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Unidentified Female: Today, we have Dr. Catherine Cerulli joining us today. She is part of the VISN 2 Center of Excellence for Suicide Prevention in Canandaigua VA Medical Center. She is a Director of the Laboratory of Interpersonal Violence and Victimization; and the Director of the Susan B. Anthony Center; and also, an Associate Professor of Psychiatry at the University of Rochester. I would like to thank her for joining us today. I will turn it over to you now.

Catherine Cerulli: Thank you. Can you hear me?

Unidentified Female: I can, thanks.

Catherine Cerulli: Okay. Hi everybody. Thank you so much for being here. Thank you for inviting me to do this presentation. I just want to take a moment to recognize the Orlando tragedy especially given the topic of today's webinar. It is quite sobering to be speaking today about these topics. The project started. What you are going to be hearing today is the project has been going on for quite some time. Susan Horowitz was a colleague of mine who passed away a few years ago. She had a vision many years ago going back probably ten years to try to think about the intersection of intimate partner violence and suicide, both among civilian and Veteran populations.

We had funding originally from the Center of Excellence for Suicide Prevention. That project was just renewed this year. I am going to be sharing with you some of what we are working on, and also some of the toolkits that we hope will be coming out shortly. My contact information is at the end of this PowerPoint. If you are interested in learning more about the project, we can continue a dialogue hopefully. We would like to start with just asking your primary role and the work that you are currently doing so I have a sense of who the audience is.

Unidentified Female: Thank you. For our attendees, you have your first poll question up on the screen. We would like to know. What is your primary role in VA? Are you a student, trainee, or fellow, a clinician, researcher, manager, or policymaker, or other/non-VA? If you are selecting other, please note that we will have a feedback survey at the end with a more extensive list of positions. You may find your exact job title there.

It looks like we have already had about 80 percent of our attendees respond. That is great. Thank you. I will go ahead and close this out, and share those results. It looks like we have 5 percent student, trainee, or fellow; and just over half of our audience, 55 percent are clinicians, 18 percent researcher, 5 percent manager or policymaker, and 18 percent other. Thank you for that. Kate, can we just jump into our second poll?

Catherine Cerulli: Yes.

Unidentified Female: Excellent, okay. For our second poll…. Which best describes your training related to intimate partner violence, \_\_\_\_\_ [00:03:11] IPV, identification and prevention? Have not had any formal training; have had a class or two in college/graduate training; I have spent time on my own reading and becoming informed. I have attended conferences or webinars, and feel competent in this area. I am sorry, that should say I have led programs or research related to IPV. It looks like about half of our audience has voted. But the answers are still coming in. We will give people two more seconds.

Okay, great, I will go ahead and share those results. It looks like about 13 percent of our respondents have not had any formal training. About 20 percent have had a class or two in college or graduate training. A quarter of our respondents have spent time on their own reading and becoming informed; 38 percent have attended conferences or webinars, and feel that this is an area in which they are competent; and 5 percent have led programs or research related to IPV. Thank you to our respondents. I will turn it back to you.

Catherine Cerulli: Thank you. As we move through today's training, I just wanted to talk a little bit about what we hoped to\_\_\_\_\_ [00:04:26]. Knowing that we have a diverse audience, which is what we anticipated, we are going to spend just a brief moment or two defining what IPV is and prevalence rates, and understanding the complexity of it. Then, thinking a little bit about the response and having the ability to respond in a way that you have comfort; and also talking about some recent research that is happening; and where we think the field might consider going next.

I think one of the issues with intimate partner violence, when we think about intimate partner violence; and we close our eyes. We have an image of someone. We often think about posters that we see hanging in medical facilities, OB/GYN office, primary care. They often tend to be sad pictures, seeing people with bruises and downcast eyes, often looking disenfranchised. I think when we perceive domestic violence through that lens, we often miss people in our midst who maybe do not exactly look like that.

When we recently did training with primary care doctors and some psychiatrists, I asked one of them a few months later. How did the training go? Was the information helpful? The doctor said, yes. I am much more comfortable screening. I only screen though when I think I need to. I said how do you know when you need to? He said well, when the persons look like they have domestic violence. I smiled and said I think we need to redo the training. The walk away today is to let you know that intimate partner violence happens in all type so relationships and across all types of abuse.

I am going to use the word specifically intimate partner violence as we move through this training. Because domestic violence tends to be a broader lens, which also includes elder abuse, child abuse, sibling abuse, and familial abuse, not intimate partner specific. It might be an odd cousin or someone along those relationship. Intimate partner violence includes what we think of as the obvious types, physical and sexual violence. But it also can include threats of violence, stalking and psychological aggression including coercive tactics.

