GBV AoR HELPDESK

Gender-Based Violence in Emergencies

Evidence Review: A Summary of the Links between Intimate Partner Violence, Military Personnel and Veterans

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Introduction

This evidence review synthesizes the available literature and data relating to linkages between intimate partner violence (IPV)[1] and military active-duty personnel and veterans in relation to their perpetration and experiences of intimate partner violence. As part of this review the GBV AoR Helpdesk also explored data on military and mental health issues (such as substance use disorders (SUD)[2], post-traumatic stress disorder (PTSD)[3]), traumatic brain injury (TBI)[4] and other factors which may interplay with, or be exacerbating factors for, IPV. This review is based on rapid desk-based research using key relevant search words and terms[5]. It is not intended to be exhaustive but to provide a summary of the available information which may be relevant and inform GBViE prevention and response programming.

The review begins with a condensed summary of the topline findings from the literature with synopses of the most key, relevant studies sub-divided by theme/focus. A summary of main findings and key implications for services follows. Finally, there is an annex with an annotated bibliography of further studies

[1] Intimate partner violence: refers to behavior within an intimate relationship that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors. This definition covers violence by both current and former spouses and partners. (WHO)

[2] Substance use disorder: reflects problems arising from the use of a range of substances to include alcohol, cocaine, opioids, and more, including physical dependence (tolerance and withdrawal), risky use, social impairment, and impaired control. (DSM-5-TR – American Psychiatric Association, 2022) In this review other terms from original articles are used (substance misuse, abuse, excessive use) to reflect problems related to substances that were not referred to as a SUD diagnosis. Some differences in definition may exist across studies.

[3] PTSD: is a psychiatric diagnosis that some individuals may develop after exposure to a traumatic event. The symptoms are characterized by (a) reexperiencing the trauma (painful recollections, flashbacks, recurrent dreams, or nightmares); (b) avoidance of trauma-related stimuli; (c) negative cognitions and mood; and (d) chronic physiological arousal (for example aggressive, reckless or self-destructive behavior, sleep disturbances, hypervigilance or related problems). (DSM-5-TR – American Psychiatric Association, 2022)

[4] Traumatic brain injury: is a disruption of brain function, ranging from mild to severe, caused by an injury to the head. (Centers for Disease Control and Prevention, 2023)

[5] Searches through Google Scholar and Zotero, and in the databases of APA Psycnet and The Lancet. Search terms used include adverse childhood experiences, ACE, childhood trauma, substance use (alcohol and drugs), PTSD, traumatic brain injury, IPV, domestic violence, perpetration of IPV, veterans, military, armed actors, armed forces, gender differences between men and women veterans.

which may be of interest to practitioners and policy-makers who wish to take a deeper-dive into this issue. References are supplied.

Key considerations when reading this review are as follows:

- Geographical scope – most of the research sourced on this topic within this rapid review search timeframe originates from the U.S., little information was retrieved from humanitarian settings. There may be limitations in extrapolating that the same risk factors for IPV occur in different cultural contexts.
- Language - This rapid review of the evidence relates to data sources available in English and may therefore omit studies available in other languages.
- This evidence review was not focused on and did not include a review of programming.
- Clinical Lens - Almost all the published research studies reviewed are from a medical/clinical framing perspective and there was a lack of sociological/social work framed studies and specifically feminist informed social work studies that have been published to include within and inform this review. This gap is important to flag in terms of potential research biases such as the extent to which women and girl survivors' experiences are factored for and how the studies interpret GBV, linkages and focus their recommendations.
- War-affected communities – with much of the relevant research coming from the U.S., there are limitations in transferring the learnings to communities who were affected by war in their own territory. In countries with active conflict, it is likely that a higher percentage of the population has fought in the conflict, and that entire families and communities have been directly affected.
- While they may be contributing factors, it is important to consider that IPV is not caused by military experience or determined by social or mental health conditions. IPV relates to abuse of power and control and is rooted in systemic gender inequalities. **IPV is usually perpetrated by men with women and girls being disproportionately impacted by, and experiencing, IPV.**

The World Health Organization (WHO) estimates 1 in 4 women has been subjected to physical and/or sexual violence from a current or former male intimate partner at least once in their lifetime. The harm caused by IPV can profoundly damage the physical, sexual, reproductive, and psychosocial well-being of survivors[6]and families. (World Health Organization & London School of Hygiene and Tropical Medicine, 2010; World Health Organization, 2022) IPV has been linked with multiple factors at individual, community, and societal levels. Younger age, economic stress, exposure to family violence during childhood, exposure to war or political violence, heavy alcohol and substance use are some of the identified risk factors that make it more likely someone may perpetrate IPV. (Capaldi et al., 2012) The available research suggests a variety of psychological health problems may present in some IPV perpetrators, including anxiety, depression, suicidal behavior, personality disorders, alcoholism, or gambling. (Sesar et al., 2018).

According to the American Psychological Association, the unique psychosocial and physical demands, and stressors in military life, may impact relationship satisfaction and vulnerability factors for military families, and may contribute to higher rates of IPV (Johnson et al, American Psychological Association Presidential Task Force on Military Deployment Services for Youth FaSM, 2007). Military service often entails intense exposure to violence, human suffering and death, life threatening experiences and physical injuries, perpetrating harm on others, as well as frequent relocation, family separation, living in isolation and under harsh conditions. Readjustment stressors affect most soldiers when returning home. Returning soldiers may be coping with injuries and psychological trauma, in some cases causing severe impairment and dependence on others for care. Many veterans experience feelings of loneliness and disconnection from friends and family upon return, they find families have reorganized roles and changed habits in their absence. They may perceive they play a less critical role within the family than before. With challenges to find employment, and experiencing a loss of the military identity, there can be a shift in power dynamics which veterans report means they struggle to find their place in the family and larger community. (U.S. Department

[6] Acknowledging that within this there may be IPV victims who did not survive.

of Veterans Affairs, 2024; National Veterans Homeless Support, 2024).

