

RESEARCH

Unintended Consequences: Intimate Partner Violence, Military Caregivers, and the Law

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Of the millions of caregivers to injured, ill, or disabled United States military veterans, many are spouses or intimate partners. These individuals must negotiate their responsibilities as caregivers with their roles as intimate partners, but not all relationships are healthy and safe. Accurate rates of intimate partner violence (IPV) against military caregivers by their veterans is difficult to determine, but it does happen. As with civilian populations, spouses of military veterans may be hesitant to leave abusive relationships because of the risks of losing access to medical and mental health care, housing, financial stability, and a cohesive family unit. Moreover, spousal caregivers who are legally obligated to their care recipients may be further deterred from leaving abusive households because of elder abuse laws enacted in many states. Such laws render caregivers vulnerable to felony neglect or abandonment charges. This article reviews current research and policy regarding IPV and discusses its impacts on spousal caregivers of military veterans by describing military caregivers as an important subpopulation; synthesizing key research on IPV in military, caregiving, and military caregiver communities; explaining how state elder abuse statutes generate unintended consequences for these caregivers; and offering recommendations to keep veterans and their caregivers safe.

Keywords: caregivers; spousal caregivers; intimate partner violence; domestic violence; abuse; statutes; law; legal

According to the first and most comprehensive examination of American military caregivers conducted by the RAND Corporation on behalf of the Elizabeth Dole Foundation, nearly 5.5 million people provide caregiving services to current and former military servicemembers (Ramchand et al., 2014). Nearly a third of these are spouses to their veteran care recipients, and they face additional complexities in their roles as caregivers. Their roles as marriage partners shift as do the relationships with their care recipients who have undergone changes, often sudden and unexpected, because of their military service. Intimate partner violence (IPV) is a serious public health concern that affects active duty military and veteran couples just as frequently as civilian couples (Marshall, Panuzio, & Taft, 2005). Identifying, reporting, and addressing IPV in military caregiving relationships is challenging for both marital partners. For military caregivers, escaping IPV is fraught with personal, financial, and legal challenges. For military spouses whose caregiving responsibilities have been cemented legally, through powers of attorney or through state or federal agencies including the Veterans

Health Administration (VA) or United States Social Security Administration, escaping intimate partner violence becomes especially problematic thanks to unintended consequences imposed through elder abuse laws in place in nearly every state. This article provides one response to Isham, Hewison, and Bradbury-Jones' (2019) call to "explore in greater detail how aspects of current legal, medical, and social practice are (unintentionally) creating the circumstances in which the issue [of violence against family caregivers] is hidden from view" by providing a literature review of current research and policy regarding IPV and its impacts on spousal caregivers of military veterans (p. 633). To do so, it begins by providing basic descriptive details about military caregivers generally and spousal caregivers specifically. Then, key research about IPV within military populations, in caregiving relationships, and in military caregiver relationships is summarized. Next, the article outlines statutes in place across several states that generate undue hardship for military caregivers experiencing IPV. Finally, it concludes by proposing some recommendations for addressing these complex cases.

Military Caregivers in the United States

Deciding who counts as a military caregiver depends on the criteria applied, so this review adopts the most encompassing definition provided by the RAND Corporation in its 2013 report.

A military caregiver is a family member, friend, or other acquaintance who provides a broad range of care and assistance for, or manages the care of, a current or former military service member with a disabling injury or illness (physical or mental) that was incurred during military service. (Tanielian et al., 2013, p. 3)

The type of support caregivers provide is divided into two categories: activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include bathing, dressing, feeding, toileting, or using a wheelchair while IADLs include issuing medications or medication reminders, medication refills, managing finances, attending medical appointments, preparing meals, providing transportation, and/or coordinating physical and/or mental health treatments and services (Ramchand et al., 2014, p. 54). Caregiver duties vary from veteran to veteran, each a unique combination of the physical, socioemotional, and/or psychological needs that reflect the diverse and lasting effects of military service on the human body and psyche.

Military caregivers are impacted personally, professionally, financially, emotionally, physically, and psychologically by the caregiving experience – especially when those experiences last years, even decades (Ramchand et al., 2014, p. 114). As a result of their caregiving experiences, most military caregivers become experts in navigating the Veterans Health Administration system (VA), military benefits, and nonprofit or community resources; develop incredible resilience, persistence, and patience as they advocate for their veteran and for themselves; and learn how to network online and in person with other caregivers to find answers and ideas, share information and experiences, and develop coping mechanisms to fight caregiver fatigue. Regardless of their relationship to the veteran, military caregivers face a variety of personal and collective challenges based on their shifting roles that can impact the unit's social dynamics. Parental caregivers may need to shift their roles in the workforce or halt retirement plans to reassume caregiving duties to adult children. Similarly, children of disabled veterans may need to leave the workforce earlier than expected, move or renovate housing, and adjust their own immediate family responsibilities around those of their veteran parent.

Quite frequently, military caregivers are the married or intimate partners of the veterans for whom they care. Of the estimated number of military caregivers to post-9/11 veterans,¹ 33.2% are spouses, and of pre-9/11 caregivers, 22.3% are spouses (Ramchand et al., 2014, p. 33). Like military caregivers of all relationship types, spouses experience changes as a result of assuming the role of caregiver. They may need to change jobs, reduce their work hours, or

leave the workforce entirely. They may have to surrender some autonomy in their lives as they attend to their caregivers' medical needs. They may have to move to be closer to medical treatment facilities or to supportive family. More uniquely, roles within the marital relationship are often modified, impacting the degree to which marital tasks, such as parenting, housework, maintenance of the primary residence, errands, and/or generating income, are shared.

One important, but often neglected, area of research and education specific to spousal caregivers and their veteran care recipients is intimacy. Passion, compassion, sex, and the interpersonal connection between spouses now must be negotiated within a new caregiver-care-recipient dyad. "As the dynamic of the relationship changes the instant the disabled veteran returns home, it is not uncommon for the love in the primary relationship to shift or wane as the partner of the soldier takes on the concurrent role of caregiver" (Satcher et al., 2012, p. 9). The caregiver may feel a sense of loss or resentment for a partner who may not be able to maintain the type of relationship they once enjoyed with their veteran while the veteran may feel a sense of burden to or emotional distance from a spouse who now takes on a caregiving role. Additionally, some injuries and illnesses contribute to shifts in the veteran's behaviors, cognition, or temperament that can further disquiet marital intimacy. For example, symptoms deriving from diagnoses like Posttraumatic Stress Disorder (PTSD), traumatic brain injury (TBI), substance use disorder (SUD), and depression can make it difficult for veteran couples to work with one another in deliberate, constructive, and thoughtful ways as they navigate the transformations they are undergoing as individuals and as a couple. The context and characteristics of these transformations are critical to both the veteran and the spousal caregiver. "Healthy intimate relationships can contribute to a person's recovery from physical and mental trauma, while a lack of them can contribute to ongoing mental health problems and even suicide" (Satcher et al., 2012, p. 6–7). Exploring ways to build and maintain healthy intimacy is a significant issue in spousal or intimate partner caregiving relationships, and this exploration must include understanding the potential for intimate partner violence.