It is important to remember, it can be from a current or former intimate partner. Former intimate partners, some often think of that in terms of stalking. If they ask the stalking question or two; and the screen is no. We ask about current partnership and the answer is no, that boxes out people who are currently experiencing violence at the hands of a former partner. Those types of abuse opportunities largely occur when there is an exchange of children, if it is not in a supervised visitation setting.

The time of drop off and pick up for children and custody exchanges is often considered a potentially volatile time where someone may continue to be harassed, annoyed, or alarmed by a former partner. We also think it is important to let you think about intimate partner violence happening between habitating and non-cohabitating partner and sexual partners as well as opposite and same sex couples. The bottom line is there is no homogenous picture of what intimate partner violence looks like. Because it can happen to anyone.

Within these categories, we also see things such as financial abuse. We know now. We did not know this ten or 15 years ago that the abusive of pets is a big indicator for intimate partner violence. Technology abuse is a form of abuse that we know less about. But we are moving forward in that. We have actually created a technology abuse screen. We compared our technology abuse screen to the danger assessment, which was created by\_\_\_\_\_ [00:08:00] Jackie Campbell. Lo and behold, abusers who used more forms of technology abuse, including manipulating cell phones, and starting bank accounts with false Ids, and using phones, Facebook, Twitters, tended to also score more high on the danger assessment.

Because of the first amendments, the technology abuse cases that come into the courts tend to get assessed based on freedom of speech. We had a Supreme Court case not too long ago, last fall, which allowed a perpetrator to appeal a case, and overturn it ultimately where he had threatened his wife on Facebook as well as his children's kindergarten class. It is important when we think about technology abuse that even though these cases may not make great headway in the courts, they were addressing them with service provision, including very important safety planning.

We also seek control over reproductive health. That includes sabotaging a partner's reproductive health, birth control, and preventing access to birth control, and destroying birth control, prohibiting its use including condoms. We know there is a connection between intimate partner violence and HIV risk, and STDs as well. It could also mean limiting one's access to reproductive health. Even though a victim may have health insurance, their partner may block their access or operate a course of control when they are in a medical facility. It is important that we are able to observe these courses of control and behaviors through the lens in which they are intended.

I was sitting in the courtroom with a victim. When we reported to the judge that her ex-partner had called her 40 times over the course of an hour or two, our response from the bench was well, sometimes that is being a supportive partner, not really recognizing the course and control that it was exhibiting there. I move briefly to looking at domestic violence and suicide policy, and background information for the project that we move forward through in thinking about the prevalence of IPV and suicide. I think largely, nationally since the passage of the VAWA statutes in the 1996, we have seen lots of different intervention and prevalence studies that have come up.

It depends on the questions that are asked and the populations that we asked those questions of what our answers are. In the most recent national survey from 2010, which is available from the CDC, there is a very good brief executive summary. If you know on page 3 of that report, within 12 months, reports from men and women across their 12 month prior to taking the survey. If you include stalking, physical abuse, and all of the types of abuse that we just talked about on the prior slide, men and women are reporting; about five percent of men and 5.9 percent of women.

When we think about intimate partner violence, we often see the face of a woman before us. The movement for including men has been quite recent in the past few years. In the national\_\_\_\_\_ [00:11:07] that which we're seeing, five percent of men reporting within 12 months intimate partner violence, that looks slightly different than it does when women report. Women still have higher rates of being killed. Women have higher rates of injuries which require medical conditions. Women report higher rates of stalking and other fears.

When you look at the face of male victims, some of that work has been reported by Dr. Karen Rhodes, and Dr. Deb\_\_\_\_\_ [00:11:37], and a number of physicians who have done this work in medical settings. You will see that when men experience intimate partner violence, the symptoms tend to be the same. They will report co-morbid mental and physical health conditions. When we look at the rates of male perpetration against females within the Veteran population, these studies are still in route, and still coming out. But rates range anywhere from 13.5 to 58 percent. Again, it depends on the audience that you are screening and somewhat questions you are asking.

There\_\_\_\_\_ [00:12:10] male\_\_\_\_\_ [00:12:11] victimization rates are much less studied. We actually published the study. We looked at the rates being about nine percent compared to 12.5 in the general population. That was using national data, a behavioral risk survey. When you look at the female to male violence rates among Veterans, again, we see women also reporting both self-report and by proxies use of violence. The rates are about 25 to 32 percent. You see less being reported. However, the female Veteran victimization rates are much higher than we see in the general population, anywhere up to 33 to 86 percent; again, depending on where those questions get asked.

Actually, today the Journal of Family Violence published a most recent report by Rachel Latta and colleagues. That was intimate partner violence screening in a female Veterans health clinic. Now, when you look in a health clinic where you are only serving female Veterans, there were 96 women that were approached. Ninety-seven percent of them answered the self-report questions. Now, that leads us to believe that if we ask, they will answer. That has been consistent with screening literature in other venues that did not necessarily include Veteran women, but other women seeking healthcare in a variety of settings.