Worldwide IPV and GBV are under-reported. Survivors can experience stigma or retaliation, there is limited information and availability of services, numerous barriers in access, and, in many contexts, de facto impunity for perpetrators. When reporting IPV, survivors may face rejection from family and important social losses, exacerbating physical, emotional, social and economic vulnerability. These factors can increase the suffering of survivors and prevent them from seeking help. (Inter-Agency Standing Committee, 2015) Partners of military personnel and veterans may face additional unique barriers. These may include, but not be limited to, practical issues such as geographic mobility, social isolation, or the reverse (e.g., a sense of pressure / surveillance from military affiliated community members), imbalance of power with their partner perceived as a reputable figure in society (e.g. considered a 'hero' for their service), and economic dependence on their partner.

Key Research Findings

Military and IPV Perpetration

Estimates on prevalence of IPV perpetration by military populations vary greatly between studies, owing to the diversity of samples used (ranging from the general military population to specific clinical populations, active duty and veterans, and service members from different eras of service), and to inconsistent definitions of IPV perpetration across studies. Most of the available data pertains to experienced IPV among women and perpetrated IPV among veteran men in heterosexual couples. (Gierisch et al., 2013).

A systematic review of studies on IPV among military populations (42 studies, including 41 from the U.S. and 1 from Canada), found a higher rate of past-year physical IPV perpetration among men in U.S. military populations (5.0%–32.0%) as compared to the U.S. general population (4.0%–15.0%). Such comparisons are limited by lack of adjustment to sociodemographic factors which can impact risks of IPV perpetration, including male predominance, relative youth and higher risk of heavy alcohol consumption in military populations. The same review found that male veterans had higher prevalence estimates of IPV perpetration (32%) compared to active-duty personnel (22%). No data was available for women veterans. Studies indicated military personnel of lower ranks presented higher rates of IPV perpetration, as compared to those in higher ranks, both men and women. (Kwan et al., 2020).

A different literature review, indicated that rates of IPV across US military populations range from 13.5% to 58%, associating the higher rates with samples selected on the basis of psychopathology. (Marshall et al., 2005).

Results of the Organization for Security and Co-operation in Europe (OSCE) -led survey on violence against women (focused on Albania, Bosnia and Herzegovina, Montenegro, North Macedonia, Serbia, Moldova, Ukraine, and Kosovo), suggest that women are more vulnerable to violence when their partner has been involved in conflict. Half of women whose partner fought in an armed conflict reported long-term psychological impacts on their partner. Women whose partners have fought in an armed conflict report higher rates of physical and/or sexual violence perpetrated by their partner compared with those whose partners have never fought in an armed conflict (19% versus 14%). (OSCE, 2019).

Risk factors for IPV perpetration among military personnel, include witnessing and experiencing abuse in childhood, previous violence victimization and perpetration, social deprivation and substance use disorders. (Trevillion et al., 2015) **A review of studies linking IPV with mental disorders** (including 10 studies from the U.S., Canada, U.K and Israel, with a combined sample of 34,939 men and

7736 women), **evidenced that mental disorders among military personnel may be associated with past year domestic violence perpetration.** (Trevillion et al., 2015) One of the studies in the review asked a sample of 236 U.S. male veterans seeking PTSD-related services to self-report instances of perpetrating violence, **27.5 % of men with PTSD reported past year physical violence perpetration against a partner and 91.0 % reported past year psychological violence perpetration against a partner**. (Taft et al., 2009) However, the co-occurrence of PTSD and IPV does not allow to conclude a causality. (Trevillion et al., 2015).

Occupation-specific risk factors have also been identified, with evidence suggesting **length of deployment as a risk factor for domestic violence perpetration**. Similarly, **combat stress is shown to be associated with domestic violence perpetration among active-duty military personnel, military veterans, and prisoners of war**. Associations between combat stress and perpetration of domestic violence are, however, found to be **partly mediated by the presence of PTSD in some studies**. (MacManus et al., 2012; Taft et al., 2009) These findings are noteworthy as **evidence suggests around 15–20 % of military personnel report symptoms of PTSD, anxiety or depression following deployment** (Corps UNN, 2010). Suicide rates among veterans exceed those of non-veterans, veterans also experience higher rates of suicidal ideation and suicide attempts. (Hoffmire et al., 2021) Despite some of the links suggested by specific studies, a systematic review of studies linking mental health and IPV in military personnel (Trevillion et al., 2015), found that measures used to assess IPV perpetration were inconsistent across studies, limiting the comparability and reliability of findings. An additional limitation is that studies included in the same review failed to control for confounders, i.e. third factors which could influence the association between mental disorders and IPV perpetration, such as exposure to violence in childhood which is a risk factor for both. (Trevillion et al., 2015).

A study on small arms and weapons in South-Eastern and Eastern Europe by the UN Development Programme, indicated that women were at heightened risk due to the increased numbers of firearms held by civilians. With perpetrators using firearms, women face additional risk to their lives in domestic violence incidents, in some cases leading to femicide by an intimate partner. Ukraine, where significant numbers of weapons have been in circulation for years, has placed in the high femicide rates category by the Small Arms Survey in 2012. (OSCE, 2019) Having children appears to increase the vulnerability to IPV, with 66% of people with children having experienced some form of psychological violence from a previous or current partner, compared to 54% among those without children. 25% of women who have ever had a partner and who have children have experienced physical violence, compared to 10% of those who do not have children. (OSCE, 2019).