IPV in Military and Veteran Populations

Intimate partner violence (IPV) is a serious public health concern affecting active duty military and veteran couples just as frequently as those without military affiliation (Marshall, Panuzio, & Taft, 2005). Definitions for IPV vary, but this document adopts a definition by Breiding, Basile, Smith, Black, and Mahendra (2015) which defines IPV as "psychological, physical, sexual violence, or stalking by a current or former intimate partner." *Intimate partners* can be married or dating partners of a perpetrator engaged in short-term or long-term heterosexual or same-sex relationships. Therefore, not all intimate partners are spouses to their perpetrators. This distinction is significant, because in military relationships, marriage provides access to certain

benefits while also enforcing (explicitly and implicitly) particular restrictions on both marital partners. For example, individuals married to a military servicemember, frequently referred to as *dependents*, usually have access to health-care, housing, and education benefits. On the other hand, dependents are expected to relocate with their military spouses, endure stressors of the military profession (e.g., deployments, training schedules), and aid in their servicemembers' success by maintaining the respect and dignity required of the United States military family. Unmarried intimate partners of servicemembers lack the security of marital benefits, but, depending on their partner's perspective, may be expected to act and think like a dependent.

Like IPV occurrence in civilian communities, accurate statistics of intimate partner violence in military communities are challenging to ascertain.² Not all incidents are reported to hospital personnel, personal health providers, law enforcement, or social services. Marshall et al.'s (2005) literature review of 48 studies on IPV within military and veteran populations produced an occurrence frequency at a wide range of between 13.5% and 58% (p. 864). Even though most military samples tend to contain an overrepresentation of perpetrators with PTSD diagnoses, removing these diagnoses still puts military families at a higher risk for IPV and domestic violence (DV) than civilian families (Blow, Curtis, Wittenborn, & Gorman, 2015; Jones, 2012; Marchiondo, 2015; Marshall et al., 2005). While underreporting is an issue in cases of IPV regardless of military affiliation, it is especially difficult to determine among active duty and veteran military populations because of additional factors that dissuade victims from reporting. These factors are often related to financial and health-related dependence upon the servicemember or veteran, the servicemember's military reputation and/or command structure, as well as reporting requirements within the Department of Defense (DoD).

Systematic conditions previously existed that posed additional barriers to reporting domestic violence and intimate partner violence within active duty military couples. The Uniform Code of Military Justice (UCMJ) did not recognize domestic violence as its own crime within the United States military until recently. In 2018, the UCMJ "was formally amended to include domestic violence as a distinct and recognized offense" (San Diego Military Defense Attorneys, 2019). Article 128 now outlines assault against a spouse or intimate partner as a separate offense (Joint Service Committee, 2019). Additionally, mandatory reporting requirements within many of the service branches have changed within the last decade:

In 2006, the DoD [Department of Defense] changed its reporting requirements for domestic violence to allow restricted and unrestricted reports for adult victims of abuse. Restricted reports allow victims to report an incident and obtain health care, behavioral health care, and victim advocacy services through the

FAP without initiating an investigative or legal process. In its explanation of the policy change, the DoD stated that 'a requirement that all domestic abuse incidents be reported can represent a barrier for victims hoping to gain access to medical and victim advocacy services without command or law enforcement involvement'. (Lutgendorf et al., 2012, p. 702)

Lutgendorf et al. (2012) investigated the impact of the removal of mandatory reporting for domestic violence to the U.S. Navy's Family Advocacy Program (FAP) on reporting of domestic violence incidents and found the number of DV/IPV reports have decreased over time. Despite changes to mandatory reporting requirements that should provide greater access to reporting relationship violence, concerns about report confidentiality and an increased risk of further violence still exist – especially for women service members (Lutgendorf et al., 2012, p. 704).

Women are also the subject of IPV research in veterans studies. Among the populations of women receiving care through the VHA, intimate partner violence seems to occur at greater frequency for female civilian partners of male veterans. Using retrospective chart review, Dichter et al. (2017, 2018) examined IPV exposure in a sample of nearly 9,000 female VHA patients between 2014 and 2016. Of the total female patients screened, 8.7% scored positive for IPV in the past year (Dichter et al., 2017, p. 764). And while fewer than 6% of the population were civilians, these women reported positive for IPV occurrence at a frequency of 14% in comparison to 8.4% of women veterans (Dichter et al., 2017, p. 764). Researchers who study IPV occurrence between veteran perpetrators and civilian partners are at a distinct disadvantage, because many civilian intimate partners of veterans are not eligible for healthcare services through the VHA or may have their own healthcare options. Without more comprehensive access to these civilian women, screening and tracking IPV perpetration by male veterans continues to be difficult.

Another difficulty in screening and tracking IPV within veteran couples (veteran perpetrators and their intimate partners) develops at the outset of initial IPV reporting to the VHA. To help combat the propensity for underreporting, medical professionals often collect reports from both members of the couple; however, each member's report does not always agree with the other. LaMotte, Taft, Reardon, and Miller (2014) conducted a study with 239 couples from the Boston and New Mexico VA Healthcare systems. Their sample included a diverse representation of service eras and ethnicities, but 93.7% of the population was male veterans with female civilian partners (p. 1370). They discovered disagreement in the intimate partner aggression (IPA) reporting among each partner in the couples, with higher rates of disagreement in instances of physical IPA (LaMotte, 2014, p. 1371). LaMotte et al. (2014) suggested one reason for a lower percentage of partner-reported physical IPA is "that the partners, who were perhaps less familiar with the VA and its policies, refrained from reporting IPA because they

were concerned about potential harmful consequences of such reports on the veterans' military career, VA healthcare, or military reputation" (p. 1372). They attribute lower rates of perpetrator-reported physical IPA to a finding consistent with other IPV literature (military affiliation notwithstanding): perceived relationship satisfaction. That is, perpetrators who reported higher positive feelings about their relationships tended to under-report their perpetration of IPA (LaMotte et al., 2014, p. 1373).

In both active duty and veteran relationships, the hesitancy to report IPV seems to coincide with reporting reluctance in civilians (e.g., confidentiality, financial risks, risks for another occurrence) while also taking on distinctive reasons related to current or prior military service (e.g., access to benefits for both the veteran and partner, risk to career or professional reputation). While much of the research related to IPV perpetration and reporting in military and veteran couples focuses on male veteran perpetrators against female civilian partners, some important studies have examined IPV with women veterans and veterans in same-sex relationships exclusively.

Women Veterans

Research with intimate partner violence perpetrated against women veterans has identified risk factors both inclusive and exclusive to their military affiliation. In comparison to nonveteran women, women veterans are at a higher risk of experiencing lifetime IPV (33% of women veterans in comparison to 23.8% civilian women) according to Dichter et al. (2011). Iverson et al. (2013) have reported at least 25% of partnered women veterans receiving VA care reported past-year physical, sexual, or psychological IPV. Iverson et al. (2013) also found that women veterans with a history of childhood sexual abuse were at a higher risk of past-year IPV than women without such a history (p. 770). Additionally, women veterans who experienced unwanted sexual experiences during their military service had double the risk of past-year IPV occurrence (p. 770). Iverson et al. (2013) have explained that these risk factors may indicate that women veterans who experienced trauma developed PTSD or PTSD-like responses to later violence that then interfered with their abilities to detect and respond to IPV. Dichter et al.'s (2017) study included 8,422 women veteran patients within the VHA system. Among their sample, higher IPV-positive scores were recorded for patients 35 years or younger (10.5%), married women, those who served in the most recent conflict era, and those who had experienced sexual assault or harassment during their military service (Dichter et al., 2017, p. 764).