Among those who took the study and reported on lifetime violence, 75 percent participated in the standard screening; and 47 percent had past or current IPV. Twenty-five percent indicated that they were currently experiencing IPV. If you were working in a Veterans setting that caters to women, you are looking at a study that came out at one of your settings that is indicating a 25 percent current rate. That is right on target with what we are seeing in some of the previous literature, but a little bit higher.

Now, when we think about Veteran perpetration of domestic violence and what some of those risk factors are for male to female violence, I want to be crystal clear here. These are some of the exact same risk factors that we see in the non-Veteran population. Those things include PTSD, substance abuse, depression, and psychopathology, TBI, Trait Anger, and physical disability. Now, when these issues are raised in the non-Veteran population. This is going back two decades.

There has been different camps within the IPV world. Some study substance abuse and domestic violence, or intimate partner, it becomes the tag on. Some study intimate partner violence through the course of lens. Drugs and alcohol is an add-on. There are now scientists who are coming out in the past five years that are studying the intersection of these two issues giving them both equal airtime and seeing a connection.

If you look at the criminal justice literature, they have been discussing the intersection of some of these factors with domestic violence for decades since the '80s when the domestic violence policing literature first came out. A number of police call for service studies report substance abuse in between 80 and 90 percent of calls for service. These symptoms that we are seeing or risk factors in the Veteran population are also seen in the general population. Some of the risk factors related to sociodemographics include young age, childhood victimization, low socioeconomic status, poor relationship adjustment, and unemployment, homelessness, and pre-deployment ITV.

With the exception of the last risk factor for sociodemographics, we see similar characteristics and risk factors in the non-Veteran population. Again, whether these are correlates or causal remains a question. The study that examined childhood victimization among Veterans was actually a mixed Veteran and active duty study. That was not conducted with Veterans exclusively. The pre-deployment IPV risk factor is one; if you could circle, if you are taking notes.

Because I think it is important to explore when we are helping Veterans get deployment ready, and really examining their family stability and structures before they are leaving. What we know about the service related risk factors includes combat exposure, wartime stress, and TBI, as mentioned earlier as well. Some is not necessarily related to their service. It happened afterwards. But it is still a correlate of male to female IPV. When we think about risk factors for female to male IPV among Veterans, we know much less. This is an area that I think is worthy of greater study especially seeing how many of our male Veterans are reporting intimate partner violence.

We know that mental health and clinical risk factors exist including depression, PTSD, and Trait Anger. But when we know a little bit more about the sociodemographic risk factors, one that is important to explore further is partner's perpetration. We know amongst civilian studies that are done, whenever we have bidirectional violence, it puts that couple at a higher risk for a whole host of poor outcomes including higher rates of violence and use of weapons. It is important within Veteran populations, if we are exploring the sociodemographic risk factors with people before us in a patient or client capacity that we think about their perpetration as a risk factor for their own victimization as well.

We are not going to be able to spend a great deal of time today on the homicide and suicide studies. There is a whole line of research that has come out in a recent article that came out and published. I call this to your attention largely from the purpose of the firearm piece. We know that perpetrators of a homicide and suicide tend to use firearms. We know that are more homicides than suicides in those homes. We should be thinking as we work with Veteran populations about firearms. Under the VAWA Act of 1994, and subsequent modifications at the federal level, which has been interpreted at the state level, there are ways in which firearms can be taken when there is domestic violence in the home subject to protection orders.

The statutes across the United States vary. Some statutes say that judges with adequate\_\_\_\_\_ [00:18:24] may take on; some require that it is a must. There are some state laws that require it when there is order of protection. Some state's laws around the revocation of firearms related to protection orders conflicts with the federal laws. Those are cases that are being worked out currently. But it is important if you are a service provider of Veteran populations who are experiencing intimate partner violence that if you do not have potential collaborations with attorneys doing legal aid or public defenders, or district attorneys, it might be helpful to have a handle on what the state laws are to provide you with more information for that. In a study that was looking at the 2008 surveillance data, 200 incidents involved homicide and suicide. Seventy-five percent of those victims were female; and 90 percent were male. Domestic violence preceded nearly 20 percent of those.

However, I would like to call your attention to homicides and suicides which included children. Three publications just came out recently from the CDC relative to child homicide and suicides. Among those stats, it is very clear that intimate partner violence was not the number one risk factor; but rather, interpersonal problems. When you looked at the list of what those interpersonal problems were, it included things like marriage dissolution, divorce, custody, and visitation, and contested cases, and the like.

When we have individuals before us in our client capacities, we want to be asking them these questions about their home life. What is their home life like? What is happening? Are there things going on such as divorce and custody disputes? Because if we have a patient with suicidal intent who is also going through these family turmoil issues, we might want to be thinking about some precautions in doing some screening and safety planning.

