Preventing Domestic Violence in Families of Veterans

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CME Objectives

After studying the Commentary by Dao et al, you should be able to:

- Discuss the links between mental distress, PTSD, and risk for domestic violence with your patients who are veterans (and intimate partners/families of veterans)
- Recognize signs of domestic violence in your patients who are family members/intimate partners of veterans and develop an appropriate intervention

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Returning veterans have both high rates of mental health issues (such as posttraumatic stress disorder [PTSD], depression, and substance abuse) and elevated incidences of physical aggression, including domestic violence.[1,2] Since returning veterans often live in civilian rather than military cultures, a need exists for community organizations to establish models of care that help returning veterans and their families reintegrate into civilian society, including a focus on mental health services, which are generally underfunded in relation to the need. Jim Dao, a correspondent with *The New York Times*, led a discussion among military and civilian experts to address these needs.

PREVALENCE AND RISK FACTORS

Mr Dao: We have been at war for almost 12 years. We know that many members of the military suffer from PTSD, but what do we know about the incidence of intimate partner violence within military families?

Dr Taft: The prevalence of domestic violence in veterans and active duty populations ranged from 13.5% to 58% in a 2005 review.[3]

Dr Nash: We need to learn how to discriminate between normal readjustment with its typical transitions and the more difficult, problematic, and sometimes almost impossible transitions. Some veterans partially lose function in the parts of the brain that control emotion. They have also experienced a moral injury, which is at the heart of refractory PTSD.

Dr Seal: About 31% of Iraq and Afghanistan combat veterans who have presented to a Veterans Affairs (VA) health care facility since 2002 have received a PTSD diagnosis, and some symptoms of PTSD lower the threshold for intimate partner violence.[4]

Dr Taft: A recent meta-analysis[5] found that PTSD from military trauma was more strongly related to domestic violence perpetration than PTSD from other kinds of trauma. The presence of either military training or experience increases the likelihood that someone will engage in aggressive behavior.

Mr Dao: What factors other than PTSD may lead to intimate partner violence?

Dr Nash: Even subthreshold PTSD may increase violence if hyperarousal is especially predominant. Abuse of substances, including alcohol, illicit drugs, and prescription drugs, is another precipitating factor for violence.

Dr Taft: Various combinations of factors affect the risk of intimate partner violence. For example, my colleagues and I[4] found that antisocial personality features and traumatic brain injury may increase risk exponentially when both are present. Similarly, the risk of domestic violence may increase in veterans with depression as substance abuse increases. To understand the complexity of violence, we have to understand the connections between various risk factors, but research in this area is just getting started.

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As part of the ongoing Veterans Initiative, a partnership of the Aspen Institute and *The Journal of Clinical Psychiatry*, a Summit was held in Aspen, Colorado, on June 21, 2013, with representatives from the Department of Defense, the Department of Veterans Affairs, veterans' advocacy groups, and domestic violence programs. The purpose of the Summit was to identify best practices in preventing domestic violence in families of veterans. This Commentary section of *The Journal of Clinical Psychiatry* presents the highlights of the Summit. This report was prepared and independently developed by the CME Institute of Physicians Postgraduate Press, Inc., and was supported by an educational grant from Blue Shield of California Foundation.

The moderator was **Jim Dao**, National Correspondent and Editor of the "At War" blog, *The New York Times*, New York, New York. Faculty were **H. Kelly Ammerman**, SGM, Sergeant Major of the Care Coalition: the US Special Operations Command's Wounded Warrior Program, MacDill Air Force Base, Florida; **Derek Bennet**, MBA, Chief of Staff, Iraq and Afghanistan Veterans of America, New York, New York; **Colonel Michael Coss**, Director, Soldier for Life Office, US Army, Washington, DC; **Eliza Daniely-Woolfolk**, CEO, Alternatives to Domestic Violence, Riverside, California; **Anne L. Demers**, EdD, MPH, Associate Professor of Public Health, Health Science & Recreation Department, San Jose State University, San Jose, California; **Vivian Greentree**, PhD, Director of Research and Policy, Blue Star Families, Falls Church, Virginia; **Koby Langley**, JD, MPA, former Senior Executive Advisor to the Deputy Under Secretary for Wounded Warrior Care and Transition Policy, Washington, DC; **Captain (Ret) William Nash**, MD, US Navy, Quantico, Virgina; **Michelle Neary**, Combat Stress Recovery Team, Wounded Warrior Project, Jacksonville, Florida; **Karen Seal**, MD, Director, Integrated Care Clinic for Iraq and Afghanistan Veterans, San Francisco, Virginia Medical Center and Associate Professor, Departments of Medicine and Psychiatry, University of California, San Francisco; **Casey T. Taft**, PhD, Associate Professor of Psychiatry, Boston University School of Medicine and Staff Psychologist, National Center for PTSD, Boston, Virginia Healthcare System, Boston, Massachusetts; and **Barbara Van Dahlen**, PhD, President and Founder, Give an Hour, Bethesda, Maryland.