Same-Sex Relationships

In comparison to research concerning intimate partner violence within heterosexual couples, a much smaller amount of data is available concerning IPV perpetration and risk factors for same-sex relationships or for people who identify as lesbian, gay, bisexual, transgender, or ques-

tioning (LGBTQ). In non-military populations, Gabbay and Lafontaine (2017) summarized "that rates of heterosexual and same sex intimate partner violence are comparable" (p. 291). Among military-affiliated LGBTQ populations, Dardis, Shipherd, and Iverson (2017) looked at IPV among women veterans who self-identify as lesbian, bisexual, and questioning (LBQ) by examining the relationship between sexual orientation status and current IPV-related PTSD symptoms. In their unadjusted models, they found, "LBQ-identified women were significantly more likely to experience lifetime fear of partners, lifetime sexual IPV, lifetime physical IPV, and lifetime intimate partner stalking than were heterosexual-identified women veterans" (Dardis et al., 2017, p. 781). Even after adjusting for age, LBQ-identified women veterans in their study reported higher rates of emotional mistreatment, sexual IPV, and physical IPV within the year prior to completing the survey in comparison to heterosexual-identified women veterans (p. 783). It is worthwhile to note a significant absence of studies examining same-sex intimate partner violence among military-affiliated men who identify as gay, bisexual, or questioning.

Additional Risk Factors for Veteran-Perpetrated IPV

Among the literature related to IPV perpetration of veterans against spouses or intimate partners, researchers have identified several additional risk factors that exacerbate its potential, including diagnoses of PTSD, depression, SUD as well as a history of IPV perpetration prior to military service (Finley, Baker, Pugh, & Peterson, 2010; Marshall et al., 2005; Teten et al., 2010). Additionally, but far less studied, is the frequency of TBI diagnoses in IPV perpetrators; however, some existing research in, and related to, brain injuries and neurodegenerative conditions also suggests an additional risk factor of which we should be aware. While military caregivers assist veterans with a variety of injuries and illnesses, PTSD, SUD, and TBI are prevalent among them – especially within veterans of the conflicts in Iraq and Afghanistan. Of post-9/11 veteran care recipients, 52% have been diagnosed with PTSD, 45.7% have been diagnosed with major depressive disorder, 15.4% with substance use disorder, and 20.3% with Traumatic Brain Injury (Ramchand et al., 2014, p. 48). This review will focus on PTSD and TBI, as a closer look at what we know about the connection between these conditions, their comorbidities, and IPV risk is important.

Posttraumatic Stress Disorder (PTSD)

Since its introduction to the mental health community as "shell shock" during World War I (see Crocq & Crocq, 2000 and Jones & Wessely, 2005 for thorough historical overviews), Posttraumatic Stress Disorder (PTSD) has yielded an abundance of research with military servicemembers and veterans globally. In the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), Posttraumatic Stress Disorder (PTSD) is categorized as a psychiatric

disorder triggered by exposure (direct or indirect) to “actual or threatened death, serious injury or sexual violation” (APA, 2019). The symptoms of PTSD range and vary from veteran to veteran, but classically, veterans with chronic PTSD must have at least one *re-experiencing* symptom and one *avoidance* symptom as well as at least two *arousal and reactivity* symptoms and at least two *cognition and mood* symptoms (NIMH, 2019). *Re-experiencing* symptoms include nightmares, flashbacks, or frightening thoughts, and *avoidance* symptoms include staying away from potential triggers as well as “avoiding thoughts or feelings related to the traumatic event” (NIMH, 2019, n.p.). “Triggers” can be related or unrelated to the initial trauma; veterans with PTSD might respond to sights, smells, sounds, feelings, or situations that can cause *arousal and reactivity* symptoms like heightened anxiety, feelings of helplessness, irritability, fear, and anger. Finally, PTSD also has an impact on *cognition and mood* in many ways that mirror depression (loss of interest; negative feelings of self or the world; distortive feelings of guilt or blame) as well as traumatic brain injury (memory difficulties, especially about the traumatic event).

Investigations into the relationship between PTSD and IPV perpetration and victimization have yielded consistent results across military and civilian populations (Hahn, Aldarondo, Silverman, McCormick, & Koenen, 2015). In short, individuals diagnosed with PTSD are more likely to perpetrate IPV against their partners and are more likely to be victims of IPV (Farrer et al., 2012; Finley et al., 2010; Hahn et al., 2015; Marshall et al., 2005; Teten et al., 2010). Citing studies by Byrne and Riggs (1996), Sherman et al. (2006), and Taft et al. (2005), Finley et al. (2010) summarized, “Veterans with PTSD have consistently been found to perpetuate more frequent and more severe IPV, at rates approaching 2–3 times the national average” (p. 738). PTSD does not manifest in the same way for every veteran, so Finley et al. (2017) wanted to better understand how IPV was experienced by PTSD-diagnosed veterans and their partners. Finley et al. (2017) conducted a mixed-methods study which included interviews with 19 male OEF/OIF veterans and 11 spouses; 16 of the veterans in the sample had PTSD diagnoses (p. 739). Of the total 30 transcripts, six veterans and five current or former spouses referenced occurrences of IPV (p. 739). From the contexts and descriptions of IPV occurrence, Finley et al. (2017) identified three types of IPV: violence in anger, dissociative violence, and parasomniac or hypnopompic violence (p. 739–40). “These case studies suggest there may be distinct patterns of violence committed by PTSD-diagnosed Veterans within the home, perhaps occurring in relation to recognized symptoms of the disorder, specifically amplified anger, dissociation or flashback, and sleep disturbance” (Finley et al., 2017, p. 740). The inclusion of the veterans’ partners in this study is critical, as the explanations these current and former spouses provide brings the context of IPV into the conversation as they interpret it through the PTSD diagnosis.

In the literature, the influence of service era on the connections between PTSD and IPV perpetration is inconsistent.

