LYNN’S PORTION OF DATA REVIEW
Assessing and Reducing Violence and Aggression in Military Veterans

Eric B. Elbogen, Ph.D., ABPP (Forensic)
University of North Carolina-Chapel Hill
Durham VA Medical Center
Acknowledgments

University of North Carolina-Chapel Hill
• Sally Johnson, M.D., UNC Forensic Psychiatry Program
• Virginia Newton, Ph.D., UNC Forensic Psychiatry Program
• Michelle Cueva, Ph.D., UNC Forensic Psychiatry Program
• Connor Sullivan, B.A., UNC Forensic Psychiatry Program

Duke University
• Jean C. Beckham, Ph.D., Durham VA/Duke University
• H. Ryan Wagner, Ph.D., Durham VA/Duke University
• John Fairbank, Ph.D., Durham VA/Duke University

Other Collaborators
• Lynn Van Male, Ph.D., VA Behavioral Threat Management Program
• Shoba Sreenivasan, Ph.D., Los Angeles VA Forensic Outreach/USC
• Jennifer Vasterling, Ph.D., Boston VA/ Boston University
• Christine Timko, Ph.D., Palo Alto VA/ Stanford University
• Han Kang, Dr.P.H., Department of Veterans Affairs, Central Office
May 2009, a random sample of 3000 names and addresses drawn by the VA Environmental Epidemiological Service of separated individuals who served in the U.S. military on or after September 11, 2001.

In total, N=1388 OEF/OIF/OND military service members completed a web-based survey on post-deployment adjustment, representing a 56% corrected response rate.
National Post-Deployment Adjustment Survey of OEF/OIF/OND Veterans

- The resulting sample included Iraq & Afghanistan Veterans from all branches of the military & the reserves.
- Participants resided in all 50 states, Washington D.C., & four territories.
- Responders were similar to non-responders in age, gender, & geographic region.
## PTSD and Violence in Veterans

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Severe Violence in Next Year</th>
<th>Statistical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>Yes</td>
<td>19.52%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>6.41%</td>
</tr>
<tr>
<td>Alcohol Misuse</td>
<td>Yes</td>
<td>17.43%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>5.97%</td>
</tr>
<tr>
<td>PTSD + Alcohol Misuse</td>
<td>Yes</td>
<td>35.88%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>6.84%</td>
</tr>
<tr>
<td>Alcohol Misuse Only</td>
<td>Yes</td>
<td>10.57%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>8.37%</td>
</tr>
<tr>
<td>PTSD Only</td>
<td>Yes</td>
<td>9.96%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>8.61%</td>
</tr>
</tbody>
</table>
### Effect of PTSD Symptoms and Covariates on Stranger Aggression

<table>
<thead>
<tr>
<th>Variable</th>
<th>Stranger Aggression</th>
<th>Severe Stranger Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>95% CI</td>
</tr>
<tr>
<td>Older Age (&gt;35)</td>
<td>0.97</td>
<td>[0.94, 0.99]</td>
</tr>
<tr>
<td>Gender</td>
<td>3.41</td>
<td>[1.16, 10.08]</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>2.52</td>
<td>[1.53, 4.16]</td>
</tr>
<tr>
<td>Witnessed Family Violence</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>History of Arrest</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>PTSD Anger</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>PTSD Flashback</td>
<td>1.16</td>
<td>[1.05, 1.28]</td>
</tr>
<tr>
<td>PTSD On Guard</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>PTSD Numb</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>PTSD Physically Upset</td>
<td>ns</td>
<td></td>
</tr>
</tbody>
</table>

- Female = 0, Male = 1

R²=.17, AUC=.79
chi²=75.38, df=5, p<.0001

R²=.20, AUC=.82
chi²=54.36, df=3, p<.0001
## Family Aggression

### Effect of PTSD Symptoms and Covariates on Family Aggression

<table>
<thead>
<tr>
<th>Variable</th>
<th>Family Aggression</th>
<th></th>
<th></th>
<th>Severe Family Violence</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>95% CI</td>
<td><em>p</em></td>
<td>OR</td>
<td>95% CI</td>
<td><em>p</em></td>
</tr>
<tr>
<td>Older Age (&gt;35)</td>
<td>0.98</td>
<td>[0.95, 1.00]</td>
<td>.0221</td>
<td>0.94</td>
<td>[0.89, 0.99]</td>
<td>.0046</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td>ns</td>
<td>0.36</td>
<td>[0.14, 0.96]</td>
<td>.0347</td>
</tr>
<tr>
<td>High Combat</td>
<td></td>
<td></td>
<td>ns</td>
<td>3.96</td>
<td>[1.30-12.02]</td>
<td>.0153</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td></td>
<td></td>
<td>ns</td>
<td>ns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Witnessed Family Violence</td>
<td></td>
<td></td>
<td>ns</td>
<td>ns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of Arrest</td>
<td></td>
<td></td>
<td>ns</td>
<td>ns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD Anger</td>
<td>1.28</td>
<td>[1.19, 1.37]</td>
<td>&lt;.0001</td>
<td>1.30</td>
<td>[1.13, 1.48]</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>PTSD Flashback</td>
<td></td>
<td></td>
<td>ns</td>
<td>ns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD On Guard</td>
<td></td>
<td></td>
<td>ns</td>
<td>ns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD Numb</td>
<td></td>
<td></td>
<td>ns</td>
<td>ns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD Physically Upset</td>
<td></td>
<td></td>
<td>ns</td>
<td>ns</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Female = 0, Male = 1*