Data indicates that military families may experience more severe forms of violence compared to the general population, and that the likelihood of severe IPV increases with deployment and with the length of deployment. (Heyman & Neidig, 1999; McCarroll et al., 2010) In a separate study, deployment was not a significant predictor of post-deployment domestic violence. However, younger soldiers, those with pre-deployment domestic violence history, persons of color (i.e., black, asian, hispanic), and those with off-post residence were more likely to report perpetrating IPV post-deployment. (Mccarroll et al., 2003).

Half (49%) of the veterans who reported utilizing Veteran Affairs (VA) healthcare[7] in the past year indicated perpetrating IPV. **Veterans who reported perpetrating IPV were more likely than veterans who did not to have received treatment for post-traumatic stress disorder (PTSD; 39% vs. 27%), chronic sleep problems (36% vs. 26%), anxiety or depression (44% vs. 36%), severe chronic pain (31% vs. 22%), and stomach or digestive disorders (24% vs. 16%).** Veterans who reported perpetrating IPV were also more likely than veterans who did not to have received medical treatment in the past year (86% vs. 80%),

[7] The Veteran Affairs (VA) healthcare system is a component of the U.S. Department of Veterans Affairs that implements a nationalized healthcare service in the United States, providing healthcare and healthcare-adjacent services to veterans.

seen psychiatrists outside VA (39% vs. 20%), and have outpatient healthcare outside VA (49% vs. 41%). (Relyea et al, 2023).

Pre-military Risk Factors

Research indicates that U.S. veterans report a higher rate of adverse childhood experiences (ACE) than people with no history of military service (Blosnich et al., 2021). ACEs are potentially traumatic events occurring in childhood (0-17 years), including experiencing violence, abuse, or neglect, witnessing violence or substance use (Trevillion et al., 2015). **Both men and women veterans were more likely to report having experienced a larger number of ACEs than civilians, indicating that those who seek a military career may originally come from backgrounds of more trauma as compared with the general population.** (Blosnich et al., 2021).

Data from the Canadian Armed Forces (*N* = 2,941, response rate = 68.7%) was used in a study to assess child maltreatment and deployment-related trauma (DRTE)[8] for impact on mental health in army personnel. The prevalence of exposure to child maltreatment and DRTEs in this sample was 62.5% and 68.6%, respectively. **Child maltreatment was associated with increased odds of past 12-month PTSD symptoms and mental disorders. Cumulative effects of having experienced both child maltreatment and DRTEs increased the odds of past 12-month PTSD symptoms, generalized anxiety, social phobia, and major depressive episode.** (Afifi et al., 2021).

ACEs are linked to chronic health problems, mental illness, and substance use problems in adolescence and adulthood. ACEs can also negatively impact education and livelihoods opportunities. ACEs have also been connected to challenges within interpersonal relationships, including IPV victimization and perpetration, relationship distress and instability, and lower relationship satisfaction. The available data is mostly from the general population, but evidence suggests similar patterns apply to military contexts. (Hughes et al., 2017; Wheeler et al., 2019; Trevillion et al., 2015).

A research study with military personnel and veterans (N=62), taking part in a domestic violence rehabilitation program, found a significant relationship between PTSD and IPV severity, as well as PTSD severity and reports of domestic violence in the family of origin. (Gerlock, 2004) The available research would indicate that considering the role of ACEs as contributing factors (and potential predictors of) IPV and the fact that military populations present particularly high levels of childhood trauma may be of significance for studies and support programs.

Substance Use Disorders (SUD)

A study examining drinking and perpetration of IPV among U.S. Army male soldiers (*N*= 9534), found **heavy drinking to be an independent risk factor for IPV, as heavy drinkers were 66% more likely to perpetrate IPV than abstainers**. In addition, self-reported moderate and heavy drinkers were three times as likely and light drinkers were twice as likely as non-drinkers to be drinking at the time of IPV perpetration (i.e., during the incident). (Bell, 2004).

Data on 7,424 U.S. soldiers, including male and female, IPV offenders, was analysed to determine the prevalence of substance use during abusive incidents, and to examine differences between substance-using and non-substance-using offenders. Results showed that **25% of all offenders used substances during abusive incidents (96% alcohol only, 1% other drugs, 3% alcohol and other drugs)**, with males

[8] DRTE: was assessed through self-reporting on 10 items including having experienced sexual trauma in the military, being in a life threatening situation, suffering injuries, knowing someone who was seriously injured or killed.

and non-Hispanic whites being more likely to have used substances. **Substance-using offenders were more likely to perpetrate physical IPV and more severe IPV[9]**. (Martin et al., 2010).

Substance Use and the Presence of Mental Health Conditions

It is not uncommon for service members and veterans to increase their alcohol and drug use during and after combat zone deployments as they may perceive such substances will help them relax, improve sleep, and reduce hyperarousal. However, **the interplay between hyperarousal and drinking frequency and quantity has been associated with higher levels of physical violence, and partners' reports of both physical and psychological abuse among a sample of military veterans** (data from 376 couples who participated in the U.S. National Vietnam Veterans Readjustment Study). Veteran's self-reported hyperarousal was significantly associated with partner's report of physical violence and psychological abuse toward them. Studies distinguished between the different PTSD symptom clusters and registered that the hyperarousal cluster was most strongly associated with the perpetration of violence. (Savarese et al., 2001). Similarly, a longitudinal study with 468 Burundian soldiers after deployments to Somalia, concluded that violent behavior during deployment was predicted by the level of appetitive aggression[10] and by the severity of PTSD hyperarousal symptoms pre-deployment (Nandi et al., 2020). Other studies with active-duty service members, found that the co-occurrence of excessive drinking and other psychosocial or behavioral variables have been associated with IPV perpetration. (Marshall et al., 2005; Klostermann et al., 2012).