Teten et al. (2010) conducted a study with 94 male veterans from two prominent service eras, OEF/OIF and Vietnam, only some of whom were diagnosed with PTSD (61.7%) to explore connections among intimate partner aggression (IPA), service era, and PTSD (p. 1618). They found, “OEF/OIF veterans with PTSD were significantly more likely to report psychologically abusing their partner than OEF/OIF veterans without PTSD” (p. 1620). This finding correlates with LaMotte et al. (2014) who determined veterans with “higher PTSD symptom severity” reported their perpetration of physical IPA at lower frequency (p. 1372). Typically, violence perpetration declines with age, so we might expect to see fewer instances of self-reported IPV reported within older veteran couples. However, in their sample which included Vietnam veterans, Teten et al. (2010) determined IPV instances were comparable across service eras. Therefore, “PTSD may heighten risk for partner aggression perpetuation acutely, and if not successfully treated, may also prevent expected age-related declines in this behavior” (Teten et al., 2010, p. 1624). Spousal caregivers to veterans whose PTSD severity and/or aggression does not decline with age are at a corresponding increase risk for long-term mental health complications. In a study with Vietnam veterans and their caregivers, Calhoun, Beckham, and Bosworth (2002) concluded caregivers whose veteran was diagnosed with PTSD reported higher levels of caregiver burden and poorer psychological adjustment. Thus, the impact of PTSD, even for aging veterans of prior service eras, extends beyond the veterans to their spouses who may already be, or may at some point become, their caregivers.

Traumatic Brain Injury (TBI)

In comparison to that of PTSD, research examining the relationship between traumatic brain injury (TBI) and IPV within military caregiving communities is scant. While PTSD is categorized as a psychiatric disorder, TBI is an injury to the brain caused from a sudden jolt or blow to the head. Such injuries result in short-term effects (such as loss of consciousness and headache) but can also have long-term impairments to memory or concentration; impacts to cognitive functioning; and/or changes in sleep patterns, behaviors, or moods (NINDS, 2019). Research on the prevalence of TBI in IPV often focuses on TBI as a result of IPV in victims rather than TBI or brain injury as a condition of the perpetrator (see, for example, Campbell et al., 2018; Hunnicutt, Murray, Lundgren, Crowe, & Olson, 2019; Iverson, Dardis, & Pogoda, 2017; Smith & Holmes, 2018). Research regarding TBI and violent behavior, a small segment of which is summarized below, helps us understand the association of IPV risk and brain injuries among veterans.

Traumatic brain injury is not an injury exclusive to military servicemembers, so studies concerning brain injuries and intimate partner violence among both populations aid in clarifying this relationship and the potential impact on caregivers. Overall, traumatic brain injury is considered a factor in and risk factor for aggressive and violent behavior,

especially if the injured person did not exhibit these behaviors prior to injury (Bannon, Salis, & O'Leary, 2015). In a meta-analysis of available IPV literature accounting for traumatic brain injury, Farrer et al. (2012) discovered, "Of the total combined sample of 222 IPV offenders, 119 had a history of TBI (53.6%)" (Farrer et al., 2012, p. 79). Therefore, "the prevalence of TBI among perpetrators of IPV is significantly higher than the prevalence of TBI in the general population" (Farrer et al., 2012, p. 80). Williston, Taft, and VanHaasteren (2015) identified TBI as an increased risk factor for IPV perpetration in military servicemembers (p. 56). In their study of 278 veterans with severe mental illness, the additional presence of either PTSD or TBI "more than double[s] the risk of violence" (Elbogen, Beckham, Butterfield, Swartz, & Swanson, 2008, p. 116). Likewise, a study of 520 Vietnam veterans who suffered head injury trauma reported increases in violent behavior almost 15 years after the injury occurrence (Schwab, Grafman, Salazar, & Kraft, 1993). Schwab et al.'s (1993) finding has been supported in nonveteran populations by Farrer et al. (2012) who concluded, "Violence and aggression resulting from a TBI may worsen over time instead of improving" (p. 80). Thus, family caregivers who support veterans with TBI over long periods of time sustain prolonged exposure to symptoms like irritability, anger, unpredictable mood changes, and potentially violent behaviors likely caused by damage to the brain's executive functioning.

Dual Diagnoses

Classifying behaviors accurately and developing effective treatment options for veterans with PTSD or TBI diagnoses who perpetrate IPV is difficult for healthcare providers; when veterans have both PTSD and TBI, these processes are even more challenging. The two diagnoses may manifest in similar behaviors impacting the veteran: "working memory problems, irritability/rage (anger), agitation, aggression, and sleep disturbance" (Tinney & Gerlock, 2014, p. 405). The difficulty in trying to distinguish PTSD- or TBI-generated behaviors from those of IPV impacts spousal caregivers, healthcare providers, and – when legal intervention is necessary – court systems.

As with PTSD, it may be difficult to differentiate between a TBI-related symptom or behavior and an IPV perpetration tactic. [...] 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. (Tinney & Gerlock, 2014, p. 405)

Additionally, as veterans age, IPV risk does not decrease for partners and spouses when those veterans have chronic,

untreated PTSD (Teten et al., 2010) or TBI symptomology (Farrer et al., 2012; Schwab et al., 1993). Partners and spouses of veterans with both diagnoses would likely experience longer-lasting IPV risks as veterans age though this particular research has not yet been conducted. Further, simultaneous diagnoses also create challenges when healthcare providers work to develop treatment plans to address violent behaviors (Teten et al., 2010). While PTSD and TBI are each risk factors that individually increase the potential for IPV perpetration in military and veteran relationships, the two combined exacerbate that potential and further complicate all components in the system of treatment and care.

IPV in Civilian Familial Caregiving Relationships

Research about IPV perpetration by care recipients against their family caregivers in civilian populations is a taboo area of study (Isham et al., 2019; Solomon, Cavanaugh, & Gelles, 2005). Generally, individuals requiring caregivers are vulnerable, elderly, or disabled and are, as a result, a population susceptible to stigmatization (Isham, Hewison, & Bradbury-Jones, 2019; Solomon et al., 2005). By virtue of needing a caregiver, these care recipients are considered vulnerable, so focusing on them as perpetrators of violence raises questions about the origin, nature, context, and quality of the violence and of their caregiving. Researchers who have explored violence against caregivers have typically examined it within adults with severe mental illness (SMI) as well as elder populations with neurodegenerative diseases like dementia and Alzheimer's. After reviewing the available research, Solomon et al. (2005) concluded, "It appears that a conservative estimate of rates of violence toward family members by a relative with a psychiatric disorder is between 10% and 40% since diagnosis...50% to 65% of these targets are family members" (p. 42–3). Dementia-related violence includes aggressive behaviors (physical or verbal) directed at an estimated 6% to 26% of dementia patients residing at home (Kunik et al., 2010). Even more complicated are situations whereby dementia-related aggression and intimate partner violence collide, as the two are often studied in isolation (Band-Winterstein & Avieli, 2019). The problem of caregivers who experience violence from their care recipients "is a complex and multidimensional phenomenon and defining when difficult and harmful behavior is and is not abusive is problematic" (Isham et al., 2019, p. 635). Understanding how relationship and diagnosis impact familial caregivers' risk of and responses to IPV by their care recipients is an important place to begin.