We have already touched a little bit about the victimization piece in terms of talking about prevalence. But I would like to share with you some of the symptoms that we see among Veteran victims. These are also true with perpetrators. Because as we indicated earlier, about 20 percent of these cases are reported currently in the studies as bi-directional. These are things that we see, symptoms that cluster together; chronic fatigue, sleep disruption, headaches, and substance abuse, depression, low self-esteem, and bipolar disorder; and a whole host of ones that we commonly think of such as PTSD and anxiety.

One of the ones I would like to call your attention currently in a healthcare setting is the increased healthcare utilization. We see repeat\_\_\_\_\_ [00:20:54] coming in who have intimate partner violence. But they do not necessarily present with that as their leading claim when they come in the door for healthcare. In some ways, it is a little bit buried in what they are talking about with all of these biopsychosocial issues that they will discuss.

I would like to call your attention also to the sleep disruption and chronic fatigue syndrome; just the work of Dr. Will Pigeon who is with the Center of Excellence in Canandaigua. Dr. Pigeon's line of research is currently looking at sleep disruption, insomnia among people who have experienced violence in their lives. That sample is being recruited from a family court setting. But when you look at their violence experiences, they very much also have PTSD; so, looking at the intersection between sleep disruption and PTSD. Again, these things cluster together.

It is worth noting when someone is coming in with a cluster of symptoms that you cannot find the root cause for, it might be an important discussion to have. Some of the things we know about male Veteran victimization is young age and their PTSD, and also substance abuse, and depression, which we also see. Some of the risk factors for female Veterans and specific IPV victimization include ones that we also see in the civilian population, with the exception of military sexual trauma, which is one of the first risk correlates noted.

Childhood victimization has been receiving a lot of attention lately for the past decades through the ACE literature, which is the Adverse Childhood Events literature. You can easily Google ACE as A-C-E. What you will see a survey regarding childhood experiences, which include things not only being abused in the home. But it is also being neglected in the home – having a parent with intimate partner violence or having a parent with substance abuse.

There is an article that recently came out looking at the ACEs scores for people who are in the military, both pre-volunteer and post-volunteer military. It showed that many of the people who are entering in the volunteer military did have adverse childhood events as well. It is something to think about exploring the childhood victimization when we have individuals coming in and presenting with biopsychosocial issues that again, we cannot get to the root cause for. It is important to notice the longer females serve, the more likely they have risk for victimization as well.

Some of the outcome correlates we see for victims are the same that we say in the civilian population as well. What are some of the protective factors? I think everyone who is on the line is probably in a helping profession, even the people who are self-identified as researchers – identified as researchers. We really want to know. What can we do that is protective? One of the things that we can do is talk about supportive family and external support systems and support groups. We talk about family cohesion and marital adjustments; and having a steady income, and high school education, and living quarters, being a healthy person; and having access to medical care.

When we see free medical care indicated here, I think it is really important that we remember what we talked about which is access. Not only is the medical care free; and that there is coverage and insurance or financial help, but how is the Veteran able to get to the medical care? Transportation is an issue for many. That is one of the things that we can be helping and be sure that people can actually get to their appointments. Alcohol, of course, we see in the civilian population also.

When we think about these protective factors for IPV, it may be that their Veteran service provider cannot do this in isolation. Based on time requirements, or restrictions to service; so, we are going to be talking about partnering with other community agencies shortly. Just to focus very briefly on mental health and IPV specifically by itself, I think this is important. Because it is so closely tied to suicide burdens. We know that Veterans' mental health status just like all of us affects our daily functioning; and our relationship with our partners and children.

Some of the barriers for seeking mental health treatment include confidentiality; leading to legal trouble. We might be afraid of what people will think of us, or stigma that we have. For male Veterans, it may be a loss of masculinity. A lot of individuals fear seeking mental health burden because they are afraid that they will be seen as weak; or perhaps a cognitive difficulties which help – will prevent them from keeping their appointments.

I think it is also important to explain to people what their policies and benefits are. I have met with a number of individuals who do not believe that their insurance actually covers mental health help. Once they learn that it does, they are more likely to be willing to seek that help. We also know that in primary care settings when Veterans are seeking help, we are seeing mental health evaluations and referrals for that largely for depression and PTSD. It is really important when we are\_\_\_\_\_ [00:26:04] the intersection of intimate partner violence; which has risk factors and outcomes related to mental health with the intersection. With suicide, which also has large risk factors being depression, and PTSD, and other mental health burdens that we get people into the help that they need. A number of people who have mental health help; and we see in mental health settings; over 50 percent of them actually report that intimate partner violence is an issue. This includes all kinds of intimate partner violence like we talked about earlier.