U.S. administrative data were used to determine the prevalence and independent correlates of Alcohol Use Disorder (AUD)[11] and Drug Use Disorder (DUD)[12] in 456,502 Iraq and Afghanistan veterans. Over 11% of Iraq and Afghanistan veterans in the U.S. received substance use disorder diagnoses: AUD, DUD or both; 10% received AUD diagnoses, 5% received DUD diagnoses and 3% received both. **Of those with AUD, DUD or both diagnoses, 55–75% also received PTSD or depression diagnoses.** AUD, DUD or both diagnoses were 3–4.5 times more likely in veterans with PTSD and depression. Results highlight the **need for improved screening and diagnosis of substance use disorders and increased availability of integrated treatments that simultaneously address AUD and DUD in the context of PTSD and other deployment-related mental health disorders**. (Seal et al., 2011) To note, this study did not examine possible linkages of substance use and PTSD, with IPV.

Another study examined links between attachment styles, depression and violent behavior, and PTSD and substance use disorders, among military veterans in the U.S. 133 veterans took part in the survey, placing in one of three categories – PTSD only, SU only, and PTSD + SU. Most participants were white male. Significant differences were found between groups on depression, avoidant attachment, psychological aggression perpetration and victimization, and physical violence perpetration and victimization. **The PTSD + SU group had significantly higher levels of depression, avoidant attachment, and psychological aggression than the SU only group. The PTSD + SU group had significantly higher levels of physical violence than did the PTSD only group**, but both groups had similar mean scores on all other variables. (Owens, 2014).

A systematic literature review of 56 studies focused on women veterans found that SUD among women veterans is associated with increased occurrence of homelessness, injuries, intimate partner violence, and

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[9] This study considered severe/moderate IPV to include behaviors such as choking, strangling, severely beating, cutting with a knife, shooting with a gun, hitting with a fist, and kicking, and *not severe* IPV including behaviors that either inflict no physical injury or inflict minor physical injury that does not require medical treatment.

[10] Experiencing positive feelings in connection with perpetrating violent behavior.

[11] AUD: substance use disorder related to alcohol, ranging from mild to severe. Criteria for diagnosis includes excessive drinking, craving, interference with daily activities, tolerance, dependency.

[12] DUD: is used in this study to refer to SUD for substances other than alcohol. Diagnostic criteria as above.

sexual assault, and it often co-occurs with depression, PTSD, and suicidal behavior. **Women with substance use issues generally had higher rates of trauma exposures, including childhood sexual abuse, military sexual trauma, and IPV than did women without substance misuse.** Trauma rates are elevated among women veterans in comparison with the general population, **suggesting that the trauma burden among women veterans with substance misuse is especially pronounced**. (Hoggatt et al., 2015) Women with SUD are likely to face additional challenges to find support, in some settings they suffer more stigmatization for substance use than men and may experience barriers when accessing services both due to stigma and discrimination, and to services being in most cases designed for men and not equally capable to support women.

Post-Traumatic Stress Disorder (PTSD)

A connection between PTSD and IPV perpetration has been identified in several studies (Taft et al., 2011; Hoggatt et al., 2015), however the existing research does not allow to establish a causality between them. As described above, childhood trauma and alcohol and substance use, both especially prevalent in military populations, are contributing factors to both PTSD and IPV independently, and are possible confounders mediating the link between PTSD and IPV.

Service members experiencing post-combat stress and PTSD may find reunification with family stressful (living with young children, being startled by loud noises). Thorough attention to service members and their family members' stress and trauma levels is important for several reasons. **Increased stress in the family** (especially tension and hostility) **can trigger PTSD symptoms**. High levels of expressed emotion in the family have been shown to impede improvement in patients with PTSD (Solomon et al., 1987; Tarrier et al., 1999). Additionally, when there is conflict relationships can become less supportive, and **social support is a critical factor associated with decreased intensity of PTSD symptoms at two and three years post-combat** (Tarrier et al., 1999). There is also some **concern in the reunion phase about the risk of domestic violence.** Studies highlighted risk factors in the military population which may contribute to increased domestic violence, including frequent relocation associated with decreased social support, multiple separations (including deployments), long work hours, inherently dangerous work environments, and exposure to violence in the military. (Johnson et al., 2007; Clark & Messer, 2006).

Couples in which the veteran was diagnosed with combat-related PTSD were compared with two other groups based on the veteran's primary diagnosis (depression, adjustment disorder[13]/V-code[14]). Both the PTSD- and depression-diagnosed veterans perpetrated more violence than did those with adjustment/V-code diagnoses (Sherman et al., 2006). It is important to note that V-codes can apply to persons with or without mental health concerns. Also, it is important to recognize that the framing of these studies and the background of the researchers indicates they are applying a medicalized / clinical lens rather than for example, a feminist social work lens and approach.

PTSD in the veteran, can dramatically impact their intimate partners and family in a broad range of ways. **PTSD-related emotional numbing and emotional/behavioral withdrawal, as well as veteran's anger outbursts are identified as particularly damaging to relationships**. (Galovski & Lyons, 2004).