Family caregivers may be at greater risk for violence by their care recipients than caregivers working in hospitals, rehabilitation centers, and nursing homes or those employed to provide professional in-home services (Isham et al., 2019). First, family caregivers are taking on roles outside those of their primary roles to the care recipient which require identity and relationship readjustment for both the caregiver and the care recipient. Abusive situations for caregivers can develop "when families live in unpredictable, often chaotic

circumstances in which the dynamics of power, love, and duty are complex and closely intertwined" (Isham et al., 2019, p. 626). Furthermore, family caregivers often lack the training required to prepare for, deal with, and respond to potentially violent behaviors. "A lack of knowledge and ability to manage violent behaviors may exacerbate aggressive incidents, putting the safety of the entire family unit at risk" (Solomon et al., 2005, p. 41). Finally, family caregivers share close emotional bonds with and/or a sense of moral responsibility to their care recipients and may not recognize, distort, or discount IPV/DV occurrences. As Isham et al. (2019) has explained, "Patterns or incidents of difficult and abusive behavior are shaped by expectations and obligations to care and to tolerate changes in behavior and to changing circumstances of a long-term relationship infused with personal meaning and social implications" (p. 627). Assuming their new caregiving roles suddenly and unexpectedly, caregivers typically focus the bulk of their efforts on the care recipient's adjustment and wellbeing; in turn, they neglect their own.

When experienced separately, being in a relationship with intimate partner violence and being a caregiver are detrimental to a person long term, but a combination of the two circumstances is especially harmful. Ferreira, Loxton, and Tooth (2017) conducted a study to examine the relationship between prior IPV history and caregiving responsibilities on the mental and physical quality of life (HRQOL) in middle-aged women. They captured data from 8,453 women from a Medicare Australia database cohort who were surveyed six times between 1996 and 2010. Ferreira et al.'s (2017) results revealed that either a history of IPV *or* taking on caregiving responsibilities are associated with poorer health and quality of life outcomes, but both combined yielded the poorest results (p. 36). The authors "suggest that there may be an accumulation or additive effect from experiencing IPV and caregiving that is greater than experiencing either in isolation" (Ferreira et al., 2017, p. 39). Combined, caregiving and IPV are not circumstances that bode well for a person's health and quality of life.

The care recipient's diagnosis can also impact how family caregivers interpret and respond to incidents of violence (Band-Winterstein & Avieli, 2019). Isham et al. (2019) noted patients requiring caregivers are often "released from responsibility of individual action in most legal or moral understandings," placing the burden of the abusive behavior on the shoulders of the caregiver rather than the care recipient (p. 633–4). Band-Winterstein and Avieli (2019) conducted a qualitative study to provide greater understanding of caregivers with care recipients who display dementia-related aggression. One group of caregivers had a history of intimate partner violence with their partner prior to the onset of dementia while the other group did not. Their findings reveal that the caregivers' prior experience with intimate partner violence pre-dementia influenced their feelings about, acceptance of, and responses to dementia-related aggression. For the women whose spouses

had been violent throughout their relationships, the violence they endured leading up to the diagnosis changed in shape and frequency, making the aggression less predictable than the cycles of violence to which they had become accustomed. "This change led to a different state of mind: viewing the spouse as an ill person, who is no longer responsible for his behavior" (p. 372). Women whose IPV experiences in their relationships came because of their husbands' dementia perceived this violence as a "drastic and sudden change" to the partners they once knew (p. 373). Both groups of women ultimately perceived their partners' aggression as an unavoidable output of their dementia with which they had to contend. Pre-dementia experiences with IPV also resulted in varied perspectives about being caregivers. The women whose husbands had been violent toward them before their dementia diagnosis felt pulled in by their spousal obligation; while love for their spouses may have been lost over time, empathy still enabled them to care for their partners (p. 374). Those who had only experienced IPV as a result of their care recipients' dementia still relied on the love between them, and the positive feelings about their pasts, to continue their relationships (p. 374).

All in all, spousal caregivers to partners with dementia who display aggressive behaviors ultimately report feeling a lack of support, isolated, and vulnerable (Tyrrell, Hillerås, Skovdahl, Fossum, & Religa, 2016). Existing research about these civilian caregivers' experiences with, interpretations of, and responses to violence in the caregiving relationship is a helpful supplement to how military caregivers might interpret and respond to violence in situations with their veterans.

IPV, Spousal Caregivers, and Post-9/11 Care Recipients

While IPV perpetration by current or former members of the military is an area of research with a well-developed history and an ongoing slate of contributions, the same cannot be said about IPV perpetration against military caregivers by their veteran care recipients. Not much is known about spousal/partner IPV in military/veteran caregiving couples despite their existence within several populations separately at risk for long-term negative health-related, socioemotional, and marital outcomes. In particular, spousal caregivers to post-9/11 veterans are at heightened risk for IPV perpetration and underreporting because of a number of factors. First, the percentage of spousal caregivers to post-9/11 veteran care recipients represents a significant portion of the total veteran caregiving population. Of the estimated 5.5 million military caregivers, approximately 20% are caring for post-9/11 service members, and of these, 33.2% are spouses (Ramchand et al., 2014, p. 30; 33). Second, post-9/11 veterans are more likely to have been deployed, experienced combat, and been diagnosed conditions that exacerbate the potential for IPV, including PTSD, TBI, SUD, and depression (Parker, Igielnik, Barroso, & Cilluffo, 2019). Post-9/11 veterans are generally younger in

age: 46.2% are between 18 and 30 years old while 47.9% are between 31 and 55 years old (Ramchand et al., 2014, p. 43). Younger veterans may be in earlier stages of adjusting to the changes in their medical and mental health conditions, to life outside of the military, and to a new identity as “care recipient” despite still being of working age. When veterans experience difficulties during these adjustments, their spouses and intimate partners – to whom they feel closest – operate on the front lines, facing the barrage of feelings and behaviors both within and beyond their veterans’ control. Their partner/spousal caregivers are also younger: about 37% are 30 years old or younger and 49% are between 31 and 55 years old, so they will face longer periods of caregiving (Ramchand et al., 2014, p. xvii). Several factors, common to and distinct from IPV in non-military relationships, might thwart military spousal caregivers from reporting IPV, seeking support, and/or leaving the relationship.

One of the difficulties in understanding and responding to the experiences of military spousal caregivers who face intimate partner violence is the way in which they may interpret their veteran’s violent or aggressive behaviors. Just as Band-Winterstein and Avieli (2019) discovered caregivers’ prior experiences with IPV influenced their perceptions of themselves as caregivers and of aggression by their care recipients with dementia, military caregivers may find their perceptions altered. “Their...care- and safety-seeking behaviors may be shaped by perceptions of IPV as a result of PTSD or the war...as an otherwise excusable consequence of the Veteran’s wartime service” (Finley et al., 2017, p. 741). Furthermore, spousal caregivers may lack formal training in understanding how to identify and associate their veterans’ violent behaviors (Isham et al., 2019; Solomon et al., 2005). They may feel unprepared with how to negotiate the symptoms of diagnoses that impact mood or behavior, such as PTSD and TBI (Temple, Miller, Witting, & Kim, 2017), as well as how to differentiate them from IPV (Shulski, 2016). When spousal caregivers interpret violent behavior as something outside of their veterans’ control, they may be less likely to report those behaviors and feel even greater obligation to stay in the relationship (Borah & Fina, 2017; Gerlock, 2016; Temple et al., 2017; Tinney & Gerlock, 2014).

