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Military veteran perpetrators of intimate partner violence: Challenges and barriers to coordinated intervention

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ABSTRACT

Intimate partner violence (IPV) is a significant concern among recently returning Veterans. In this paper, we discuss the etiology of IPV in this population and the intersections between Veteran healthcare and criminal justice system policies regarding Veteran IPV. We describe the current socio-political context in which clinical interventions and criminal justice diversion policies and pilot programs are emerging. Challenges to coordinating prevention and intervention across Veteran healthcare and criminal justice systems are discussed and highlighted via material on a Veteran-specific IPV intervention, and we discuss strategies for overcoming coordination challenges as well as areas for further innovation.

Contents

1. Introduction

Since 2001, men and women in the United States Armed Forces have been deployed in unprecedented frequencies and duration (Hosek, Kavanagh, & Miller, 2006; MacGregor, Han, Dougherty, & Galameau, 2012). These deployments put significant stress on the service member, family, and community, and place the Veteran at high risk for experiencing intimate relationship problems, including intimate partner violence (IPV) (Finley, Baker, Pugh, & Peterson, 2010; Jakupcak et al., 2007). Data from representative samples suggest that military populations report higher rates of IPV than their civilian peers even when controlling for age and race (Heyman & Neidig, 1991). Additionally, the Battered Women's Justice Project reports that military-related calls into the National Domestic Violence hotline increased from 457 in 2006 to over 1100 in 2010, and 61% of these calls reported physical abuse (Battered Women's Justice Project, 2011, August 22), suggesting that the IPV problem may be worsening in this population. IPV negatively impacts the military family in a myriad of ways including increased mental health problems, somatic symptoms, and physical injury in abused spouses, as well as lower parenting satisfaction (Marshall, Panuzio, & Taft, 2005). Additionally, children in military families exposed to IPV may exhibit increased behavior problems in school or social situations, inappropriate aggressive behavior, lower academic performance, and a higher propensity to engage in violence in their own adult relationships (Marshall et al., 2005; Murrell, Kristoff, & Henning, 2001; Street, King, King, & Riggs, 2003). From a military perspective, family conflict is also associated with higher health-care service utilization, lower military morale, poorer job performance, and increased mission safety risk (Fontana & Rosenheck, 2010; Kelley

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et al., 2002; Raschmann, Patterson, & Schofield, 1990; Segal, Rohall, Jones, & Manos, 1999).

Considering the far-ranging deleterious impacts of IPV, it is critical to identify the intervention needs of this population and to develop effective interventions to meet those needs. It is also essential to have effective coordination across the multiple relevant systems to ensure that appropriate care is provided. Thus, the purpose of this paper is to explore the connections between Veteran healthcare and criminal justice system policies in relation to the assessment and treatment of Veteran IPV, and to discuss barriers to effective coordinated intervention as well as strategies to overcome such barriers. We focus on National Guard and Reserve as well as Veterans discharged from military service, as Active Duty initiatives responding to IPV are beyond the scope of this paper. We begin by outlining etiological factors that may underlie Veteran IPV perpetration, and describe the current context of civilian IPV interventions in which Veteran-specific interventions are developing. We then cover a range of challenges in identifying male Veteran perpetrators of IPV in criminal justice system and healthcare settings as well as coordinating intervention across these systems. Next, we highlight state and federal innovations aimed at addressing these challenges related to Veteran IPV intervention. We then illustrate a number of specific strategies for overcoming barriers in effectively coordinating IPV intervention by discussing our own work the development and implementation of a service member and Veteran-specific IPV intervention. Finally, we discuss areas for further enhancement in the areas of Veteran IPV coordination, intervention, and research.

2. Etiological factors in military-related IPV

Military occupational stress is significantly different from civilian occupational stress. This difference is amplified in the context of the current wars in Iraq and Afghanistan, with stressors stemming from multiple deployments and mission ambiguity (Campbell & Nobel, 2009). Thus, the nature of military stress and training poses a unique challenge to developing and coordinating intervention with military perpetrators of IPV. While clear rules on the "escalation of force" are taught, guiding service members to use only level of force that is necessary to subdue a threat and ensure survival (United States, Army Field Manual 3–21.12, 2008), this population has nonetheless been trained to engage in mission-driven violence over the course of multiple combat deployments (Reger, Gahm, Swanson, & Duma, 2009). This sets this population apart from civilian populations in which the behavioral and psychological skills to engage in and instantaneously respond to violence are not taught systematically. Additionally, during military training, recruits are drilled physically, technically, and psychologically so that they can operate under a new set of norms, both emotional and physical, including hypervigilance to perceived threats and emotional distancing, with the ultimate goal of battle-preparedness (Grossman, 1995). Under these circumstances, service members learn new ways of responding to perceived threats of violence and/or hostility.

