Intimate Partner Violence – A Risk Factor for Suicide Among Veterans

From Science to Practice

Using Research to Promote Safety and Prevent Suicide

To avoid stigmatizing language, VA in its publications often refers to intimate partner violence use (not perpetration) and experience (not victimization).[1] However, much of the research literature on intimate partner violence refers to perpetration and victimization; those terms appear in this document.

Overview

Intimate partner violence (IPV) "includes physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)".[1] Note that IPV occurs in heterosexual and same-sex relationships;[2,3] is unidirectional or bidirectional;[2,4] and can (and often does) occur after a relationship has ended.[5] IPV is associated with suicidal ideation, attempts, and death.[6,7,8] IPV is also a significant pathway to physical, mental, and social health problems including posttraumatic stress disorder (PTSD), depression, anxiety disorders, substance misuse, financial difficulties, and homelessness.[9,10,11,12,13] Addressing the risk factors and mental health conditions that may have been present before, during, or after IPV use or experience can improve health outcomes and reduce or eliminate suicidal ideation and behavior.[6]

Key Findings

- Suicidal ideation or behavior and IPV are prevalent, and often co-occur, among Veterans. Veterans may be at increased risk for IPV compared with non-Veterans due to environmental, psychological, and social stressors associated with military service including deployment, family separation and reintegration, mental health disorders, head trauma, substance misuse, and military sexual trauma.[8,14,15,16] People who have served in the military are more likely than the general population to have had adverse childhood experiences (ACEs) or other forms of premilitary trauma,[17,18] which are associated with increased likelihood of IPV.[19,20]

IPV Experience (Victimization)

- A rapid review of seven studies including 2,140 Veteran women found that 58% reported lifetime IPV or sexual assault. However, the strength of the evidence that contributed to the overall estimate was rated as low.[21]
- Thirty-three percent of women Veterans report lifetime IPV victimization compared with 24% of non-Veteran women.[22] Over 18% of women Veterans receiving primary care from the Veterans Health Administration (VHA) reported experiencing IPV in the past year.[15]
- Women Veterans and service members, regardless of whether they are rural- or urban dwelling, have higher rates of IPV victimization than their civilian counterparts. The Centers for Disease Control and Prevention (CDC) found that 23.5% of rural women Veterans and service members have experienced IPV and 23.3% of urban women Veterans and service members have experienced IPV. Women civilians living in rural or urban areas have IPV victimization rates of 14.6% and 14.5%, respectively.[23]
- Women Veterans who have experienced IPV are twice as likely as women Veterans who have not experienced IPV to receive suicide-related ICD codes.[7] And among women Veterans, IPV-related traumatic brain injury (TBI) is positively associated with worse health status across physical and mental health domains, even after controlling for PTSD and military sexual trauma.[12]
- A systematic review of two studies including a total of 5,025 participants determined the overall prevalence of lifetime IPV experience among Veteran men to be 12.6%.

The evidence contributing to this estimate was rated as low strength.[21]

- Analysis of CDC data found similar risk for experiencing IPV among male Veterans and their non-Veteran counterparts under age 55. However, male Veterans aged 55 or older reported a lower lifetime IPV experience rate (9.5%) than did their male non-Veteran counterparts (12.5%) of the same age.[9,24] More recent CDC data found that male civilians had slightly higher rates of IPV victimization than male Veterans and service members, regardless of whether they resided in a rural or urban area.[23]
- A study of post-9/11 Veterans in intimate relationships found that 60% of women and 65.6% of men had experienced IPV in the past six months. Psychological IPV (e.g., threatening, yelling, insulting, swearing) was the most reported IPV type among men and women, followed by physical IPV (e.g., beating, kicking, pushing, slapping) and sexual IPV (e.g., sexual assault), which was more commonly experienced by female than by male Veterans.[11] Another study of post-9/11 Veterans found that experiencing physical IPV was associated with increased presenteeism (lost productivity) among men, but not women, whereas experiencing sexual IPV was associated with both absenteeism (time absent from work) and presenteeism among women, but not among men.[25]

IPV Use (Perpetration)

- IPV use may be higher among military than civilian populations. A meta-analysis found that for US military populations, past-year physical IPV use ranged from 5% to 32% while the same type of past-year IPV use among US civilians ranged from 4% to 15%.[26] All types of IPV use appear to be more prevalent among Veterans compared to active duty service members.[26]
- One of the most cited potential risk factors for IPV use among Veterans is PTSD and PTSD symptom severity, particularly anger and hyperarousal, may be associated with IPV use among male and female Veterans.[27,28,29,30,31,32] Substance misuse,[27,33,34,35] ACEs,[33] and being younger[34] are also possible IPV use risk factors for Veterans.
- Research on women Veteran use of IPV is scarce. However, one study found women Veterans were more likely to use physical IPV than their male partners. No differences in psychological IPV use were found between male and female Veterans.[30] Another study of women Veterans found that 16.6% reported using IPV within the past six months,[36] and there is some evidence that women's use of IPV may be in response to their own IPV experiences and/or PTSD symptoms.[28]

Ways You Can Help

- Ask about Veteran patients' experiences with IPV. Use the IPV screening protocol as mandated by VHA. Screenings should occur in a one-on-one setting to ensure privacy and safety and should use a tone that is open, noncoercive, and non-stigmatizing. The protocol can be found ***here.***
  Provide referrals for care based on IPV and suicide risk screenings, as necessary.
- Visit the Intimate Partner Violence Assistance Program (IPVAP) ***website*** to learn more about VA's IPV programming and resources. IPVAP supports the practice of screening for both IPV and suicide risk, as risk for one can increase risk for the other. The IPVAP directive (VHA Directive 1198) is available ***here***.
- Contact your local IPVAP Coordinator. They can provide consultation services and resources for Veterans affected by IPV. Locate your IPV Program Coordinator ***here***.

There is no single cause of suicide. It is often the result of a complex interaction of risk and protective factors at the individual, interpersonal, community, and societal levels. To prevent Veteran suicide, we must maximize protective factors and minimize risk factors at all of these levels.

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