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ASSESSMENT AND REPORTING

Mr Dao: How does the unique nature of the military community inform assessment and reporting?

Dr Taft: It is not easy for veterans to ask for help. Similarly, service members are concerned about the effects of reporting domestic violence on their careers. Often the partners of service members do not report abuse because they are worried about the financial effects. Any violence charge that comes to a commander may lead to a prohibition on carrying a weapon or discharge from the military.

Dr Seal: Because reporting violence is difficult for both the perpetrator and the victim, it is clear that we do not know the true prevalence. Is there a brief screening tool for front-line providers to use? The tool needs to frame the questions in a way that will allow veterans to give an honest answer.

Dr Taft: The VA currently lacks a single official assessment tool for domestic violence. The Revised Conflict Tactics Scales (CTS2), including a 4-item version, are available.[6] The screening question used by the Strength At Home program does not identify who engaged in the violence. It is one long question that asks about a number of behaviors—eg, pushing, grabbing, shoving—that veterans can answer without identifying themselves as a perpetrator.

We should routinely screen our patients for domestic violence. When we started screening veterans with PTSD for domestic violence in our VA PTSD clinic, we found that one third of the veterans reported they had engaged in domestic violence toward their partner.[7]

Ms Daniely-Woolfolk: The civilian health care world has developed standard domestic violence protocols, including assessment tools, which could be adopted by the VA.

Mr Dao: It sounds like there is almost an institutional dynamic against reporting domestic violence or seeking help for it. What is the best way to address this issue?

Dr Seal: Perhaps we should be asking our patients about their level of relationship stress.

Ms Daniely-Woolfolk: That question makes me think about domestic violence.

Dr Taft: Whichever screening questions we use, we need to screen every veteran we see for signs of intimate partner violence.

Col Coss: Ultimately, the reporting requirements of military health care providers are different than those of providers outside the military. Military health care providers are well versed in the science of domestic violence, appropriately relaying the message to other health care providers. Also, unique to the military, they relay information to commanders as appropriate.

Mr Langley: Common private sector privacy protections in the behavioral health space generally do not apply to the military. When health care providers agree to accept money from the Department of Defense (DoD) to treat active duty service members, they are knowingly or unknowingly subjecting themselves to a request from the command for medical records.

For instance, a commander may actually refer a service member for mental health screening, and the care provider must provide the commander an assessment of that screening.[8] In addition, every member of the military, upon entry, must agree to a security clearance, and that security clearance expressly requires that the

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Clinical Points

- Learn about resources for veterans and their families within your community.
- Become familiar with military culture, especially the customs, habits, and norms that affect a veteran's reaction to suggestions about mental health treatment.
- Whenever possible, involve the significant other when treating someone for signs of deployment-related mental health stress.

service member disclose any consultation with a health care professional regarding an emotional or mental health condition.[9]

Sgt Major Ammerman: I work with the Special Operations community, in which the stigma attached to mental health treatment is considerable. One response has been to establish a military family life consultant program on military bases to offer service members a nonthreatening person to listen to them and provide advice. The consultants, who are generally housed by the commands, often meet their clients off base. They are not permitted to take notes, and nothing is entered into the service member's medical records. Generally, they do not report their findings to the command, which alleviates the fear that seeking treatment will automatically affect someone's career.

Dr Van Dahlen: That program is a great first step, but these consultants are not able to provide necessary mental health treatment.

Dr Seal: Programs like this serve as engagement interventions because they start the conversation. We know that helping people to start telling their story is crucial.

Dr Taft: We must deal with the privacy concerns of our clients. Both active military and veterans need a system to voluntarily seek help without fear of repercussions.

Mr Dao: Because domestic violence is a crime, are health care providers required to report it to law enforcement officials? And, if there are legal implications for talking about domestic violence, why would anyone seek help?

Ms Daniely-Woolfolk: In California, physicians are mandated to report domestic violence, so Alternatives to Domestic Violence created a curriculum to train medical personnel about it. We are bringing training to those who see victims.