There is also a range of service-related risk factors that may increase risk for perpetrating or experiencing aggression and IPV. For example, the research literature demonstrates that the presence of combat-related posttraumatic stress disorder (PTSD) places a Veteran at a substantially higher risk for experiencing relationship conflict and for perpetrating physical and psychological IPV, and higher PTSD severity is associated with more severe IPV perpetration (Taft, Stafford, Watkins, & Street, 2011). Research among nationally representative surveys of Vietnam Veterans (Jordan et al., 1992) indicates that the prevalence rate of IPV perpetration among Veterans with PTSD is approximately three times the rate of those without PTSD (Marshall et al., 2005).

Researchers have suggested that PTSD may lead to aggressive behavior due to information processing difficulties (Taft et al., 2011). Chemtob, Novaco, Hamada, and Gross (1997), Chemtob, Novaco, Hamada, Gross, and Smith (1997), and also Novaco and Chemtob (2002) conceptualized problems with aggression among combat Veterans with PTSD as occurring due to Veterans entering into a "survival mode" of functioning. They posited that combat Veterans with PTSD are more likely to perceive threats in their environment due to their prior combat experience. This occurs even in contexts in which there is an absence of realistic threat. In response to these perceived threats, the Veteran experiencing PTSD symptoms is more likely to employ an overly hostile interpretation of events, an inclination towards confirming a potential threat, and a lower threshold for responding to the threat. Once Veterans enter into survival mode, these processes override adaptive social information processing, including the ability to engage in self-monitoring to lower the risk for aggressive reactions.

A number of other difficulties may result from deployment or develop independently and increase risk for IPV, such as depression, substance use problems, and traumatic brain injury (TBI). Each of these problems can have a negative impact on information processing, and each has been associated with the perpetration of IPV in previous research (see Heyman, Taft, Howard, Macdonald, & Collins, 2012). It is rare that Veterans who engage in IPV report a singular risk factor. In our own work, we have found increased violence risk among those with antisocial personality characteristics who experience a traumatic brain injury (Taft et al., 2012), and have shown that among those with PTSD, comorbid drug use problems and depression increase violence risk in a multiplicative fashion (Taft et al., 2005). Others have shown that among those with PTSD, TBI (Elbogen, Beckham, Butterfield, Swartz, & Swanson, 2008) and alcohol use problems (Zoricic, Karlovic, Buljan, & Marusic, 2003) potentiate or increase violence risk. Beyond psychiatric IPV risk factors, returning Veterans experience changes in the ways in which they view the world after being exposed to extreme stress, combat, and possible war-related atrocities, including difficulties with respect to trusting others, developing closeness and intimacy, and struggles with power and control (Taft et al., 2011).

3. Current context of IPV perpetrator interventions

Given that over two million Veterans have been deployed in support of missions in Iraq and Afghanistan, and are disproportionally making contact with the criminal justice system compared with civilian peers (Elbogen et al. 2012), it is important to contextualize interventions for Veteran IPV within the larger civilian community IPV response system. Firstly, the systemic response to victims involves essential collaboration between mental health services, social work services, legal services, and case management (Goodman & Epstein, 2011). It is understood that effectively responding to victim's needs requires interdisciplinary effort in the multiple domains of their lives in order to support recovery and promote safety. The civilian response to perpetrators of IPV is often less interdisciplinary. It typically involves a short period of incarceration followed by mandated intervention and sustained legal supervision, often with probation. While less research has focused on evaluating coordinated responses to civilian perpetrators of IPV, Murphy, Musser, and Maton (1998) found that lower recidivism was associated with the cumulative and coordinated work of multiple systems including the court and prosecution system, probation oversight, as well as counseling intake, consistent attendance of counseling, and completion of counseling program in a civilian sample of IPV perpetrators.

Also central to the context of civilian IPV intervention are state intervention standards. Currently 45 states have mandated intervention standards, most following the "Duluth model" that uses a psychoeducational framework incorporating feminist theory on gender (Pence & Paymar, 1993). Such IPV intervention guidelines have been challenged on a number of ethical and practical grounds, perhaps the most important of which is that they are not based on scientific evidence for effective intervention (Dutton & Corvo, 2006; Rosenbaum, 2010) and they may promote overly confrontational intervention tactics (Rosenbaum, 2010). Additionally, the "fit" of such state guidelines may be particularly poor for military Veterans experiencing traumatic