At Risk for Violence in the Military

Stephen N. Xenakis, MD, US Army Q2 Q3

KEYWORDS

• Violence • Military • Military culture • Military training • Combat experience

KEY POINTS

- Violence and violent deaths afflict servicemembers, families, and the communities they inhabit.
- Military personnel train for and conduct violent missions to kill the enemy and achieve victory in support of the national interests.
- The military has inherent protective factors and constraints on violence that provide counterbalancing forces.
- Understanding the occurrence and nature of violence in the military entails appreciating military culture, the sociology and demographics of its personnel, military training, combat experiences, and injuries and illnesses that veterans suffer.
- The spillover of violence to the home stations and communities has multiple elements.

INTRODUCTION Q5

> *Once an army is involved in war, there is a beast in every fighting man, which begins tugging at its chains, and a good officer must learn early on how to keep the beast under control, both in his men and himself.*
>
> *—General of the Army George C. Marshall – on violence and the Army (1942)*

The risk of violence and its tragic consequences for servicemembers and families impinges across the military. Violence and violent deaths afflict servicemembers, families, and the communities they inhabit. Violent behavior and conduct manifests as homicides, suicides, rape, sexual trauma, and spouse and child abuse. Understanding the source and nature of unwanted and illegitimate violence across the military presents unique considerations. The military, as a profession of arms, has distinctive cultural and environmental factors. Military personnel train for and conduct violent missions to kill the enemy and achieve victory in support of the national interests. The American military provides sophisticated training for combat that influences and shapes the psychology of the young warfighter from the moments of first entering active service. The impact and consequences of training and engagement in combat

The Austen Riggs Center, 25 Main Street, Stockbridge, MA 01262, USA Q4
E-mail address: snxenakis@hotmail.com

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profoundly influence the attitudes and behavior of servicemembers, raise unique risk factors toward violence, and broadly affect military institutions and the services.

The military has inherent protective factors and constraints on violence that provide counterbalancing forces. Modern warfare follows implicit and explicit rules that guide commanders and warfighters on the ground. Successful military operations, particularly in the twenty-first century, do not involve indiscriminate violence. The doctrine of counterinsurgency institutionalized in Iraq and Afghanistan is based on principles of balance in infantry tactics and building relationships with the local population. As the former commander in Afghanistan, General Stanley McChrystal, stressed, modern warfare requires "courageous restraint" and imposes responsibility on soldiers to know when and where to act.[1] But, war is messy and chaotic, and combat confounds and disorganizes soldiers' attitudes and behavior.

The focus on moral injury highlights the dilemmas facing soldiers on how and where to act violently. Sherman[2] has written on the moral conflicts, psychological state, and attitudes toward violence in the military: "(w)ar is a moral maze about killing and being killed, about liability to lethal and nonlethal harming, about the boundaries of wartime and peacetime, and adapting to the fuzzy boundary crossing." Q6

Understanding the occurrence and nature of violence in the military entails appreciating military culture, the sociology and demographics of its personnel, military training, combat experiences, and injuries and illnesses that veterans suffer. The military is grounded in the principles and practice of conducting violent operations, and the psychology of violence fundamentally anchors its professionalism. The occurrence of unwanted violence and tragic incidence of suicides, homicides, and abuse expose the challenges to containing the behavior outside of the combat and training theaters.

BACKGROUND

In 2009, the Army Medical Department conducted an extensive survey of violent deaths at Fort Carson, Colorado. Eight homicides had allegedly occurred in the previous year perpetrated by 6 soldiers. The Senior Mission Commander, Major General Mark Graham, had initiated a dedicated Task Force in 2008 to investigate the soldiers involved in the incidents and explore the causative factors. The Army and congressional leadership called for a wider review of policies and practices to get to the source of the problems. The Army responded by sending a dedicated team of clinicians and epidemiologists to the Colorado post to conduct an extensive survey and investigation of conditions and environmental factors.

For the preceding several years, the media had focused increasing attention on stories at Army installations on troops returning from the combat theaters. There had been reports of alarming accounts of homicides, suicides, and abuse. A string of murders and suicides had occurred at Fort Bragg and shocked the Army leadership.[2] At least 8 soldiers and family members died by homicide and suicide, and the incidence of serious domestic violence rose sharply. Readers became increasingly aware that soldiers returning from combat in Iraq and Afghanistan were bringing the violence home.[3]

The attention on violent deaths of soldiers heightened with reports of the surprising spike in suicides documented among servicemembers. The Army suicide rate increased dramatically after 2005 while the civilian rate had leveled off. The vast majority of Army suicides were attributed to gunshot wounds. In an attempt to identify risk factors and initiate preventive strategies, the Army allocated $50 million to an extensive Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS).