[13] Adjustment disorder: subjective emotional distress, with depression, anxiety, or both, following a significant life change or stressful life event that interferes with a person's ability to function effectively. (DSM-5-TR – American Psychiatric Association, 2022)

[14] V-codes are used to identify non-medical factors which may negatively impact the patient's mental health, including psychosocial, financial, and education-related aspects.

Traumatic Brain Injury (TBI)

Combat deployments may expose service members to blast injuries, shrapnel or bullets above the shoulders or falls or other injuries that may result in a head injury. Service members and veterans are among the groups at higher risk of sustaining a TBI, compared to the general population. More than 450,000 U.S. service members were diagnosed with a TBI between 2000 and 2021. (Department of Defense, 2022).

Most TBIs are mild (mTBI), and symptoms resolve quickly within weeks to a few months. Some TBIs are more serious ranging from moderate to severe, and full recovery could take one year or longer. **Aggressive behavior is typically seen with more serious head injuries but may also be associated with other co-occurring mental health disorders such as depression and pre-injury substance abuse**. (Carlson et al., 2011; Hoge et al., 2008).

A study with Israeli war veterans indicated that bodily injury is a risk factor for PTSD, with odds of developing PTSD following traumatic injury approximately eight times higher than following injury-free emotional trauma. As for SUD, intoxication is itself a risk factor for TBI, and TBI can also exacerbate previous substance use. (French et al., 2011). Among U.S. veterans with TBI screens in Veterans Affairs health facilities, 80% indicate they also have a psychiatric diagnosis. (Carlson et al., 2010). Up to half of all service members with combat-related mild TBI (mTBI) also meet criteria for PTSD, over one-third with a history of mTBI have depression, with increased risk of suicidal ideation and attempts. Additional impacts of mTBI in veterans can include cognitive impairment, alcohol and other SUD, chronic pain, and unemployment. This corresponds to civilian research where TBI has been linked to suicide, lower quality of life, and mood and anxiety disorders. (Silver et al., 2001; Rabinowitz & Levin, 2014; Tinney & Gerlock, 2014; Centers for Disease Control and Prevention, 2023).

Cognitive deficits caused by TBI interfere with work, relationships, leisure, and daily activities. The cognitive impacts of TBI are determined by a number of injury related variables including TBI severity, complications, linked injuries to other body regions, and chronicity of the injury. Patient characteristics such as age, pre-injury neuropsychiatric status, and genotype also play a role. In addition, cognitive recovery from TBI can also be moderated by the quality of the post-acute environment. (Rabinowitz & Levin, 2014). There is a lack of studies examining a linkage between IPV and TBIs in veterans and the current available evidence base remains weak with a generalized link to more aggressive behavior for those with severe TBIs or dual-diagnoses. Again, studies are largely drawn from a medical base and approach rather than a socio-ecological social-work research perspective.

Summary of Main Findings and Implications for Services

In general, this evidence review has indicated a lack of feminist-led, social work informed research studies published on the linkage between IPV and service or former-service as a member of the armed forces, especially within humanitarian settings. Therefore, it is key that the existing international inter-agency guidelines and standards are applied and maintained (such as the IASC GBV Guidelines (2015), The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming (2019) and the GBV Guiding Principles, for example) when designing and implementing programs and setting up services.

This review has, however, found the following main points in the existing research: Due to many factors, including the easy access to weapons, intimate partner violence is a serious threat in military families. The unique stressors in military life may increase vulnerability factors and contribute to higher rates of IPV. Military families often live in social isolation, dislocated from relatives, in a situation of financial dependency on the military spouse, these factors can be barriers for survivors to seek support. In some cultural contexts, among civilian and military populations alike, risk factors for IPV perpetration include childhood trauma, and

alcohol and other substance use disorders. Research also indicates that some of the cognitive, physical and social impacts of traumatic brain injury can be contributing factors for IPV perpetration. As for PTSD and other mental health concerns such as anxiety, depression or sleep disorders, studies find they are prevalent in many IPV perpetrators, however this is likely attributed to co-occurring confounding factors[15], such as childhood trauma and alcohol misuse. Indeed, research shows that adverse childhood experiences, substance use, traumatic brain injury, PTSD, or other mental health conditions, often co-occur, and combinations of these variables appear to aggravate the likelihood of someone perpetrating IPV. Military veterans have additional risks for several of these variables, reporting higher rates of childhood trauma, many being subject to life threatening trauma during deployment which in some cases can cause traumatic brain injury, PTSD, and/or a range of mental health conditions.

Implications for GBV Service Delivery with Survivors and Families in Community-based Settings

This evidence review focused on summarizing research on military personnel and veterans and IPV perpetration. From the data reviewed and the existing GBV-related guidelines it is possible to draw some general implications for services. There is a need for service providers to be cognizant of specific risks to survivors who experience violence from a current or former member of an armed force and to ensure that there is sufficient attention to:

Assessment and Program Design

- GBV is a human rights concern. In accordance with the **IASC GBV Guidelines** (Inter-Agency Standing Committee, 2015), all services and programs must prioritize the safety, respect, confidentiality and non-discrimination of survivors and people at risk of GBV.
- GBV **programs must be tailored to each context with their design informed by relevant local assessment data** as well as global evidence of what works to prevent and respond to violence against women and girls.
- It is relevant for assessments to **consider general and specific barriers IPV survivors in military families may experience when accessing services**. Providers must identify barriers to access services and define tailored context-specific actions to remove the identified barriers, facilitate awareness and promote access.
- Meaningful **community participation and local engagement and partnership** are key elements for designing effective programs and doing no-harm. Interventions must be survivor-centered, human rights-based, be designed and implemented through meaningful participation, have clear pathways for change indicated (e.g. Indicated in a theory of change) and take a socio-ecological model and systems-approach to addressing GBV.
- It is important for **military institutions and leadership to engage with GBV and Mental Health and Psychosocial Support (MHPSS) providers (and vice versa)** to ensure that effective response and prevention measures are designed, implemented, embedded, and institutionalized. Depending on context, key stakeholders may include local governments, military bodies, existing military health and social support systems, academia and professional societies, local women's and girl's rights organizations and specialized GBV service providers, other local and international organizations with GBV expertise, as well as military and veteran communities. An example of this multi-sectorial approach is outlined in the report *The psychological needs of U.S. military service members and their families: A preliminary report.*, developed by the American Psychological Association in response to concerns of the military community (Johnson et al, American Psychological Association Presidential Task Force on Military Deployment Services for Youth FaSM, 2007).
- **Based on the available local and global data carefully identify and select a service delivery model**