<table>
<thead>
<tr>
<th></th>
<th>R²</th>
<th>AUC</th>
<th><em>chi²</em></th>
<th>df</th>
<th><em>p</em></th>
<th>R²</th>
<th>AUC</th>
<th><em>chi²</em></th>
<th>df</th>
<th><em>p</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>.11</td>
<td>.71</td>
<td>53.85</td>
<td>2</td>
<td>&lt;.0001</td>
<td>.19</td>
<td>.80</td>
<td>41.34</td>
<td>4</td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>
Protective Factors and Violence in Veterans

Protective factors indicate health and well-being in the following domains: living, work, financial, psychological, physical, and social
LYNN’S PORTION OF THREAT ASSESSMENT
Acknowledgments

WVPP deeply appreciates the work of:

• Frederick Calhoun
• David J. Drummond, PhD
• Eric Elbogen, PhD
• Anders Goranson, PsyD
• Stephen Hart, PhD
• J. Reid Meloy, PhD, ABPP
• Stephen Weston
• Stephen White, PhD
Outline

• Modes of Violence
• Pathways to Violence
• Prediction, Threat Assessment, and Accuracy
• Structured Clinical Judgment Approaches to Violence Risk and Threat Assessment
Modes of Violence
Bimodal Theory of Violence

Predatory vs. Affective
Meloy’s Modes of Violence
Predatory vs. Affective

- Minimal or absent ANS arousal
- No conscious emotion
- Planned and/or purposeful violence
- No or minimal threat
- Goal: many goals

- Intense ANS arousal
- Subj. exp. of emotion
- Reactive & immediate violence
- Perceived internal or external threat
- Goal: threat reduction

X Predatory  X Predatory/Affective  X Affective/Predatory  X Affective

J. Reid Meloy, 2006
### Modes of Violence (cont.): Predatory vs. Affective

<table>
<thead>
<tr>
<th>Predatory</th>
<th>Predatory/Affective</th>
<th>Affective/Predatory</th>
<th>Affective</th>
</tr>
</thead>
<tbody>
<tr>
<td>No displacement of target of violence</td>
<td>Rapid displacement of the target of violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No time limit on behavior</td>
<td>Time-limited behavior sequence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preceded by private ritual</td>
<td>Preceded by public posturing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primarily cognitive</td>
<td>Primarily emotional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heightened and <em>focused</em> awareness</td>
<td>Heightened and <em>diffuse</em> awareness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

J. Reid Meloy, 2006

*Note: The table above illustrates the differences between Predatory and Affective modes of violence.*
What About Recently Returned Soldiers?

- Minimal or absent ANS arousal
- No conscious emotion
- Heightened and *focused* awareness

- Intense ANS arousal
- Subj. exp. of emotion
- Heightened and *diffuse* awareness

Traditional “predatory” violence indicators may need a closer look in the context of normative post-deployment readjustment and/or PTSD

J. Reid Meloy, 2006
Pathways to Violence
On the Nature of Threats

• Subjects who pose a threat may never make a threat
• Conversely, Subjects who make a threat may never pose a threat
• Consequently, threats should be treated as one of many Subject behaviors that need assessment
Pathway to Violence

- Subjects who engage in either affective (impromptu) or predatory (intended) violence must follow a path of certain behaviors
- The pathways are similar, predatory adds two unique steps
- Steps along both paths are behaviors, thus they are identifiable

Calhoun and Weston, 2003
Contemporary Threat Management
Pathway to Violence: Affective

Grievance → Ideation → Breach → Attack

Contemporary Threat Management
Calhoun and Weston, 2003
Pathway to Violence: Predatory

Grievance → Ideation → Research/Planning → Preparation → Breach → Attack

Contemporary Threat Management
Calhoun and Weston, 2003
Prediction, Threat Assessment, and Accuracy
Predictive Accuracy: Base Rate

The occurrence of a particular behavior in a defined group of individuals during a specific period of time.
## Predictive Accuracy