Dr Taft: In the VA, we are not required to report when someone volunteers information about an incident of domestic violence unless a child was exposed to that violence. We are also required to report if we learn that someone plans to perpetrate domestic violence.

Dr Greentree: In the military, the immediate commander has some discretion about reporting domestic violence to law enforcement officials. Sometimes this system works well and sometimes it does not.

Col Coss: The cultural challenges are enormous in the military. The Soldier for Life program is working to adapt the customs, habits, and norms of how the military reacts to the presentation of mental health issues. As young soldiers, we are taught that we are invincible, we will accomplish the mission, we will never quit, and we will never accept defeat. Therefore, mental health issues were seen as a deficiency and a sign of weakness. Now we are trying to teach soldiers and veterans that seeking help is not a sign of weakness.

Dr Van Dahlen: Programs like Give an Hour provide help outside the military system without reporting requirements and at no cost. The community-based response is critical as we continue to work on changing military culture.

Mr Dao: Will someone from the DoD or VA direct a family in need to an outside practitioner?

Col Coss: Commanders must be reassured the people in their command are mentally stable. These are people who carry weapons as part of their job. They are deployed overseas and can be asked to exact extreme violence on individuals or communities in the course of their duties.

Many solutions to the problem of domestic violence will come from the community. If prevention and treatment services are available in communities, many service members, veterans, and their families may choose to use them rather than use military health care. But, for the solutions to work, community providers must understand military culture and be prominently available to local service members.

COMMUNICATION, PREVENTION, AND TREATMENT

Mr Dao: What advice would you give to clinicians who encounter veterans who may have been involved in domestic violence?

Dr Taft: First, it is critical to listen to veterans' stories, but providers must be trained to listen and react appropriately. You have to be empathic about their problems, but, at the same time, emphasize their own personal accountability for their behavior. Having PTSD does not excuse abusive behavior. Ask veterans how their deployments and the trauma they have been exposed to have impacted their relationships. The more that you listen in a nonjudgmental fashion, the more likely they will work with you to end the abuse.

However, too few treatment programs are in place for those who screen positive for domestic violence. My colleagues and I developed the evidence-based Strength At Home program with the intent of establishing it in every VA hospital. Today, if a veteran admits to a problem with intimate partner violence, we have few treatment programs. Most community-based domestic violence programs do not meet the needs of combat veterans. Court-mandated programs for batterers, which are the most common kind of program, are generally aggressively confrontational.

The Strength At Home program employs veterans in an outreach team. They talk directly to military families and make a compelling case for engaging in the prevention program before becoming involved with the criminal justice system. They also meet with other veterans who are in jail or in court for issues related to domestic violence. No one can make a better case to veterans than another service member or veteran who has been where they are and understands what is at stake.

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Dr Greentree: One resource that Blue Star Families refers spouses to is the Battered Women's Justice Project (http://www.bwjp.org/), which provides specific information for military families. My hope is that battered women who understand their options are more likely to seek professional help.

Ms Daniely-Woolfolk: The domestic violence field works across the spectrum from prevention to intervention. We would prefer to use our resources on prevention but are forced to intervene when a case gets to the justice system.

Dr Demers: We need to emphasize healthy relationships. Those who are invited to programs about healthy relationships will be more open to listening and learning than those who are required to attend programs on domestic violence.

Ms Daniely-Woolfolk: My organization developed the Military Families Initiative, a comprehensive program to address the unique issues faced by military personnel and their spouses and children, with a grant from Blue Shield of California Foundation. We provide counseling and support services to military families in and around Riverside County, California. The key to a successful beginning was a conversation with the local base commander. We needed to understand each other's areas of responsibility and to establish ground rules we could both live with. Each of us had to be willing to adjust our processes to make the program work. After the initial discussions, we were able to engage other key people on the base. From then on, we have made substantial efforts to follow through on everything we have promised to do.

Dr Nash: As a clinician, I would say one best practice would be, whenever possible, to involve the significant other when you are treating someone for deployment-related mental health problems.

Dr Taft: I agree that it is important to include the significant other when it is done in a careful way. For assessment purposes and establishing safety of the victim, it is important we reach out to partners and provide them with resources for dealing with the violence and education about abuse. Working on the violence may be appropriate in a couples' therapy context, but only under certain conditions, for example, if the violence is not severe and the partner does not report fear of retaliation from the veteran for discussing the abuse.