The caregiver’s role in the veteran’s physical and mental health treatment serves as an additional barrier facing spousal caregivers in relationships where IPV is present. Veterans who have designated caregivers rely on those caregivers, even if they are not always aware of the degree or scope of assistance their caregivers provide. In addition to any support with ADLs, caregivers provide IADL support critical to helping the veteran manage PTSD, TBI, depression, and other mental health issues, injuries, or illnesses that may impact the veteran’s thinking, processing, or responding to the world around them. April A. Gerlock is one of the few scholars exploring the impact of veteran-perpetrated intimate partner violence on the experiences and perceptions of military caregivers. In interviews with veterans and their caregivers, Gerlock (2016) noted that many

“partners and spouses do not want to abandon their intimate partners [disabled veterans]” (n.p.). This seems especially true when the veteran has a PTSD diagnosis. Gerlock (2016) continued, “When discussing the volatile and sometimes violent behavior of the veterans, partners expressed anxiety regarding his emotional state and a desire to avoid triggers” (n.p.). Helping their veterans avoid and/or manage triggers is a role many caregivers assume in order to help the veteran manage their world, ensure feelings of safety, and navigate uncomfortable circumstances (Shulski, 2016; Temple et al., 2017). Caregivers themselves are not the only ones placing the burden of their veterans’ treatment on their own shoulders: healthcare professionals often rely on them too. Gerlock (2016) stated, “Healthcare providers rely on caregivers (usually the partner or spouse) to make sure the veteran complies with treatment” (n.p.). Spousal caregivers serve as a reliable, effective tool within veterans’ healthcare management teams both at their own behest and that of their providers (Borah & Fina, 2017; Gerlock, 2016). Thus, removing themselves from the relationship comes with knowing they are leaving their veterans in a state of vulnerability even when the same situations they are helping their veterans manage are often causing detriment to their own wellbeing.

Victims of IPV often cite financial restrictions or manipulation as a cause for not reporting IPV or not escaping violent relationships, and financial abuse occurs in 99% of domestic violence cases (NNEDV, 2017). Some military caregiving families are in financially strained conditions, living entirely off the benefits and entitlements received by the veteran spouse, to include disability payments, retirement, social security disability, and VA military caregiver assistance. In making determinations for benefits and services in the VA system, both a veteran’s service era and the caregiver relationship are considered:

While caregivers from all eras can receive aid and attendance benefits (a pension for veterans who require assistance with ADLs), respite care, social support services, and training, the VA Program of Comprehensive Assistance for Family Caregivers (PCAFC) provides supplementary services to eligible post-9/11 caregivers, including a monthly stipend, coverage for travel expenses, access to health insurance, mental health counseling, and additional training and respite care. (Ramchand et al., 2014, p. 33)

In some cases, caregiving responsibilities prohibit individuals from gaining or maintaining their own employment (Tanielian et al., 2017; Van Houtven et al., 2012). In a national survey of military caregivers, Van Houtven et al. (2012) found 62.3% of caregivers depleted their assets and/or accumulated debt, and 41% of working caregivers left the labor force (p. 347). IPV perpetrators often withhold money, control family finances, or manipulate financial resources or assets in order to entrap the victim. For spousal caregivers, their

veteran care recipients may withhold money, prevent them from accessing accounts, or threaten to ruin the caregiver's credit (Shulski, 2016).

Finally, spousal caregivers to post-9/11 veterans are also more likely to have minor children in the home, and these children serve as both a reason to stay and a reason to leave a relationship experiencing IPV. The number of post-9/11 veteran families with children in the home ranges. In their study with current and former military and veteran spouses, Borah & Fina (2017) reported 73% had children living at home while Teten et al. (2010) found that 63% of the OIF/OEF veterans with PTSD in their study had children at home. The RAND report of military caregivers reported 39% of post-9/11 veteran families had children under the age of 18 in the household (Ramchand et al., 2014, p. 99). Without a doubt, relationships with IPV impact children across domains even when the violence is not directed toward them (see, for example, Carlson, 2000; Kernic et al., 2003; Margolin & Vickerman, 2007; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). Military spouses, partners, and caregivers report concerns about the impacts of their veterans' behaviors, moods, and medical and mental health diagnoses on their children (Borah & Fina, 2017; Tanielian et al., 2017; Temple et al., 2017). Though it seems tempting to assume caregivers with minor children would leave violent relationships, this assumption can be faulty. For many disabled veterans, children are a source of improved health outcomes. In a study of 234 male veterans, Weisenhorn et al. (2017) reported small decreases in suicidal ideation among those with children 18 or younger, and they surmised that for male veterans, having dependent children in the home "may provide a sense of meaning and purpose to life" (p. 48). If veterans like the ones in Weisenhorn et al.'s (2017) study also have spousal caregivers in the home, these caregivers may be aware of the positive impact younger children are having on their veteran's physical and/or mental health. Bearing the heavy weight of responsibility for their veterans' care may influence caregivers to think that removing children from the home could exacerbate the potential for future violence and even for suicidality.

A variety of family, financial, logistical, and health-related concerns provide barriers to spousal caregivers impacted by IPV. Members of military caregiving families, including minor children in the household, often rely on the veteran for financial stability, access to physical and mental health care (including insurance), and a home. Leaving a domestic violence situation is difficult for survivors, but leaving with minor children who need stability, care, and the things of their daily lives is an incredible challenge. Along with a number of risk factors that increase the potential for violence in particular kinds of caregiving relationships, this report has accounted for a number of reasons that discourage spousal caregivers from leaving relationships within which their veteran care recipient has become violent. For spousal caregivers in many states, however, the risk of leaving their veteran in the case of IPV is even greater. Disabled and

vulnerable adult abuse laws are designed to protect those without the physical or mental capacity to care for themselves, and these laws generate from an authentic need to keep them safe and secure – physically, psychologically, and financially. However, the unintended consequences of these laws also put spousal caregivers at great legal risk.

Criminal Statutes in the U.S

In the United States, 42 states and the District of Columbia have statutes designed to protect adults with disabilities from abuse, neglect, abandonment, and exploitation. Most of the statutes in place are categorized under criminal elder abuse laws. In most cases, these statutes are also expanded to include coverage for individuals 18 years of age or older deemed *vulnerable* (Alaska; Arizona; Florida; Idaho; Maryland; Michigan; Minnesota; Mississippi; Nebraska; Nevada; New Jersey; North Dakota; Oklahoma; South Carolina; Washington; Wisconsin), *disabled* (Georgia; Louisiana; Montana; North Carolina; Oregon; South Dakota; Texas; Utah; Vermont; Wyoming), *dependent* (California; Hawaii; Iowa; Maine), *endangered* (Arkansas; Indiana), *incapacitated* (Virginia; West Virginia), *impaired* (Arkansas), *at risk* (Colorado), *infirm* (Delaware), or *in need of adult protective services* (Alabama; District of Columbia; Kentucky) (Hamp, 2003). Some states (Kansas; Missouri; New Hampshire; New Mexico; Tennessee) simply protect *adults* broadly under the applicable statutes with a variety of conditions, impairments, or disabilities listed that may prevent them from protecting themselves or their assets (Hamp, 2003). In nearly all of these examples, the statutes are criminal in nature, and violators can be charged with a felony.