### Violence Prediction

<table>
<thead>
<tr>
<th>Actual Violence</th>
<th>Predicted Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>NO</td>
<td>NO</td>
</tr>
</tbody>
</table>

- **True Positive**: Correctly predicted as positive violence.
- **False Negative**: Incorrectly predicted as negative violence when it was positive.
- **False Positive**: Incorrectly predicted as positive violence when it was negative.
- **True Negative**: Correctly predicted as negative violence.
Predictive Accuracy

• An attempt to find the optimal balance between false positives and false negatives: as one increases the other always decreases

• Consequences of generating false negatives typically are worse than those of generating false positives

• Clinicians tend to over-predict violence
Prediction vs. Threat Assessment

Prediction: Yes or No

Risk Factors

Protective Factors

Threat Assessment
Structured Clinical Judgment Approaches to Violence Risk and Threat Assessment
Evolution of Threat Assessment

Purely Clinical Approach
• Intent, plan, access, identified target, imminent?
• High(er) face validity
• Clinicians often barely as good a chance

Purely Actuarial Approach
• Increased predictive validity over purely clinical
• Low(er) face validity
• Does not inform risk mitigation strategies
Evolution of Threat Assessment

Structured Clinical Judgment

- Combines the “best” of clinical and actuarial approaches
- Informed by empirical literature
- Standard items, often normed
- Increased predictive validity over actuarial alone
- Informs risk mitigation strategies
Sample Structured Clinical Judgment Guides

WAVR 21
• S.G. White and J.R. Meloy, 2007
• Workplace Assessment of Violence Risk

HCR-20
• Correctional, Forensic and Civil Psychiatric Assessment of Violence Risk

VRAI [VRAI presentation on Day 2]
• Incorporates Veteran-specific risk factors
• Pilot planned for FY14
• Motives for Violence
• Homicidal Ideas, Violent Fantasies or Preoccupation
• Violent Intentions and Expressed Threats
• Weapons Skill and Access
• Pre-Attack Planning and Preparation
• Stalking or Menacing Behavior
• Current Job Problems
• Extreme Job Attachment
• Loss, Personal Stressors and Negative Coping
• Entitlement and Other Negative Traits
• Lack of Conscience and Irresponsibility
• Anger Problems
• Depression and Suicidality
• Paranoia and Other Psychotic Symptoms
• Substance Abuse
• Isolation
• History of Violence, Criminality, and Conflict
• Domestic/Intimate Partner Violence
• Situational and Organizational Contributors to Violence
• Stabilizers and Buffers Against Violence
• Organizational Impact of Real or Perceived Threats
P.R.O.T.E.C.T.

- Positive Personal Attachments
- Remorse is Genuine for Transgressions
- Obeys Limits Set by Employer or Authorities
- Takes Sanctioned Action to Address Wrongs
- Enjoys Life and Freedoms
- Coping Skills Are Positive
- Treatment Compliance
HCR-20: Historical Educational Use Only

- Previous Violence
- Young Age at First Violent Incident
- Relationship Instability
- Employment Problems
- Substance Use Problems
- Major Mental Illness
- Psychopathy
- Early Maladjustment
- Personality Disorder
- Prior Supervision Failure
Lack of Insight
Negative Attitudes
Active Symptoms of Major Mental Illness
Impulsivity
Unresponsive to Treatment
• Plans Lack Feasibility
• Exposure to Destabilizers
• Lack of Personal Support
• Noncompliance with Remediation Attempts
• Stress
QUESTIONS?
LYNN’S PORTION OF VHA STRATEGIES AND PROGRAMS/INITIATIVES
VHA’s Workplace Violence Prevention Program (WVPP): The Big Picture Overview

Lynn M. Van Male, Ph.D.
Director, VHA Workplace Violence Prevention Program (10P3D)
WVPP Model

Element I: Employee-Generated Disruptive Behavior
- Employee Threat Assessment Teams (ETATs)

Element II: Patient-Generated Disruptive Behavior
- Disruptive Behavior Committees (DBCs) and Patient Record Flags (PRFs)
- Behavioral Limit-Setting Mini-Residency Program

Element III: Employee Education and Training
- Prevention and Management of Disruptive Behavior (PMDB)
- MyVeHU On-Demand Trainings

Element IV: Disruptive Behavior Reporting and Tracking
- National Violence Reporting System

Element V: Environmental Design
- National Conferences
- National Violence Reporting System
WVPP: Getting to the Next Level in Addressing Patient-Generated Disruptive Behaviors
Conference Questionnaire Results

Disruptive Behavior Committee Chairs Conference

Questionnaire

VHA Workplace Violence Prevention Program (WVPP)