Dr Van Dahlen: I would like to reiterate the push for a community-based response. Providers need to learn about available local resources for veterans with mental health issues, and they need to understand military culture. Some communities have well-coordinated efforts to engage veterans, create channels of trust, identify the kind of help that is needed, and get those who need care into care. Those models need to be expanded.

AWARENESS AND MANAGEMENT IN THE CIVILIAN COMMUNITY

Mr Dao: What are the best ways for communities to approach the issue of domestic violence with veterans and their intimate partners?

Mr Langley: Many of my friends in the military who have sought care have done so without discussing it with their spouse or acquaintances. Accessible self-referral tools that lead veterans to see a health care provider would be useful.

Dr Seal: Before we institute a population-wide domestic violence screening program, we need a national campaign to raise awareness about the problem, which could include in-service training, webinars, online courses, and pamphlets for both clinicians and patients. Providers need to understand basic facts about domestic violence and PTSD. They also need to know the cues for domestic violence in patients with PTSD and the resources that are available for both patients and providers.

Dr Van Dahlen: I agree. Providers should be educated about military culture and the risks for domestic violence. They need to know what to do if they suspect domestic violence in a patient or a patient's partner.

Mr Dao: Where can a provider go to learn about military culture?

Dr Nash: Online courses are available through the National Center for PTSD and the Centers for Deployment Psychology. Another online series, created by the VA/DoD Integrated Mental Health Strategy, should be available within the next 6 months.

Dr Greentree: Another recommendation is to focus on prevention when working with active duty personnel because they are dealing with the effects of deployment and war. Organizations like mine (Blue Star Families) could easily inform our members about available self-referral tools and pamphlets and consider that part of our mission in pursuit of family wellness.

Dr Van Dahlen: A toolkit for warriors could focus on prevention. It could ask a series of questions about behavior and provide information about how the brain is impacted by trauma. Helping a warrior or a family member put behavior in a context before it is pigeonholed as domestic violence can be empowering.

Ms Neary: Reaching out to warriors through peers is a key to connect with isolated warriors. Wounded Warriors Peer Support Program is able to connect with warriors who are struggling and get them connected with help that can address issues such as domestic violence.

Dr Taft: As providers, we need to consider the whole person and all the other problems he or she may be dealing with, such as homelessness, financial instability, joblessness, substance abuse, and others. The more we are able to address those other issues, the better we can address the violence.

Mr Bennet: We are all relatively familiar with the relationships between PTSD and domestic violence, but many providers are not. At the Iraq and Afghanistan Veterans of America, we have heard of providers who responded unprofessionally to a patient who described either being a victim of domestic violence or perpetrating domestic violence or one who recounts a PTSD-enabling story from Iraq or Afghanistan. We need to create a simple protocol to help providers avoid reacting to these triggers, because warriors or family members who feel insulted will not return for help.

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Dr Taft: Training is the key. Clinicians who are successful in helping this population have received supervised training in domestic violence and ideally have had experience in working with veterans.

As part of a project funded by the Blue Shield of California Foundation, I trained a group of therapists in Fresno, California, and followed it up with bimonthly phone supervision. Even after training, some therapists would react inappropriately to their clients.

Mr Langley: The Corporation for National and Community Service supports about 2,000 grantees a year, and, over the past 10 years, several of these grantees have created outdoor, peer-peer physical activities for veterans that have led to improved behavioral health. These programs are being developed because of community demand. One example of this emerging practice for rehabilitation is placing wounded warriors with groups like Habitat for Humanity, where Lt Gen Eric B. Schoomaker, former Surgeon General of the Army, once remarked that the model of national and community service as rehabilitation is one that he would like to see replicated Army-wide.[10]

Ms Neary: Wounded Warrior Project collaborates with outside mental health providers for our Project Odyssey, which is a 5-day outdoor rehabilitative retreat for alumni with PTSD who have served in combat. Project Odyssey focuses on team-building activities such as a ropes course and scuba diving instruction. Project Odyssey helps warriors connect with fellow peers, experience their unit again, and build their self-esteem and sense of purpose. The warriors are able to connect with Wounded Warrior Project staff, a mental health provider, and a peer mentor. Project Odyssey helps break that stigma that has kept warriors isolated and prevented them from reaching out for help.

Col Coss: Team-building activities such as those described provide wounded warriors with a new sense of camaraderie and belonging. Having these activities occur in the context of a service project shows them they can continue contributing and moving forward. This is care in the deepest sense because it helps break down the initial barrier to seeking help and enables positive behavior. Without that breakthrough, the warrior's life can become a downward spiral through unemployment, substance abuse, homelessness, and suicide.