The potential for violence emerges in families with physical and emotional abuse of children and spouses. The Department of Defense (DoD) has conducted major programs in prevention and treatment of spouse and child abuse for several decades and supported dedicated programs across its installations. Almost all military installations offer Family Advocacy Programs staffed by social workers and other support personnel for the identification, tracking, and treatment of child and spouse abuse.[4] The *Washington Post* reported that DoD confirmed 7676 cases of child abuse or neglect in fiscal year 2014, an increase of 10% from the previous year. Confirmed cases of neglect, which excludes physical and sexual abuse, rose by 14%, military officials said.[5]

More recently, attention has focused on military-related sexual trauma (MRST). The alarming accounts of rapes and sexual assaults has drawn congressional attention and legislative proposals for changes in DoD policies and practices. The overall prevalence of MRST is 7.6% and associated with elevated rates of major depression, posttraumatic stress disorder, and generalized anxiety disorder.[6] Senator Jon Tester (D-Mont.) introduced The Ruth Moore Act in 2015 to ease the processes for veterans who suffered sexual abuse in the military to get help from the Department of Veterans Affairs (VA) and modify the standards for "burden of proof."

EPIDEMIOLOGIC OVERVIEW

The Army has periodically conducted epidemiologic surveys of suicide, violence, and related incidents on installations over the years. The survey of Fort Carson in 2009 stands out as a landmark case. The investigators collected valuable findings on rates and trends of violent deaths and laid the basis for a broader understanding of the nature of violence among military personnel in the garrison environment.[7] The US Army Center for Health Promotion and Preventive Medicine deployed an epidemiological consultation (EPICON) team to investigate common threads among homicide perpetrators, factors unique to Fort Carson, the fraction of waivers among perpetrators, the relationship between deployment and risk factors for violence, and the adequacy and effectiveness of behavioral health services. The EPICON survey represents the most in-depth examination of violent crimes in the Army in the context of community behavioral health risk factors and combat exposure.

The analysis of the cases uncovered findings that have broader implications for understanding untoward events among military personnel:

1. From 2005 to 2008, 13 soldiers at Fort Carson were charged with homicide, attempted homicide, or accessory to homicide.
2. Common threads identified among the index cases included unit of assignment, deployment/combat exposure, military occupational specialty, and behavioral risk factors.
3. Most index cases were assigned to one particular unit.
4. More than 80% of the index cases had deployed at least once to the combat theater. The soldiers deployed had experienced higher levels of combat intensity then other companion units.
5. Half of the cases that deployed and redeployed did not receive normal reintegration training.
6. Half of the index cases were infantry soldiers, and 5 had received enlistment waivers.
7. A high prevalence of behavioral risk factors appeared in the index cases, including substance abuse, diagnoses for mental health conditions, and criminal activity while on active duty.

8. The index cases were at high risk for negative behavioral outcomes, including contributing factors of mental illness, past history of violence and criminal behavior, and substance abuse.
9. Index cases had a higher likelihood of exhibiting misconduct more than other soldiers who deployed in the same units.

The analysis of environmental factors at Fort Carson and the installation revealed important findings and trends:

1. The rates of arrest for major crimes increased across the Army from 2003 to 2009, with the highest rate increase from 2007 to 2008.
2. The arrests for rates increased at Fort Carson from 2006 to 2008.

The epidemiologic team concluded that

1. The soldiers who deployed with the index unit experienced greater combat intensity than comparison units.
2. Those soldiers experienced higher levels of postemployment behavioral health problems, traumatic brain injury, and positive tests for illicit substances.
3. The survey indicated that increasing levels of self-reported combat intensity associated with increased risk for self-reported acts of aggression, problematic alcohol use, criminal conviction, behavioral health problems, and engaging in physical altercations.
4. The focus groups revealed a strong theme of soldiers using alcohol and drugs to "self-medicate."
5. Many soldiers who tested positive for illicit substances did not receive appropriate referrals for evaluation and treatment for substance and alcohol abuse.
6. Soldiers granted waivers for alcohol/drugs or serious nontraffic offenses had a higher likelihood to test positive for listed substances and to be discharged from the Army for misconduct.
7. The survey identified significant barriers to receiving appropriate and timely behavioral health services.

The EPICON concluded that soldiers implicated in criminal activity related to homicide demonstrated risks for engaging in violent behavior based on a cluster of factors, including behavioral health problems, psychopathology, and misconduct. Neuropsychiatric conditions, including alcohol/drug disorders, mood disorder, anxiety disorders, and traumatic brain injury, presented clear risk factors for aggression. Nearly 80% of alleged perpetrators for homicide and related violence had documentation of alcohol or drug abuse, and fewer than half had received appropriate evaluation and treatment. The alleged perpetrators clustered within one particular index unit and had experienced higher levels of combat intensity. The survey indicates an association between increasing levels of combat exposure and risk for negative behavioral outcomes. Although not conclusive, the findings of this Army survey clearly implicated a combination of individual, unit, and environmental factors that converge to increase the population at risk for committing homicide and violence.

