this..."*
 - *"It is driving your partner and family further from you..."*
 - *"There is help available. Would you like help?"*

Providing Education: INTERVENE

- Provide education:
 - "Violence against family members is against the law...anyone, including non-family members may call the police...you may be arrested."
- These behaviors are hard on your health...(give examples e.g. heart, blood pressure, anxiety)
- Referrals:
 - *"You don't have to treat your family like this, there is help available...Would you like information on where you could get some help?"*

Take home points:

- There is evidence that patients access the health care system at a significantly higher rate when IPV is present.
- Our patients provide us with numerous opportunities to assess for violence and abuse in the home.
- Despite these opportunities, we fail to ask a few more questions to help determine if there is IPV, and if there are factors that affect dangerousness (e.g. suicide/homicide).
- We fail to provide patients with critical information on how their IPV affects their health and the health of others, and fail to provide critical information (legal and resource).

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

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