RESOURCES AND RECOMMENDATIONS

Mr Dao: What resources for providers are currently available?

Ms Daniely-Woolfolk: Those of us who work in the domestic violence field are eager to collaborate with experts in treating mental health issues in the military. For example, the Department of Justice Office of Violence Against Women maintains an extensive list of resources on domestic violence, and national and state alliances of domestic violence providers have created resources.

Dr Nash: The VA and DoD have jointly published clinical practice guidelines for the treatment of PTSD.

Dr Van Dahlen: Give an Hour has links to all these guidelines and others on our Web site (http://www.giveanhour.org). There are plenty of resources in a variety of formats that would be helpful for clinicians about to meet with a veteran for the first time. Many clinicians who volunteer for Give an Hour have never worked in a military environment before, so we provide them with resources to teach them where to start with the veteran.

Sgt Major Ammerman: Education needs to go both ways. Many veterans are skeptical of therapy. They think, "This person hasn't walked a mile in my shoes. What right do they have to talk to me about what I have experienced?"

Ms Neary: That is a great point. The Wounded Warrior Project conducted a series of focus groups with veterans to discover their attitudes about mental health treatment. We used the results to create a resource for the veterans and family members who visit our site (http://www.woundedwarriorproject.org/). The resource tells them what to expect when they see a mental health provider and helps them choose the provider who is best for them.

Sgt Major Ammerman: The purpose of the first visit to a therapist is to make an appointment for a second visit, which is more difficult than you imagine. It is hard to admit you need help and go to a therapist. But then, you have many excuses not to return—eg, the therapist does not speak military language or never went into combat. So clinicians need to understand this perspective and engage wounded warriors who come to see them.

Mr Bennet: Groups like the Iraq and Afghanistan Veterans of America and Wounded Warrior Project build a sense of community among veterans. Much of the work we do is online. You may not have another post–9-11 veteran who went to Iraq or Afghanistan in your community, but you can engage with them on Facebook or Twitter. We also organize offline social activities and over casual conversation, a couple of people may say, "I don't sleep that well at night," which starts the narrative that can lead to treatment.

Ms Neary: Our Wounded Warrior Project programs provide a holistic approach for mind, body, economic empowerment, and engagement. We also have a strong alumni program where alumni are able to connect with peers. We had an alumni member share how he went to a football game, where he was able to talk with peers and learn about other Wounded Warrior Project programs. This alumni member now works for the Wounded Warrior Project, truly representing our logo of one warrior supporting another.

Wounded Warrior Project Resource Center is our gateway for alumni programs. The Resource Center provides a warm handoff to outside agencies for support, if, for example, an alumni member needs inpatient care for PTSD.

Mr Dao: If I am a clinician and a veteran who comes to see me is worried about being battered or being a batterer, should I call the Wounded Warrior Project or the Iraq and Afghanistan Veterans of America?

Ms Neary: The Wounded Warrior Project has a Combat Stress Recovery Specialist Manager in each office. We do not have clinicians on staff who deal with domestic violence

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exclusively, but we can provide a warm handoff to a group that does to ensure that warriors are connected with the care they need.

Mr Bennet: We at Iraq and Afghanistan Veterans of America are sometimes better equipped to take initial calls from service members or veterans and their families than clinicians; we are in a position to help connect them with clinicians with specific expertise.

Dr Seal: Do either of your services provide peer coaches? If a veteran is ambivalent about seeking or continuing with mental health treatment, can you assign a peer coach?

Ms Neary: The Wounded Warrior Project has a peer support program. Peers who are further along in recovery are trained to be peer mentors. They go into communities to connect with warriors who may be more isolated. We also are piloting peer-to-peer support groups, where peer mentors are trained to be peer facilitators in specific cities throughout the country. We have 35,000 alumni in our database and 400 staff members to help wounded warriors throughout the country. Many of them want to give back to their communities and, specifically, to other veterans.

Dr Nash: Personally, I am a big fan of mentored peer support for veterans, but there are some hazards to consider. It will not be successful unless the mentors are adequately trained and supervised.

Col Coss: We also need to make sure that active military members who are about to transition into civilian life are aware of the available services and programs. The US Army's Soldier for Life Office tries to educate our service members and link them to peer networks before they leave service. We think this is a practical strategy to prevent access-to-care challenges later in the service member's life cycle.

Mr Dao: We have talked about best practices regarding the veterans. Is there anything clinicians should know about dealing with their intimate partners?

Dr Greentree: The actual first point of contact with a clinician is more likely to be the spouse of a service member or veteran.

