



# Intimate Partner Violence and Neurocognitive Disorders

Amanda Kraker, LCSW  
Phoenix VA Healthcare  
System

# Disclaimer

This presentation contains content related to Intimate Partner Violence (IPV) and trauma.

Given the prevalence of IPV in the general population, attendees are encouraged to practice self-care and step away if triggered or disturbed by any content.

# Agenda

- Define Neurocognitive Disorders and understand how they impact areas of functioning
- Define Intimate Partner Violence (IPV)
- Understand the intersection of IPV with aging/elderly, and caregivers
- Identify recommendations for interventions when assisting with IPV and Neurocognitive Disorders
- Identify community and VA resources that may assist with this population

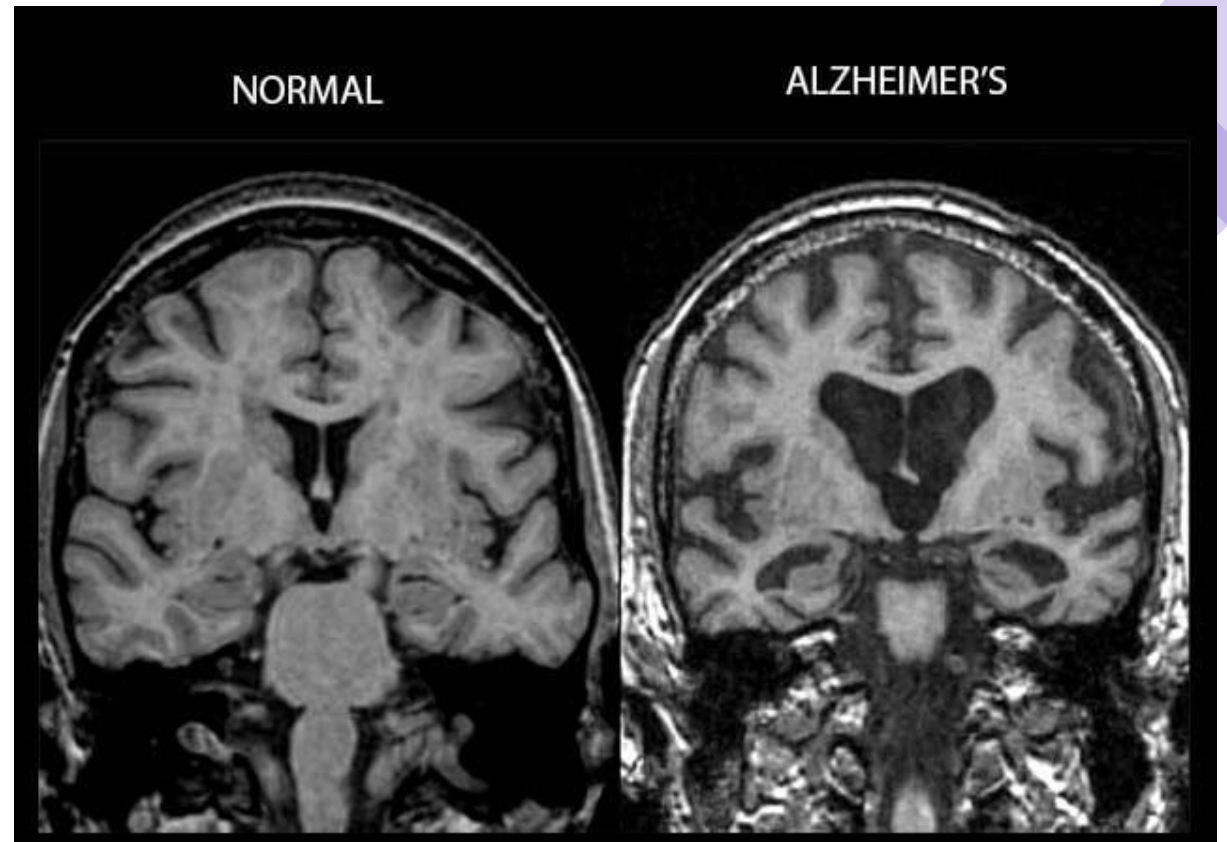
# Neurocognitive Disorder - per DSM-V

Several conditions causing cognitive decline in multiple domains;