I think again, we are seeing this constellation for the perfect storm if we do not address each one specifically. I think it is important in this particular study cited, which we provide the citation for at the end of the program. You will see that service branch was in fact not a factor. It is very important when we think about depression as one of the most cited correlates for IPV and for suicide. It is important and imperative that we get people screened and referred for both their mental health and their IPV.

Post traumatic stress disorder is a close tie in the civilian population. We see that among IPV victims recruited in several studies, about 70 to 80 percent of them have depression. These were studies that were conducted in non-clinical settings. Of those with depression, about 40 percent also have PTSD. Again, as I stated earlier, PTSD being highly correlated with depression, it also needs help. We are currently looking at some studies that are helping people prioritize their needs.

You can imagine if you are someone who is suffering from depression, and PTSD, and intimate partner violence is an issue in your life. You are screened and assessed for all of these burdens in one healthcare visit, you might leave feeling worse. You may leave feeling overwhelmed and unsure what the next step is.

We have papers coming out currently; Dr. Ellen Poleshuck and myself looking at domestic violence victims in various settings. Helping them prioritize, which was worked on by Dr. Marsha Wittink – helping the patient prioritize what is most important to them. If a community health worker or social worker, or case manager can be helping the domestic violence victim get the care that they need in the order that makes sense to them? We may have better compliance of not only the referrals that we are making, but with the progress that the client can make.

When we look at substance abuse, this is another area that many people in the domestic violence fields have noticed is an issue. Well, this is also an issue among the Veteran population as well; about seven percent of Veterans meeting the criteria for substance abuse in some studies. It is also important to note that this does not just develop after deployment. It can be independent of deployment status. In having people who have come into Veterans' services who have not necessarily been deployed, still obviously linking them with substance abuse.

As in with the civilian population as we noted earlier, IPV perpetration and victimization is linked to substance abuse. We know that alcohol moderates the effect between hyper arousal symptoms and aggression. We want to be sure that we are looking at the overlapping circles of intimate partner violence, mental health, and substance abuse. The center of those intersecting circles to really be able to get the best care that we can for the patients that we are seeking. We know that alcohol also increases – substance abuse also increases risk of suicide. Again, we are seeing these overlapping risk factors again and again in an attempt to figure out what is it that we are actually going to do with these individuals? How can we help them?

We currently have a toolkit that is going to be coming out soon. What you will see in the next four slides is a preview of what the toolkit will look like. But it will be expanded upon. The toolkit that we will be providing; and it will be posted on the Internet. It will have what the risk factors are for domestic violence and suicide indicated in Venn diagrams, which may be helpful to share with clients in a very easy way. It will also have an Excel matrix with the articles that we have been reviewing with the risk factors noted.

These are some of the examples that you see will be coming out in the toolkit, which we just spoke about. This is an overview of the perpetration in suicide for males; perpetration in suicide for females, all of the reviews that we just went through. Victimization and suicides for males, again, sociodemographic, it is one of the biggest victimization risk factors as being younger aged. Then victimization and suicide combined for female Veterans. We see great overlap between female and male Veterans' victimization and perpetration in suicide risk factors. That will be presented in the toolkit as well.

I do want to move briefly before we open the floor for questions to discussing cultural issues. Each of these studies that was done that we presented to you largely focused on mental health and IPV. But there is a whole other line of research which is desperately needed; and which can explore cultural issues within the Veteran population. We know that Veterans are not a homogenous group. For one, to say that Veterans are experiencing something is like saying an American is experiencing something. Or, another group is experiencing something. There is great heterogeneity in each individual's sample that we would look at.

It is important that we start to think about cultural issues within Veterans. What are the community that the Veteran lives in? What cultural environment did the Veterans get raised in? These things can affect survivors' coping strategies; and better perpetrator tactics that can result in how the community responds, or certain institutional responses. If the Veteran family is involved in a religious institution, that may indicate how they respond to learning about intimate partner violence. What the individual meaning of violence is?

Again, we talked about whether they have average childhood event experiences, which may put a lens on the way that they view the violence in their life as an adult. It also could look at the provider family relationships. If you have somebody who was raised in a cultural environment where the police are not trusted or law enforcement\_\_\_\_\_ [00:32:34] trusted. Or, the court system is not trusted. The first-line response for intimate partner violence is often the police. You may have a victim who is reluctant to help seek with law enforcement because they come from an environment where they do not trust their particular police department or law enforcement.

You also have barriers that might be specific to Veterans, which is that they do not want to be stigmatized or be seen as weak. They may be worried about losing benefits. Or, having a lack of resources to help them. I think an area of research that could be fruitful for us is to begin to understand among Veterans living in certain cultural communities, how can we help those particular Veterans in this area of intimate partner violence while we are respecting not only their Veteran status, but their cultural heritage as well? We know very little about the LGBTQ community within Veterans as well. To date, we are still looking for studies among that population. There is a little bit of work coming out of the CoC, in Pennsylvania. We are reviewing those articles as well. To turn briefly to the service provider's role for those of you who are service providers on the phone. Or, those of you who are researchers on the phone partnering with service providers.