While the language of these statutes varies from state to state, most of them declare it unlawful to abuse, neglect, exploit, or abandon a person when in the role of that person's caregiver or caretaker. In many cases, the terms *caregiver* and *caretaker* are defined in a broad enough sense to encompass anyone providing primary support to a disabled or vulnerable adult. Alabama, for example, defines a caregiver as "an individual who has the responsibility for the care of a protected person as a result of a family relationship or who has assumed the responsibility for the care of the person voluntarily, by contract, or as a result of the ties of friendship" (Hamp, 2003). The role of the caregiver, therefore, can be assumed in a legal sense of the word (court order, power of attorney, or registration for state services for example) or in a sense which has not been legally recognized but in a way that *could be* recognized (with an adequate burden of proof) as a caregiving relationship. States like South Carolina increase the burden even greater, defining a caregiver as "a person who provides care to a vulnerable adult, with or without compensation, on a temporary or permanent or full or part-time basis and includes, but is not limited to, a relative, household member, day care personnel, adult foster home sponsor, and personnel of a public or private institution or facility" (Hamp, 2003). This definition includes three aspects applicable to military caregivers: compensation, a

time frame, and the basis of caregiving. Spousal caregivers who are not receiving support through the VA's PCSFC or Social Security Administration may *still be included* in broad definitions such as these even if they are not being compensated for providing care. Additionally, providing care on a temporary or part-time basis qualifies the person as a caregiver in some states and, as such, assumed responsible under those statutes.

None of the statutes provide provisions or exemptions in cases of violence, abuse, or abandonment by the care recipient. These statutes operate off a presumption that we recognize to be untrue in some cases: those who require caregivers are incapable of inflicting *intentional* violence or harm on others, including their caregivers. Intentionality is key, as questioning this assumption is not to deny that individuals with particular illnesses, disorders, or diseases may unknowingly and unintentionally be violent and cause harm. However, in some cases, care recipients can be perpetrators of IPV in ways that go beyond the scope of the injury or illness. In the case of PTSD, for example, Tinney and Gerlock (2014) explained, "Irritability and anger receive a great deal of attention when trying to differentiate between PTSD symptoms and IPV tactics. [...]. By asking about targeted patterned behaviors that result in injury and fear, a clearer distinction between PTSD symptoms and IPV tactics becomes possible" (p. 404). While we might assume only younger-aged care recipients might be capable of IPV, Isham et al. (2019) discovered otherwise. After a comprehensive analysis of studies with older people experiencing violence by their care recipients, Isham et al. (2019) concluded:

In light of our synthesis, we question whether it is appropriate to assume that behavior on the part of an ill or disabled older person should be automatically considered to be without intention or meaning. [...] Moreover, even when illness appears to be an appropriate and valid way of understanding violent and abusive behavior, the impact on the family caregiver should not be obscured or minimized. (p. 634)

Statutes that fail to recognize the complexity in caregiving relationships, especially those involving family caregivers of care recipients who have an increased risk potential for violence, stifle the self-preservation of these caregivers. Military caregivers, particularly spousal caregivers with minor children in the home, are especially deterred by these statutes.

In relationships where IPV is present, the current statutes dissuade spousal caregivers from leaving abusive relationships with their care recipients by criminalizing the behavior and classifying it as "abandonment." These laws privilege the rights of the veteran over those of the caregiver, holding caregivers at risk for abandonment in the event they leave the household. Certainly, in cases where caregivers knowingly abandon, abuse, neglect, intimidate, or exploit their veterans who are not committing violence, intimidation, abuse, or neglect against them (or minor children present

in the home), the law is appropriate, and charges should be filed. However, in circumstances where the veteran in perpetrating IPV, these laws create another barrier unintentionally discouraging battered partners from leaving in a population already dissuaded from leaving for many complicated reasons. "One could argue that this vulnerable population and their families are in need of special protection to assure their safety and the safety of others" (Solomon et al., 2005, p. 51). Without special legal protections, caregivers might conclude that their departure would result in significant legal consequences and choose to remain in abusive relationships.

When spousal caregivers are considering leaving relationships with IPV, whether or not they have minor children in the home factors into their decision making. As a reminder, approximately 39% of post-9/11 veteran families have children under the age of 18 in the household (Ramchand et al., 2014). In the case of separation or divorce, custody and visitation issues come to the fore.

Since so much is at stake in a domestic violence hearing related to criminal records and custody or visitation decisions, there are more delays in court proceedings, including applications for protection orders. The delays, uncertainty, and costs of legal proceedings often force abuse victims into compromised joint custody or unsafe visitation plans, which may endanger abused women and their children. (Jaffe, Crooks, & Wolfe, 2003, p. 209)

Custody and visitation agreements could be further compromised in a circumstance where the caregiver is, could be, or was in danger of facing felony abandonment charges. Caregivers, then, might be further deterred from leaving abusive relationships with veterans when custody of minor children could be at risk.

Some people might dismiss the assertion that caregivers should be concerned about elder abuse statutes, because state and federal laws exist to protect domestic violence victims. Federal and state laws exist to protect victims of domestic, family, or intimate partner violence. To generalize, these laws allow victims access to legal protections (e.g., restraining orders, the right to sue abusers, custody and child support) and resources (e.g., medical care, housing, and legal aid). However, two considerations are appropriate to this discussion. First, domestic violence protections require law enforcement or legal interventions to enact; therefore, survivors must take active steps to put the abuse into an official record (legal, medical, law enforcement). Spousal caregivers must, then, first recognize the behavior as abuse and then actively take steps to have that abuse documented. This review has already discussed the challenges survivors face in both recognizing their veterans' behaviors as abuse (and not as a result of a medical or mental health condition) and reporting the behaviors as abuse. Second, domestic violence protections exist within legal statutes in the same way

as elder abuse laws. Positioning statutes against one another (that is, enacting domestic violence protections vacates the charges of elder abuse) puts spousal caregivers in a battle that can only be settled through the legal system, a battle that requires time, resources, and – at the very least – a caregiver well versed in the legal aspects of their situation. Unfortunately, many are not.

Others might suggest that to remedy their concerns, caregivers who want to leave abusive relationships need only put in place a secondary plan. That is, the caregiver could have someone else assume temporary caregiving duties until a long-term plan could be developed. This way, the veteran retains the care to which they are entitled, and the caregiver can leave the relationship without any legal consequences. This sounds ideal, but the plan ignores one of the most salient circumstances of an IPV departure: many survivors flee with little or no warning. If, for example, a spousal caregiver senses an immediate threat to her child's physical safety, she might leave at the next available opportunity, deprioritizing a plan for her veteran while prioritizing a plan for herself and the child. Additionally, sending a caregiver replacement to the veteran's household without the veteran's knowledge may trigger dangerous behaviors for which the secondary caregiver is unprepared. This remedy also assumes that all spousal caregivers have someone who can serve as a backup or replacement caregiver at their disposal. Even if caregivers attempt to make arrangements for a secondary caregiver through more official channels (such as the VA Caregiver Coordinator's office), this request could set off notifications within the system that may unintentionally endanger her. All in all, while this proposal may be an option for some spousal caregivers, it is not an option for all.