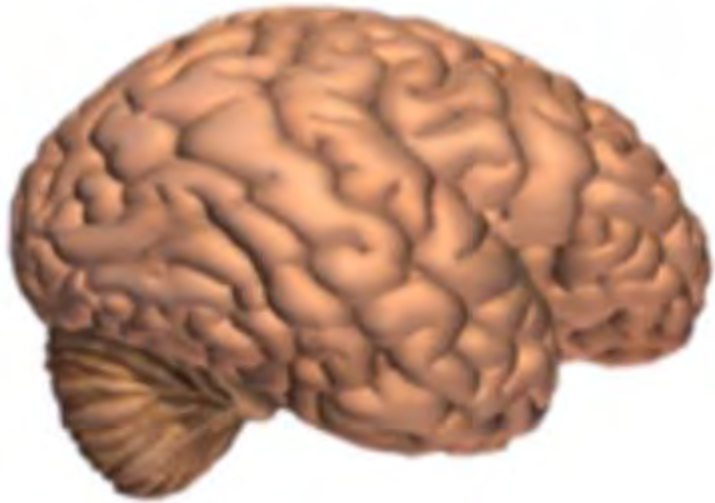
- Language
  - Expressive language – Recalling words you want to use, word finding
  - Receptive language – Knowing/understanding the concept/meaning of a word when you hear it
  - Grammar and syntax – Grammatical errors, may leave out words or use them incorrectly
- Learning and Memory
  - Ability to store short term and long-term memories, and later retrieve the information
    - Repeating themselves, requires reminders or use of lists more frequently
- Complex attention
  - Ability to focus on one thing despite other stimuli, maintaining focus over time
  - Easily distracted, difficulty multitasking, task completion takes longer, errors in routine tasks
- Perceptual-motor
  - Interacting with our environment with our 5 senses, hand-eye coordination
    - Getting lost in familiar environments, trouble understanding what you see, difficulty with spatial reasoning
- Social cognition
  - How we process/use information in social contexts
    - Decreased insight and empathy, insensitivity to social standards re: dress, behavior etc., inability to read social cues
  - Executive functioning
    - Planning, decision making, inhibition, cognitive flexibility (shifting between topics, tasks, conversations etc.)
    - Difficulty with decisions/problem solving, distractable, overwhelmed in social settings, assistance with ADLs
- AND causes significant decline in the person's functioning

# Impacts on the Brain

- The brain atrophies and holes form in the brain. Changes to the brain's physical structure are visible
- The cortex begins to shrivel, damaging areas that involve thinking, planning and remembering
- Ventricles filled with cerebrospinal fluid grow larger
- Hippocampus shrinks severely, impacting memory and learning