Blue Star Families, with a grant from Blue Shield of California Foundation, conducted a survey of service members and military families. We found that the stress of deployment may increase the risk for psychological problems.[11]

Mr Langley: The main reason for not reporting violence, per the Blue Star Families Military Lifestyle Survey,[11] was concern about the service member's career. Clinicians, particularly those without connections to the military community, might not understand that a service member's employment prospects can be endangered when abuse is reported. Although the command has made great strides in communicating that seeking behavioral health treatment is not a career killer, no one is saying that the stigma is gone. What this recent survey tells us is that it is not.

Dr Van Dahlen: Spouses will often seek help for their children before they will seek help for themselves. We need to raise awareness about the problem in schools and in pediatricians' offices.

Dr Nash: Spouses may or may not subscribe to military culture. Many active duty spouses live off base. Some want nothing to do with the military, while others appreciate being connected with military-specific services.

Mr Dao: What would be the key elements of a self-referral kit for service members or veterans?

Mr Langley: Veterans, unlike the active component military, need to believe that any information they provide is confidential. Their experiences with the behavioral health community as a service member do not give them that confidence. Ideally, the kit should not be part of a government Web site.

The kit also needs to be simple to use and easily peer-rated. I would be more likely to go to a Web site if a friend told me it was useful. I do not think that is a unique attribute of a behavioral health online tool—entire online business models are built from peer reviews and the inherent level of trust that comes from peer reviews.

Dr Van Dahlen: The kit would have more credibility if it were on a Web site of a known organization like Blue Star Families, the Wounded Warrior Project, or Iraq and Afghanistan Veterans of America. They are well-known and trusted.

Dr Taft: Intimate partners should understand that domestic violence is not a symptom of PTSD. If you are experiencing abuse, you need to take steps to make sure you and your family are safe. You should not avoid reporting violence to protect the service member or veteran.

Resources

- Blue Star Families (www.bluestarfam.org)
- Centers for Deployment Psychology online course in military culture (http://deploymentpsych.org/)
- Centers for Disease Control Intimate Partner Violence and Sexual Violence Assessment Instruments for Use in Healthcare Settings. (http://www.cdc.gov/ncipc/pub-res/images/ipvandsvscreening.pdf)
- Give an Hour (www.GiveanHour.org)
- Iraq and Afghanistan Veterans of America (www.IAVA.org)
- National Center for PTSD online course in military culture (http://www.ptsd.va.gov/professional/index.asp)
- Strength at Home (www.strengthathome.com)
- VA/DoD Treatment Guidelines on PTSD (www.healthquality.va.gov/post_traumatic_stress_disorder_ptsd.asp)
- Wounded Warrior Project (www.woundedwarriorproject.org)

Disclosure of off-label usage: The faculty have determined that, to the best of their knowledge, no investigational information about pharmaceutical agents that is outside US Food and Drug Administration–approved labeling has been presented in this article.

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Posttest

To obtain credit, go to PSYCHIATRIST.COM (Keyword: October) to take this Posttest and complete the Evaluation online.

1. All of the following are common risk factors for a veteran becoming a perpetrator of domestic violence except:

a. Substance abuse
b. Posttraumatic stress disorder from military trauma
c. Reexperiencing symptoms
d. Symptoms of hyperarousal

2. You are meeting with a married veteran and want to know if he/she has been involved in domestic violence. What question should you ask during the initial history?

a. Have you been diagnosed with posttraumatic stress disorder?
b. How has your military service affected your relationship with your spouse?
c. Were you involved in active combat during your military service?
d. Did you experience any injuries during your military service?

3. You are a primary care physician. A patient who has recently left the military after several deployments in Iraq and Afghanistan has come to see you for the first time. He is reluctant to answer your routine questions and appears to be angry. What do you decide is your first goal?

a. To engage him in conversation to increase his likelihood of returning for a second visit
b. To order a complete blood count and urinalysis and inform him of the results
c. To confront him, ask him why he is angry and order him to schedule another visit
d. To tell him all about your experience with military service to increase his likelihood of returning for a second visit

4. You have opened a practice in a community with a substantial number of veterans returning from Iraq and Afghanistan. You have never served in the military. What steps can you take to prepare for veterans or spouses who may be involved in domestic violence?

a. Apply for permission to receive payment from the VA for treating veterans
b. Take an online course to learn about military culture and investigate local resources for veterans and their families
c. Do some research on local resources for veterans
d. Talk to a friend who served as a doctor in the military, but never left the United States

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