Recommendations

Supporting spousal caregivers in relationships with IPV is a complex issue that requires a multifaceted approach. To be successful, addressing IPV in spousal caregiving relationships must work from multiple angles – including amending statutes to include IPV provisions and ensuring those in law enforcement, family courts, domestic violence programs, and adult protective services are better prepared to understand the unique circumstances of military and veteran families. Even still, without effective caregiver education, safe and integrated reporting mechanisms, and consistent screening for IPV, treatment plans for veterans and support for caregivers will still fall short.

Effective solutions begin at the ground level by working with military and veteran families, especially caregivers (including, but not limited to, spouses and partners) directly to provide access to education and resources for identifying, reporting, and navigating IPV in the household. Education should include risk factors that heighten the potential for IPV. Many military caregivers are better educated about their caregiving situations, their veterans' medical and mental health issues, the VA healthcare system, and resources (within the VA and in the private and nonprofit sectors) than

the general public, providers, and researchers may realize. Most of them are open to gathering even more intelligence that would assist them in their caregiving duties, help their veterans, and improve quality of life for their families and them. They may not, however, have a clear understanding of the bigger picture of military caregiving families, what IPV might look like, and the prevalence of risk factors beyond the specific scope of their own family. They may also not understand protections granted to them by federal and state domestic or family violence laws or how to get accurate answers to the legal questions they may have if they are considering leaving the relationship. New caregivers often receive the opportunity for training or resources to assist them in understanding and navigating their new roles; these training materials should include modules related to their rights and resources should IPV occur. Importantly, proposed changes to the VA's Program of Comprehensive Assistance for Family Caregivers includes a ruling that would provide caregivers who request discharge from the program because of domestic violence or intimate partner violence would be eligible for 90 days of program services and support to aid in their transition. While this change has not yet been officially approved, it represents a step in the right direction. Caregivers within the existing PCAFC system may not know about these changes, so upon implementation, the VHA should develop a targeted and diverse communication plan to alert existing caregivers.

The depth, frequency, and documentation related to IPV screening within the VA continues to impair efforts to assist veteran spouses and partners by neglecting opportunities to screen for IPV perpetration. Caregivers will likely hesitate to report IPV as partner violence rather than as aggression related to the veteran's injury, illness, or disorder. Hence, the VA needs to provide a safe way for caregivers to report IPV given the interconnected logistical, financial, and personal barriers present. Gerlock et al.'s (2011) retroactive analysis of patient records from 2002 to 2007 revealed 71% of the sample showed no evidence of screening or assessment of IPV perpetration (Gerlock et al., 2011, p. 29). Of the cases where IPV was self-reported by veterans, 90% of the screening or assessment documentation occurred within outpatient and inpatient mental health settings (p. 29). However, as Tinney and Gerlock (2014) have noted, "Most mental health providers at VAs, military installations, and community health settings do not have the training or expertise to fully assess for IPV" (p. 411). Knowing where veterans are likely to self-report helps identify key areas where training in screening mechanisms and frequency as well as referrals for services should be better developed.

Reporting and screening outside of the VA healthcare system needs improvement through more effective integration. Spousal caregivers may be more likely to report occurrences of IPV to civilian healthcare providers in hopes of protecting the veterans' benefits eligibility, reputation, and financial support. Medical, mental health, and social services in nonmilitary sectors should be trained to understand

IPV in military communities; in particular, this training should include risk factors that exacerbate IPV potential. Furthermore, these providers should have a secure mechanism to report IPV into the VA system for veterans or spouses receiving VA benefits with a special flag for those who are documented caregivers. VHA and community partners should continue to work together to share resources and put in place treatment programs, support services, and safety plans for caregivers that keep both the spouse/partner and veteran safe.

Removing the threat of possible legal repercussions from caregivers dealing with IPV is a critical step toward improving circumstances for military caregivers. Lawmakers should amend state statutes to provide exculpatory clauses in the event a caregiver files a Temporary Protection Order or can show documentation of positive IPV screenings through medical, mental health, or social services providers within and outside of the VA system. Likely, lawmakers will hesitate to offer such amendments unless directed by the expertise of their state agencies, so opportunities for conversations about real situations, real families, and real caregivers are essential.

Finally, members of law enforcement, family courts, domestic violence, and adult protective services should be educated about the unique situations facing military and veteran caregivers – especially when violence is reported or alleged. Tinney and Gerlock (2014) have identified some critical limitations confronting law enforcement and family court officials. Similar to ineffective, incomplete, or infrequent screening among healthcare providers, law enforcement and family courts also suffer from a lack of information. In particular, Tinney and Gerlock (2014) contend, “Most police reports and court documents have insufficient information to determine the context of the violence or the level of risk and danger” for the spouse/partner or the family (p. 409). Improving the information available would help, but law enforcement and court personnel also need to know what questions to ask especially when military-related risk factors are present.

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. (Tinney & Gerlock, 2014, p. 403)

If law enforcement and court officials do not better educate themselves to investigate and understand the intricacies in veteran caregiving relationships with IPV, “victims do not receive needed resource information or victim advocacy” (Tinney & Gerlock, 2014, p. 410). Minor children in the household can also be left without support or in situations with continued risk factors for violence unless agencies work together to improve their communication and knowledge.

This article has attempted to highlight a unique but troubling health concern within military caregiving families: veteran perpetration of intimate partner violence against their caregivers. Veterans and military servicemembers are at higher risk for IPV in their relationships than their civilian counterparts; veterans diagnosed with PTSD, TBI, SUD, or depression even more so. When those veterans are also care recipients, relying on their spouses or intimate partners for caregiving support, intimate partner violence can go unnoticed, unrecorded, untreated, and unsupported. By threatening caregivers with felony charges for abandoning their care recipients without provision or nuance in cases of violence, criminal statutes in nearly every state in the country further discourage actions toward self-preservation in a population already adverse to leaving abusive relationships. To protect spousal caregivers who are surviving IPV perpetrated by their care recipients, these statutes should be amended to include legal and custodial safeguards that coincide with domestic violence protections. Additionally, caregivers need educational resources to help them recognize distinctions between IPV and disease- or disorder-related aggression, the VHA and civilian healthcare systems need to improve integration and consistency of IPV screenings, and applicable agencies need to improve access to and facilitation of caregiver support.

Notes

- ¹ U.S. veterans are generally broken into two categories: pre-9/11 and post-9/11. Pre-9/11 veterans are those whose military service occurred in the period leading up to but not after September 11, 2001. Post-9/11 veterans include those whose service period included and persisted beyond September 11, 2001.
- ² Some IPV studies referenced henceforth may include unmarried and married intimate partners as part of their populations while others may have limited their research to spouses only.

Competing Interests

The author has no competing interests to declare.

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How to cite this article: Hinton, C. E. (2020). Unintended Consequences: Intimate Partner Violence, Military Caregivers, and the Law. *Journal of Veterans Studies*, 6(1), pp. 211–225. DOI: <https://doi.org/10.21061/jvs.v6i1.166>

Submitted: 09 January 2020

Accepted: 02 May 2020

Published: 16 July 2020

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