[15] i.e. third factors which could influence the association between mental disorders and IPV perpetration, such as exposure to violence in childhood which is a risk factor for both.

that aligns with the program objectives, aligns with achieving change on all the indicated pathways of the theory of change developed and which is guided by the participation and inputs received from women and girls**.** A consideration, for example, will be whether to select an integrated or standalone service delivery approach. There will be benefits and drawbacks to each of these which should be carefully considered.[16] Where feasible, survivors should be offered a range of choices as to where they can access services.

- Take **an intersectional approach to designing and implementing** GBV programs to maximize opportunities for inclusion of marginalized individuals and groups and leave no one behind.
- Adopt a **multi- or cross-sectorial approach**, which includes strengthening linkages and capacities of other services such as health, schools, and social service centers etc. (for example, to provide safe referrals for survivors) should be considered in locations and contexts where this is feasible.

Survivor-Centered GBV Case Management

- Implement survivor-centered holistic service provision delivery to **prioritize the safety of the survivor and support the survivors' needs, wishes and choices** in relation to services, referrals, and decisions affecting their life and the relationship.
- Ensure that **safety planning within the GBV case management process** (which can account for the survivor's experiences as well as the relevant and specific risks that may be posed by the veteran or active service personnel and any potentially linked issues such as substance use or PTSD) occurs and that risks are regularly discussed and assessed with the survivor.
- Ensure comprehensive survivor-centered risk assessment and safety planning is consistently embedded within practice and consider the **safety of children or other relatives (eg. Elders/grandparents)** who may also experience or be at risk of violence. This may involve liaison with child protection services, as applicable. This is given the growing evidence[17] that there are high levels of co-occurrence between intimate partner violence and violence against children, particularly within the same household.
- Ensure that there are **comprehensive referral pathways for survivors** in place e.g. shelter, health, psychosocial, livelihoods, child protection, etc. as well as generally available services available for veterans in the community (e.g. for their communication, health, substance use etc. needs). Where IPV occurs within households with children, children may be directly or indirectly impacted and require support from agencies (for example, child protection services). Veterans/active service personnel should not be the sole focus for support from all service providers in conflict/post-conflict situations as it is important to promote community cohesion and reduce risk of stratification.

Expertise / Capacity Building

- Ensure that service providers have adequate **understanding of the imbalance of power and abuse of power and control that survivors experience** and that women and girls encounter gendered discrimination when trying to access services. Given that veterans / active service personnel are often associated with authority / institutions, there is an increased risk that when they are perpetrating violence towards their partner and/or children, that survivors' experiences will not be believed, or the abusers' violence will be minimized. There is also some risk that institutions may seek to 'protect' the abuser from interventions or legal justice if they are an active service member or veteran by deploying strategies which aim to discredit or silence survivors. Service providers should receive training on these

[16] See, for example, GBV AoR Helpdesk (2022) Understanding the Core Functions and Differences between Women and Girls Safe Spaces. https://www.sddirect.org.uk/sites/default/files/2022-12/GBV%20AoR%202022%20WGSS%20OSC.pdf

[17] See, for example, Guedes, A., Bott, S., Garcia-Moreno, C., & Colombini, M. (2016). Bridging the gaps: a global review of intersections of violence against women and violence against children. Global health action 9(1): 31516. And Fulu, E., McCook, S & Falb, K (2017). What works to prevent violence against women and girls evidence review. Intersections of violence against women and violence against children. What Works to Prevent Violence: Global Programme.

aspects and there should be positive engagement with armed forces leadership and training provided to relevant personnel and armed forces family/or rehabilitation focal points.

- Service centers must be designed to provide safety and confidentiality to all IPV survivors. They should also have **trained case workers who understand and relate to the specific circumstances, factors and pressures present in military families and military structures more broadly**, so that they can relate to these and can also leverage/ identify relevant support mechanisms for the survivor.

Prevention, Communication and Outreach

- Develop **community-based prevention and promotion programs** that take into account the multiple risk factors for IPV present in military populations, and provide adequate information to women, girls, men, and boys, including on available services.
- **Consider the sensitivity of IPV** in military communities when designing prevention, communication, and outreach activities.
- Create a choice of **support networks for survivors** including the partners of veterans/armed service personnel who are experiencing violence and abuse. Creating general support networks for all veterans and armed personnel in general (irrespective of perpetration of IPV or not) is important in order to reduce isolation.
- **Advocate for military training and support systems to integrate robust sensitization regarding GBV and specifically IPV** and risk factors for IPV perpetration present in military personnel, promoting a culture of zero tolerance to GBV in the armed forces.

  Advocate for GBV considerations and key messaging to be integrated across services offered to military families, and build capacity across sectors to promote all services to be safe entry points for access to support, including in health, MHPSS, social services, education, other community supports, etc.