SUICIDE

Nearly 2000 soldiers have committed suicide since the first combat engagements in 2001. The words "contagion" and "epidemic" are often used to describe the losses, but the causes and contributing factors have eluded investigation despite the efforts of medical researchers and the Army leadership. The former Vice Chief of Staff of the

Army, General Peter J. Chiarelli, initiated a major review and analysis in 2010 to mitigate the problem. The Army Health Promotion, Risk Reduction, and Suicide Prevention report published under his direction in 2010 documented that more soldiers died as a result of high-risk behavior in the previous year than had died in combat.[8] The report concluded the following:

1. Individuals, families, friends, and leaders have the opportunity to intervene along the care continuum to mitigate suicide and equivocal deaths with an understanding of high-risk behaviors.
2. High-risk behaviors include abuse of alcohol and illicit substances and behavioral health problems.
3. The greatest increase in military suicides has occurred among soldiers who experienced the highest levels of combat intensity.
4. The manner of death determination may underestimate the actual incidents and extent of the problems.
5. The perceived stigma for seeking behavioral health treatment constitutes a real barrier to decreasing the suicide rate. The soldiers most likely needing behavioral health care are the least likely to seek treatment.
6. The relevant risk factors include medical conditions, high-risk behavior, life conditions, and stresses in relationships. The comorbidity of multiple medical conditions, including traumatic brain injury, increase the risk for suicidal behavior.
7. Early recognition and intervention of legal, medical, and disciplinary risk factors present opportunities to prevent negative outcomes. Early detection of behavioral health conditions reflects a willingness to begin treatment and better resolution of symptoms.

The Army STARRS identified multiple factors associated with a high incidence of suicide among military personnel. Nock and colleagues[9] reported that one-third of postenlistment suicide attempts are associated with preenlistment mental disorders. Their studies indicated that reenlistment onset rates among soldiers were lower than civilian cohorts, whereas postenlistment onset of ideation correlated with episodes of intermittent explosive behavior. The documentation of higher fatality rates among Army suicide attempts spotlights the importance controlling the means of suicide, such as availability to and familiarity with firearms. The studies implicate a higher incidence of behavioral health problems and troublesome behavior among soldiers who attempted suicide while on active duty.[10] The incidence of suicide attempts correlates with long-standing observations that mental disorders are leading causes of morbidity among US military personnel.[11]

The extensive and multiple epidemiologic studies sponsored by Army STARRS do not identify specific causative factors for suicide attempts among soldiers.[12] They confirm a steadily rising rate of suicide attempts and deaths from suicide since the beginning of the Iraq and Afghanistan conflicts. The findings constitute potentially useful indicators for preventive strategies but do not help inform clinicians on identifying an intervening without risk cases.

None of the studies comment on the contributing effects of concussions, improvised explosive device blasts, sleep problems, chronic pain, or comorbid medical on suicide, mental health problems, and duty performance. The constellation of Q7 combat intensity, stress, sleep disruption, injuries, and pain comprise the prevailing experience and reality of servicemembers in combat. The data and findings on concussions, related injuries, and intensity of combat await analysis by the researchers.

CHILD AND SPOUSE ABUSE

Military families experience unique environmental and social factors that influence quality of life and the nature of their relationships.[13] The impact of the Global War on Terror and engagement of military personnel on repeated deployments to Iraq and Afghanistan have uniquely influenced military families and community life.[14] The intensity of combat and repeated deployments to the combat theater have inflicted multiple direct and indirect stresses on the lives of the servicemembers and their families. Psychopathology and the emotional adjustment in military children and families has been linked to the continuous impact on the military at war since 2001.[15] Findings indicate that parental combat deployments impose multiple and cumulative consequences and psychological distress on children. The cumulative length of parental deployments during the child's lifetime correlates with increased risk for depression and externalizing symptoms in the children. A consistent finding of developmental literature has been the association of children's and parental distress, demonstrated again by the findings that 30% to 40% of military parents experience depression and anxiety.

The DoD reported marked increases in the confirmed cases of child abuse in 2014.[5] The DoD data indicate a steady increase in cases from 2008 and contrasts with concurrent declines in rates of abuse in the civilian population. The data require further analysis to identify the characteristics of the families and victims of abuse and neglect reported by the DoD. The DoD has not compiled data on the correlations of numbers and kinds of deployments of servicemembers, prevalence of anxiety, depression, and other emotional disorders with the incidence of child and family abuse, despite the relevant findings over many years.