It is important when we were thinking about this that we make connections between the client suicide symptoms and their intimate partner violence status. Often, putting intimate partner violence of a chronic health problem helps the patient think about it somewhat differently. When we talk about it as a health problem, they tend to be more open to seeking services, and discussing it; and potentially thinking there is help in sight. It is also important to acknowledge and break the isolation that IPV exists in many relationships. To try to normalize the IPV questions in the first place \_\_\_\_\_ [00:34:18] some ways the practitioners can do that. Or, I routinely ask the following questions of all my clients. Or, I always ask my patients this.

It is important that if you start to screen or if you are not already for intimate partner violence in the setting that you sit to be thinking about safety planning. Not everyone on the phone indicated that they feel confident in the area of intimate partner violence. What you will want to be thinking about is how you can link with community partners to help make an appropriate safety plan. We will talk about that in a moment. Some of the ways to ask these questions are to understand that intimate partner violence victims happens within a complex setting and a complex behavior.

When we have intimate partner violence, it is not just the individual that is affected, but their relationship to their other family members; their children, their parents, and their siblings. It affects the community within which they live and the society in general. To be thinking about the socioecological model as you are screening a patient, it helps to put their intimate partner violence into perspective; not only for them, but for you as well. It is also important as the service provider that we understand that it is obviously the client's decision what they choose to do with the information that we give them. But to know that your client may be in a precontemplative state when you first approach them, your very question may move them from precontemplation to contemplation.

It is not very easy to go back to precontemplation once a client has entered the contemplation stage. Sometimes, while it may not feel that way to you as a service provider, just asking the very questions about their safety and intimate partner violence may move your client along the line of readiness for change to be able to eventually do something about it. Sometimes it can take weeks, months, or years of being in the planning stage. Understanding your state regulations and your VA regulations regarding child protective reporting because this intimate partner violence is revealed to you in these questions.

Children and minors are involved. You will have another set of steps that you will need to take. We want to support the abuse person and not blame them. Let them know they are not crazy. Many victims will report that they feel crazy. But they cannot believe they got themselves into this situation. There is a lot of self-blame that happens. We think one of the most helpful things we can to our clients is that they do not deserve this type of treatment. Letting them know that they have the right to be safe at home.

It is also important when we learn about the client, if they report perpetration, that we also provide support. We know that there are perpetrator interventions out there. Some of them are the subject of controversy. Some do not believe in the efficacy of programs. But we do have some effective treatments coming out. I will speak more to those in a moment. When we ask how do we ask? There is a difference between inquiry and assessment. Screening is when you get the yes or no. Assessments is how bad is it and figuring out what you are going to do about it. There are potential screens and questions recommended by the CDC.

There is a wonderful website which offers free screening questions for domestic violence. Some of them that I have picked for purposes of today are has anyone close made you feel unsafe? Has anyone close to you insulted you, embarrassed you, or withheld financial resources; food, medication, shelter? Have you been pushed, grabbed, shoved or slapped? Have you been bit, kicked, choked, or hit with a fist? Has anyone forced you to engage in sexual activities against your will? Have you physically hurt anyone close to you in any of the above ways?

The CDC resources for screening recommendations are excellent. Some of your decisions about how you are going to screen and what you are going to ask depend on where you are located. How much privacy you have. How much time you have with the client. There are three\_\_\_\_\_ [00:37:57] questions that were tested in an Emergency Room setting. Then asking those three questions, they resemble a 20-item measure that can be asked with 80 percent effectiveness. It really depends on where you are. What you need to do with the ask. What your next step is. If you are in a facility that has a social worker. Or, if you are asking the screening questions, but a social worker is doing the assessment, you are going to perhaps ask different questions than if you are the person responsible for the screening assessments and referrals.

Our group at the hospital has created palm cards, which we passed out. They could easily hidden in someone's shoe, or in a purse, or in a glove box. Those palm cards do not just have the numbers of the domestic violence provider on it. But we provide the series of helping organizations, including transportation, housing, shelter, and food, clothing. Because often a victim may be in need of more than just one thing.

Obviously, maintaining privacy is imperative. But we also know that sometimes that is difficult especially if you are working in a VA setting that has an Emergency Room. Many Emergency Rooms simply have a flimsy cot and curtain between the two patients. Obviously, maintaining privacy within those settings is difficult. You may ask the service provider on the floor, if you can move the patient safely to an area where you can ask privately? Or, if the patient is going to be moved for some tests? The testing site that they are moved to may have a more private area. If they are with a family member, you might ask the family member to step out and say that it is protocol that you have to have a series of investigations or questions you need to do in private.