Dallas, TX    January 28-30, 2014

Name: ________________________________

Title & Credentials: ___________________________    Discipline: _______________________

Service Line or Department: _______________________

VISN#: __________    Facility Name & Station#: ___________________________

Preferred Email: _______________________________    Preferred Phone Number: _______________________

Number of Months Served as DBC (co-)Chair: __________

* If there is a DBC co-Chair at your facility, please provide the following information:

Name of other co-Chair: ___________________________    Discipline: _______________________

46
Months of Service as DBC (co-)Chair

<table>
<thead>
<tr>
<th>No Entry</th>
<th>0-12</th>
<th>13-24</th>
<th>25-36</th>
<th>37-48</th>
<th>49-60</th>
<th>61-72</th>
<th>&gt;72</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>9</td>
<td>7</td>
<td>6</td>
<td>9</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>

VHA Workplace Violence Prevention
Help Improve Ability to Serve as DBC (co-)Chair

- “Protected time”
- “Administrative support”
- “Clarification of role of DBC”
- “More training in risk assessment” [for self and committee members]
- “Clearer understanding of policy and expectations—what is mandatory, what is flexible”
Gaps in VHA’s Violence Prevention Efforts

• “Lack of resources/support at the hospital level (i.e., dedicated FTE)”
• “Time for training staff—severe limitations and TMS is not very effective”
• “Disambiguate DBCs from ETATs”
• “Address the impact of environment and systems issues on Veteran violence”
• “Standardizing physical expectations in PDs for high risk areas”
WVPP 5-year Priorities
Violence Risk Assessment Instrument (VRAI): General and Sexual Violence

Lynn M. Van Male, Ph.D.
Director, VHA Workplace Violence Prevention Program (10P3D)
Outline

• Context
• VRAI Development
• Current Status
Context
“(2)(A) The development and use of specific risk-assessment tools to examine any risks related to sexual assault that a veteran may pose while being treated at a medical facility of the Department, including clear and consistent guidance on the collection of information related to—

“(i) the legal history of the veteran; and

“(ii) the medical record of the veteran.
ACTION

b. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for:

(2) Developing and utilizing evidence-based, data-driven assessment tools to examine any risks related to sexual assault that a Veteran may pose while being treated at a VHA facility to include, as appropriate, the legal history of the Veteran and the medical record of the Veteran, within the limitations of laws and policies.
VRAI Development
Plan for Implementing Violence Risk Assessment of Veterans

The 12-member Workgroup:

- Reviewed peer-reviewed literature on the process of violence risk assessment.
- Identified factors associated with increased and decreased risk of perpetration of violence, both general violence and sexual violence.
- Developed a violence risk assessment instrument (VRAI) for assessing general violence derived from existing scientific research.
- Developed a violence risk assessment instrument (VRAI) for assessing sexual violence derived from existing scientific research.
- Outlined how to use information contained in medical records and collect information about a Veteran’s legal history appropriately in conjunction with utilizing risk assessment tools.
Plan for Implementing Violence Risk Assessment of Veterans

Workgroup Report Contains 8 Recommendations:

1. The VRA Workgroup recommends that VRAIs be used by the Disruptive Behavior Committee (DBC) to guide evidence-based assessment of behaviors that occur while a Veteran is at a VA medical facility seeking or receiving healthcare services from VHA.

2. The VRA Workgroup recommends that VRAIs be made available to qualified and trained providers at VA medical facilities treating Veterans seeking or receiving healthcare services from VHA.

3. The VRA Workgroup recommends that any information in VA medical records be available for use by authorized staff when completing VRAIs.

4. The VRA Workgroup recommends qualified and trained providers implementing VRAIs follow Sexual Assault Legal History Policy Recommendations (SALGWG) Workgroup guidance for collection/documentation of legal history of Veterans.
Workgroup Report Contains 8 Recommendations:

5. The VRA Workgroup recommends creating a VRAI Implementation Workgroup in order to evaluate the VRAIs, to construct training materials for use of VRAIs, and to examine use of VRAIs in telehealth as outlined in recommendations below.

6. The VRA Workgroup recommends evaluating the reliability and validity of the VRAIs developed in response to Public Law 112-154, section 106.

7. The VRA Workgroup recommends developing training modules to educate DBCs and qualified providers at VA how to conduct structured violence risk assessments with the VRAIs.

8. The VRA Workgroup recommends identifying unique aspects of using the VRAIs in telehealth settings relevant to training and implementation.
Current Status
From Recommendations to Implementation

- Concurrence from stakeholder program offices and VA/VHA leadership
- Training Development
- Electronic Application Development
- Instrument Validation
- Instrument Utilization Impact Evaluation
- Revision
- Policy and Advisory Board
- Implementation
QUESTIONS?