The presence of psychopathology in abusers of children, spouses, and intimate partners has been documented extensively.[16] Many parents who abuse children and spouses have verified histories of being victims of abuse themselves. Victims of abuse in childhood and adolescence have higher incidence of depression, anxiety, substance abuse, and related disorders. As such, physical abuse constitutes a form of violence that begets violence for subsequent generations.

The causation and antecedents of child and family abuse is multifactorial and complicated. Multiple environmental and social factors contribute to the incidence of child, family, and spouse abuse. Stresses associated with employment, finances, standard of living, and stability in relationships impact the likelihood and nature of abuse. Multiple modalities are used in clinical practice to treat abusers and victims, including the identification and interventions for problems with substance abuse and behavioral health problems that commonly occur.

The Army Health Promotion, Risk Reduction, and Suicide Prevention documented the fragmentation of mental health services across the Army and DoD, including prevention and treatment services for child and family abuse.[8] The gaps in health care services impact formulating and providing coordinated care for servicemembers likely to commit abuse of children and family members and treating contributing conditions, such as alcohol and substance abuse, posttraumatic stress disorder, and postconcussion syndrome. There appears to be an absence of relevant data across the DoD and implementation of integrated programs.

MILITARY SEXUAL TRAUMA

The Congress and news media have spotlighted a rising incidence of sexual assault across the military. Despite the drop in rates across the DoD in recent years, the documentation of nearly 19,000 cases indicates that sexual assaults constitute a significant

problem and reflect a disturbing aspect of the military's "organizational culture."[17] The public statements by the DoD do not indicate that the leadership has studied the links between deployments of service members, incidence of psychopathology and other health consequences of combat, and sexual assault in contrast to the VA that has published relevant findings.[17] It is reasonable to assume that the causation of military sexual assault is multifactorial and involves elements of organizational climate, policies for prevention and reporting, and individual contributing factors, including psychopathology and comorbid medical conditions.

SUMMARY

The history of warfare from ancient times recounts vivid tales of returning soldiers, their agony and hardships, and their plunging into violence and despair. More than 14 years of combat in Iraq and Afghanistan involving 2.7 million men and women reaffirms the impact of war on the individual warriors. The violence of war cannot be contained to the battlefield and spills over to the families and communities of the returning soldiers. Violence erupts in many forms when soldiers come home. The rising incidence of suicides among returning servicemembers has become the signature indicator. Additional indicators include highly worrisome reports of homicide, violent crime, risky behavior, accidents, family violence, and sexual assault. The occurrence of such troubling conduct and events is expected among a population of young men and women attracted to the military and volunteering for combat duty. The services rely on the temperament and instincts of the young recruits toward violence to prepare and train the force. Despite the dedicated training that all servicemembers receive on the rules of engagement, containing the occurrence of violence to the special conditions and circumstances of combat comprise a formidable challenge.

A survey of programs and policies across DoD since 2001 uncovers few initiatives to prevent and contain untoward conduct and violence among returning servicemembers. The Army specifically declined to institute decompression programs to facilitate the adjustment of returning soldiers in 2009. Unlike the military services of several European countries and Canada, the United States does not practice formalized decompression and readjustment to assist with the transition from the combat theater. The series of repeated deployments for many soldiers presents serious risks for untoward conduct and violence.

The failure to anticipate the adverse conduct and health consequences of combat on servicemembers ignores the history of warfare and well-recognized lessons learned. In part, the absence of effective policies and practices can be attributed to the current climate across medical and social research. The guidance for military medicine is reductionist and grounded in the predominant principles and thinking on evidence-based approaches across health care research. Accordingly, evidence-based research has translated into conclusions strictly based on empirical findings of narrow studies, but lacks relevance to clinical practice and real-world situations.

The principles of true evidence-based practice involve the integration of best-available research, clinical judgment, and individual preference.[17] These principles apply to understanding the nature and occurrence of violence across the DoD in servicemembers, their families, and their communities. The best-available research goes beyond formal studies and scientific projects and extends to thoughtful reading and understanding of the history of war. Plain and good judgment compels leaders and military medical researchers to acknowledge that many young returning warriors have required dedicated interventions to comprehend the impact of combat duty

and reset their personal lives and careers to noncombat environments. The glaring prevalence of drug and alcohol abuse across the range of misconduct related to violence points to the compelling need to design more effective interventions for prevention and treatment. The customary practice across the Army of subjecting young soldiers who use illicit substances to dishonorable discharges from duty merely transfers the problems to the VA and the country at large. Such practices do not protect Americans or heal the damaging consequences of combat.

The spillover of violence to the home stations and communities has multiple elements and appeared tragically during the extended years of these wars. The military, and the nation, are responsible to document the nature and impact of such violence, capture the lessons learned once again for future generations, and act to protect the health and welfare of the citizens who go to war and who live in their communities on returning.

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