Be aware of the noise factor, obviously; and know where the other party is waiting and present. It is also possible that other people who may not be necessarily the perpetrator or the batterer could overhear your conversation; but are related to the batterer and may have pressure to report such screening to the person who is providing the perpetration. You always want to screen clients separately from each other. We have one more polling question and then a closing slide before we move to questions and answers at 3:45.

Unidentified Female: Thank you. So for our attendees, I am putting up your final poll question now. The question is…. I will wait for that to come up. Challenges to addressing IPV in any setting are many. What future training would help you do your job better? You can select more than one option. Feel free to select as many as apply to you. The results are starting to stream in. we have already about a third of our audience respond. We will give people some more time. Alright, it looks like we have about 70 percent of our audience reply. I see some pretty clear trends.

I will go ahead and close that out and share those results. It looks like 62 percent of our respondents would like to know how to conduct an initial safety plan. Thirty-one percent, how to facilitate an effective referral. Seventy-nine percent, to understand what interventions work best; and 50 percent, to form partnerships with local IPV community. Thank you to our respondents. I will turn it back to you, Dr. Cerulli. I apologize.

Catherine Cerulli: That is okay. I am just pulling up my slides here. It should go right to the slideshow where we were, right?

Unidentified Female: Yes.

Catherine Cerulli: Thank you for answering those. One of the things about conducting an initial safety plan and why I think it is important that we offer and that you receive training on that safety planning is first of all, not all of you work in a facility where you have a social worker that you could make that referral for. Understanding how to conduct a safety plan is really important training. If you do not have one provided through the VA system within the next little bit, I would contact your local domestic violence provider in town and ask them.

The next time they are doing safety plan training for their own staff, outline staff, if you could sit in on those. They tend to be free. Also, I am thinking about facilitating an effect referral by allowing yourself to be a participant in safety planning. You start to build a relationship with your local provider. It makes an effective referral much easier. Rather than doing a warm handoff – I'm sorry – a cold handoff where you are giving your client a phone number, you are actually able to pick up the phone and make a warm handoff and an effective referral knowing which agency in town meets the needs best that your client has.

I think that my experience in doing this work for over 30 years, it is very different for a client. For when I pick up the phone and make a person to person transfer. I let them talk to the other provider on the telephone – than me simply handing them a palm card. Then perhaps, having to hear when they place the call. Now, there is intervention guides that are coming out very soon in publications. What interventions work the best for what particular issue facing intimate partner violence? The questions that often come up are what do you treat first? Do you treat the alcohol and drug abuse? Do you treat the intimate partner violence? If it is the victim versus the perpetrator, what do you do?

There is work being done by Caroline Easton who was out of Yale. She is now currently at\_\_\_\_\_ [00:43:16]. She has a series of articles coming out and looking at cognitive behavioral therapy for men who are substance users. Who also use alcohol, drugs, and a perpetrators of intimate partner violence? You may want to look to some of her work. There is also being done with batterers' intervention programs that are Veteran and military specific, which has had very good success rates especially with active duty as well.

One of the things sadly that we do not know is when interventions work best for female perpetrators. Very little information is out on female perpetrators within Veterans on the intervention side of the fence. There is some done with bidirectional couples.

Again, we are putting together a grid on what is out there that has been published. That does not mean there is interventions happening that we do not know about. If they have not been published. We welcome you to contact us through our e-mail at the end of this presentation, if you're working on interventions that you find are helpful and you would like us to know about.

In connecting with others, we cannot be experts at everything. It is really important that we ask for help when dealing with difficult domestic violence cases. Also, that you take care of the caretaker. When we start to ask these questions of our clients, they are actually the clients that haunt us. Because we heard so often in the press about homicides and murder suicides that are Veteran family involved.

We know that while these are low based rate phenomena, we do not want this to happen to anyone. We know the tragedy that can happen in the wake of these cases. If you could reach out to your local domestic violence providers and build bridges with those agencies, you may have some comfort not feeling so alone in dealing with these complex cases; but also, in being able to rely on the expertise of others.

I did provide some resources for you. These are some of the hotlines that are our GoTos. A great resource for us is the National Domestic Violence Hotline. We just finished a project with them, a three year project in talking about suicide and domestic violence\_\_\_\_\_ [00:45:18] with their front line workers who answer the telephone. I am so impressed with the people who work there in terms of their commitment to the issue of eradicating and ameliorating domestic violence; but also, the way in which they handle their hotline calls. I was able to sit in on a number of meetings and really get to know the counselors there.

I strongly recommend, if you do not have a local hotline that you call your National Domestic Violence Hotline. In doing so, they have a resource at their fingertips and connect the Veteran clients that you are working with, with resources that are local for you. That is my contact information. Now, we can move to questions.