These are some of the key considerations that are likely to be important based on the current evidence. This list is not exhaustive, and it is always recommended that local contextualized assessments and studies are carried out when designing and implementing services which may be accessed by the key groups mentioned in this paper. Such studies and assessments should be informed and guided by all relevant stakeholders including local women's and girl's rights organizations and specialized GBV service providers.

Based on the findings of this review, the design of IPV prevention and response services for military communities – including services for survivors, and support to military personnel and veterans and their families, considering GBV prevention and response, MHPSS and child protection – is both relevant and sensitive. A specific programmatic review of existing services, including in humanitarian contexts and war-affected communities, would be relevant to identify best practice and lessons to guide future programs in such contexts.

Annex - Annotated Bibliography of Additional Relevant Research and Resources

This section contains additional research identified by the author which may be of supplementary interest.

Annan, J., Brier, M. (2010). The risk of return: Intimate partner violence in Northern Uganda's armed conflict, Social Science & Medicine, Volume 70, Issue 1, Pages 152-159, ISSN 0277-9536, https://doi.org/10.1016/j.socscimed.2009.09.027

This paper describes emerging themes from qualitative interviews with young women who have returned to their communities after being abducted, many sexually exploited, by armed groups in northern Uganda. Their interviews reveal multiple levels of violence victimization, including physical and sexual violence in an armed group, verbal and physical abuse from extended family members, and intimate partner violence. Striking is the violence they describe after escaping from the armed group, when they are back with their families. Interviews highlight how the conflict-related violence suffered by women, may heighten vulnerability for further victimization at home. The interviews point to how abduction into the armed group may exacerbate problems but highlight the structural factors that permit and sustain intimate partner violence, including gender inequalities, corruption in the police system, and devastating poverty. Findings suggest that decreasing household violence will depend on the strength of interventions to address all levels, including increasing educational and economic opportunities, increasing accountability of the criminal justice system, minimizing substance abuse, and improving the coping mechanisms of families and individuals exposed to extreme violence.

Dichter, M.E., Cerulli, C. and Bossarte, R.M. (2011). Intimate partner violence victimization among women veterans and associated heart health risks. *Women's Health Issues, 21*(4), pp.S190-S194.

The results of this study found veteran women were more likely than non-veteran women to report lifetime IPV victimization (33.0% vs. 23.8%). IPV exposure was associated with depression, smoking, and heavy drinking. Reflecting on its results, the study also considers that previous research indicates that women veterans and civilians differ on sociodemographic characteristics correlated with substance misuse, and women veterans have a higher prevalence of risk factors for substance misuse including childhood abuse, intimate partner violence, lifetime history of sexual assault, and adverse mental health conditions.

Elbogen EB, Johnson SC, Wagner HR, Sullivan C, Taft CT, Beckham JC. (2014) Violent behavior and post-traumatic stress disorder in US Iraq and Afghanistan veterans. Br J Psychiatry. 204(5):368-75. Doi: 10.1192/bjp.bp.113.134627. Epub 2014 Feb 27. PMID: 24578444; PMCID: PMC4006087. DOI: 10.1192/bjp.bp.113.134627

This study investigated the extent to which PTSD and other risk factors predict future violent behavior in military veterans. 1090 veterans from 50 US states and all military branches completed two survey waves mailed 1 year apart. Younger age, financial instability, history of violence before military service, higher combat exposure, PTSD, and alcohol misuse at baseline were significantly associated with higher severe violence and other physical aggression in the past year at the 1-year follow-up. Co-occurring PTSD and alcohol misuse was associated with a marked increase in violence in veterans. Compared with veterans with neither PTSD nor alcohol misuse, veterans with PTSD and no alcohol misuse were not significantly more likely to be severely violent and were only marginally more likely to engage in other physical aggression.

Horn, R., Puffer, E.S., Roesch, E. *et al.* Women's perceptions of effects of war on intimate partner violence and gender roles in two post-conflict West African Countries: consequences and unexpected opportunities. *Confl Health* 8, 12 (2014). https://doi.org/10.1186/1752-1505-8-12

This paper explores women's perceptions of the causes of IPV in West Africa, and the ways in which they understand these causes to interact with the experiences of war. The study was conducted in two locations in Sierra Leone and two in Liberia, through 14 focus group discussions and 20 individual interviews. Women perceive the causes of IPV to be linked with other difficulties faced by women in these settings, including their financial dependence on men, traditional gender expectations and social changes that took place during

and after the wars in those countries. According to respondents, the wars increased the use of violence by some men, as violence became for them a normal way of responding to frustrations and challenges. However, the war also resulted in women becoming economically active, which was said by some to have decreased IPV, as the pressure on men to provide for their families reduced. Economic independence, together with services provided by NGOs, also gave women the option of leaving a violent relationship.

Kelly, JTD. Colantuoni, E. Robinson, C*. et al (2018).* From the battlefield to the bedroom: a multilevel analysis of the links between political conflict and intimate partner violence in Liberia. *BMJ Global Health* 2018;3:e000668. https://gh.bmj.com/content/3/2/e000668

This research examined the relationship between residing in a place affected by political conflict, and violence against women years after peace is declared, focusing in the Liberian context. According to the results, residence in a district affected by conflict and conflict-related fatalities was associated with a 50% increase in risk of IPV, after adjusting for individual-level characteristics normally correlated with this type of violence. Women living in a district that experienced 4–5 cumulative years of conflict were almost 90% more likely to experience IPV than a counterpart living in a district with no conflict.