Unidentified Female: Excellent, thank you so much. For our attendees, if you are looking to submit a question or a comment, please use the question section at the control panel on the right-hand side of your screen. Just click the plus sign next to the word questions. That will expand the dialogue box. You can submit your question or a comment there. We will get to it in the order that it is received. The first question…. Do you know of any VAs that have peer led support groups for survivors or ITV?

Catherine Cerulli: The answer for that is no. I am unaware of that. I know that a good person you might want to reach out to is Melissa Dichter, who is out of the Philadelphia VA. Or, Kate Iverson, I know both of them are working on intimate partner violence and victimization within the VA. If whoever that is\_\_\_\_\_ [00:46:44] meeting, I can connect you with Melissa.

Unidentified Female: Thank you. Are there any tips on assessing whether or not our clients are perpetrators of ITV outside of just asking the screening questions?

Catherine Cerulli: That is an interesting question. The screening questions involve both victimization and perpetration. But sometimes, some of the symptoms that you will see with perpetrators depending on the type of perpetration that you are seeing. There was a perception that perpetrators only perpetrated at home. But we are starting to see that there is a group of perpetrators that have problems in many settings in their lives. They are getting in trouble at work. They are getting in bar fights. They are having traffic infractions and DWIs. They are involved in law enforcement issues. They are in the courts.

You will sort of start to see their lives just entangle a little bit across multiple sectors. Those are some red flags I would look at. Obviously, alcohol, or drug use, a history of childhood abuse, and some of the risk factors that we mentioned. I think short of asking them, and, or\_\_\_\_\_ [00:47:49] that comes to you from another family member or employer; I think short of asking them and getting an honest answer, there is no definitive way to know.

Even if you have a client that you are working with who is arrested for intimate partner violence, you may not necessarily…. They may deny it. They may say that in fact, the arrest was unjustified. They were acting in self-defense or a whole host of other conditions. But no, I do not think there is a definitive way to know.

Unidentified Female: Thank you. What do you consider the best screening tool for IPV?

Catherine Cerulli: Again, I said earlier, I think – and this question may have predated the screening conversation or comments that I just made. I think it really depends on who you are screening. What you are screening for. How much time and resources you have. I think the difference between screening and assessment is a wide gap. For assessment, there is a whole host of long assessment questions that you can ask that are going to get at not only the intimate partner violence, severity, and frequency, but also the other issues, which are comorbid.

The best screening instrument for danger assessment, which we have used on our team for years is the danger assessment, which was put up by Jackie Campbell. You can go online and download that for free. Then there is a training online that you can do for a minimal cost. The danger assessment is one of the best tools. Because it gets at the intersections of homicide and suicide. Suicide not only for the victim, but also for the perpetrator; so, it lets you examine the risk factors for the homicide and suicides that we talked about earlier.

The danger assessment, it also provides a weighted score. You might get a two out of 20. But if the two are he threatens to kill me. Or, she threatened to kill me. I have a – she or he has a gun. You are going to be weighted higher. Each question is weighted based on the weight of that particular question in a risk factor profile. The danger assessment is one that I think is very good. If you work with a younger population, the CDC also has teen dating violence questions as well, or dating violence questions.

Unidentified Female: Thank you. In our VA, there is a need for resource, for instance support groups for all females only. Is this a common situation in other Vas or similar settings?

Catherine Cerulli: That gets back to the question that was asked earlier about support groups. I am familiar with some female only support groups at VAs. I do not know that they are – what curriculum they are using. Or, if there is evidence based to them. There are some evidence based groups seeking safety and a couple of others that are out there. Again, I would probably refer people to Melissa Dichter for those questions.

Unidentified Female: Thank you. That is the final pending question at this time. Do you have any concluding comments you would like to make?

Catherine Cerulli: No. I would just like to thank you all for joining the webinar. I know domestic violence and suicide are difficult topics to talk about. But I do believe as pressing public health concerns both of them independent of each other, the combinations makes them even more pressing to address in a way that is evidence based.

I will just close with saying if you are interested in the toolkit that we are putting together, which will be a list of articles, and which highlight the risk factors. Hopefully some very simple Venn diagrams that you will be able to review with clients. Please do let us know. If you think of any questions after you have gotten offline, feel free to e-mail.

Unidentified Female: Well, thank you so much, Dr. Cerulli for coming on and lending your expertise to the field. Of course, thank you to our participants for joining us today. In just a moment I will close out the meeting.

Please wait just a second while a feedback survey populates on your screen. We do look very closely at your responses. It helps us improve sessions we have already given; and as well as ideas for new sessions to support.

Thank you once again everyone. Have a great rest of the day. Thank you, Kate.

[END OF TAPE]