Misca, G., & Forgey, M. A. (2017). The Role of PTSD in Bi-directional Intimate Partner Violence in Military and Veteran Populations: A Research Review. *Frontiers in psychology*, *8*, 1394. https://doi.org/10.3389/fpsyg.2017.01394

This paper reviews literature investigating the role of PTSD in bi-directional IPV in military and veteran populations, as a potential contributing factor for perpetration but also as a risk factor increasing vulnerability for victimization.

NPR (2016) After Combat Stress, Violence Can Show Up At Home. https://www.npr.org/sections/health-shots/2016/04/27/475908537/after-combat-stress-violence-can-show-up-at-home. (Accessed: 28 Nov 2023).

This NPR news piece, whilst not a research study, does include testimonies of women survivors of intimate partner violence by military partners in the U.S., which bring insights into some of the specific barriers facing military spouses in reporting and seeking help in situations of violence. The potential impacts on their spouses' military career, and financial penalties for the entire family, are some of the barriers preventing survivors from asking for support in such cases of IPV. Some of the women interviewed also mention a normalization of violence among veterans, and a sense of duty towards the country, mentioning this is their role in the war.

Sparrow, K., Kwan, J., Howard, L. et al. (2017) Systematic review of mental health disorders and intimate partner violence victimisation among military populations. Soc Psychiatry Psychiatr Epidemiol 52, 1059–1080. https://doi.org/10.1007/s00127-017-1423-8

An analysis of thirteen studies which showed stronger evidence for an association between IPV victimization and depression/alcohol problems than between IPV victimization and PTSD. An association between IPV victimization and mental health problems was more frequently found among veterans compared to active duty personnel. However, the link between IPV and alcohol misuse was more consistently found among active duty samples. Finally, among active duty personnel psychological IPV was more consistently associated with depression/alcohol problems than physical/sexual IPV.

Suffoletta-Maierle, Samantha Phd; Grubaugh, Anouk L. Ma; Magruder, Kathryn Phd, Mph; Monnier, Jeannine Phd; Frueh, B. Christopher Phd. (2013) Trauma-Related Mental Health Needs And Service Utilization Among Female Veterans. Journal Of Psychiatric Practice 9(5):P 367-375.

This study examined the extent to which female veterans exposed to trauma receive treatment for trauma-related problems such as PTSD and substance use within the Veterans Affairs (VA) healthcare system in the U.S. The literature documents a high rate of trauma exposure among female veterans, and indicates

that female veterans with SUDs have higher rates of childhood sexual abuse, military sexual trauma, and domestic violence victimization than female veterans without SUDs, and women with PTSD are particularly at risk of developing substance-related problems. The review also indicates that trauma-related mental health problems, such as PTSD and substance-use problems, are under-diagnosed and under-treated among female veterans in VA healthcare settings. The few available studies examining general service utilization among female veterans are also reviewed, and implications for future research and clinical practice in the area of female veterans' trauma-related mental health needs and service use patterns are discussed.

Sullivan CP, Elbogen EB. PTSD symptoms and family versus stranger violence in Iraq and Afghanistan veterans. Law Hum Behav. 2014 Feb;38(1):1-9. doi: 10.1037/lhb0000035. Epub 2013 May 6. PMID: 23646917; PMCID: PMC4394858. DOI: 10.1037/lhb0000035

This paper examines the relationship between PTSD symptoms and different types of violent behavior in Iraq and Afghanistan veterans of U.S. military forces, specifically family versus stranger violence. 1,090 veterans, from 50 states and all military branches were randomly sampled and responded to surveys at baseline and at 1-year follow-up. 13% reported aggression toward a family member and 9% toward a stranger during the 1-year study period. The results provide limited support to the hypothesis that PTSD "flashbacks" in veterans are linked to violence.

Taft, C. T., Walling, S. M., Howard, J. M., & Monson, C. (2011). Trauma, PTSD, and partner violence in military families. In S. M. Wadsworth & D. Riggs (Eds.), *Risk and resilience in U.S. military families* (pp. 195–212). Springer Science + Business Media. https://doi.org/10.1007/978-1-4419-7064-0_10

This chapter summarizes evidence on links between PTSD, violence and abusive behavior in relationships in U.S. military populations. The review discusses the link between PTSD and IPV and potential moderators of this association. Military IPV prevention and response activities are also discussed.

Wojda, A., Heyman, R., Smith Slep, A., Foran, H., Snarr, J., Oliver, M. (2017). Family Violence, Suicidality, and Substance Abuse in Active Duty Military Families: An Ecological Perspective, Military Behavioral Health, 5:4, 300-312, DOI: 10.1080/21635781.2017.1343698

This article consolidates risk and protective factor studies on family violence, alcohol abuse, and suicidality investigating various ecological levels (individual, family, workplace, and community) in random population samples of U.S. Air Force active-duty members.

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The GBV AoR Help Desk

The GBV AoR Helpdesk is a unique research and technical advice service which aims to inspire and support humanitarian actors to help prevent, mitigate and respond to violence against women and girls in emergencies. Managed by Social Development Direct, the GBV AoR Helpdesk is staffed by a global roster of senior Gender and GBV Experts who are on standby to help guide frontline humanitarian actors on GBV prevention, risk mitigation and response measures in line with international standards, guidelines and best practice. Views or opinions expressed in GBV AoR Helpdesk Products do not necessarily reflect those of all members of the GBV AoR, nor of all the experts of SDDirect's Helpdesk roster.

The GBV AoR Helpdesk

You can contact the GBV AoR Helpdesk by emailing us at: enquiries@gbviehelpdesk.org.uk

The Helpdesk is available 09.00 to 17.30 GMT Monday to Friday.

Our services are free and confidential.