# Brain Comparison



**Without the disease**



**Advanced Alzheimer's**



**Comparison of both brains**

# What is Intimate Partner Violence (IPV)?

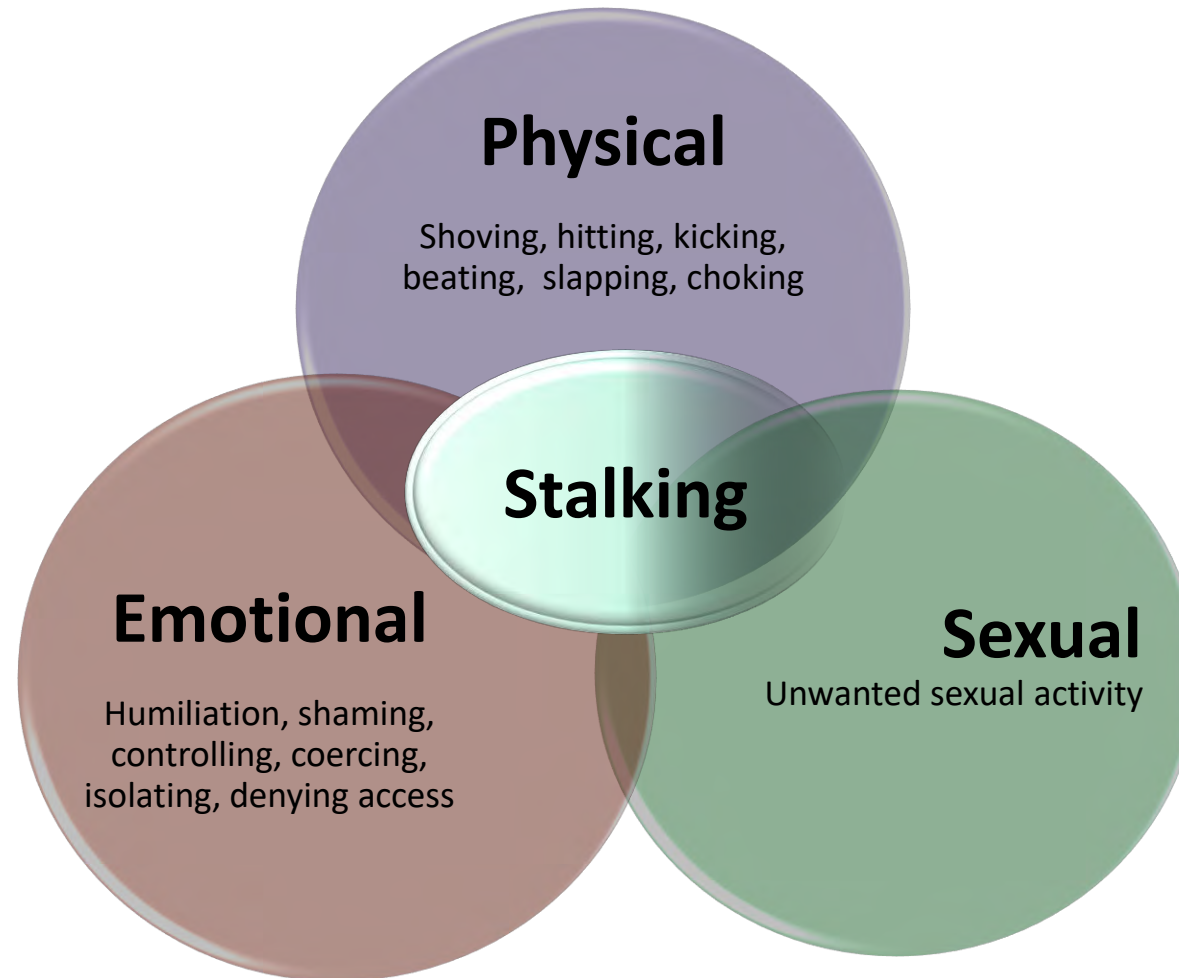
## **Intimate Partner Violence:**

“The term intimate partner violence describes physical, sexual, or psychological harm or stalking behavior by a current or former partner that occurs on a continuum of frequency and severity ranging from emotional abuse to chronic, severe battering or even death. It can occur in heterosexual or same-sex relationships and does not require sexual intimacy or cohabitation.”

# Types of Intimate Partner Violence

**1:3** women and  
**1:4** men report  
experiencing IPV  
across their  
lifetime

IPV rates and  
risks are even  
**higher** among  
LGBTQ+  
relationships





# Impacts of IPV

## Physical health

- Bodily injuries, headaches, abdominal and pelvic pain, chest pain and palpitations, IBS and GI problems, STIs, Fibromyalgia or chronic pain syndromes, TBI, medically unexplained symptoms, impacts on reproductive health

## Mental health

- PTSD, depression, anxiety, substance misuse, suicide, homicide, stress reactions/crisis state, intrusive negative emotions; shame, guilt, helplessness

## Social Health

- Work disruption, finances, housing, interpersonal relationships d/t difficulties with trust, safety, intimacy, legal impacts, isolation, poverty

# IPV and Older Adults

- 40 million adults over 65yo in the US and 16.9 million are caregivers
- 1 out of 10 report experiencing elder abuse
- Studies have found that medical teams do not often screen for IPV among older adults
  - Assumption that cognitive decline is age related
  - Assumption physical injury/bruises are d/t unsteady gait or other medical factors
- Most common injuries:
  - Head/neck injury is the most likely injury
  - Arms/trunk is 2<sup>nd</sup> likely
  - Bruises also common
- Risk Factors for IPV:
  - Cognitive Impairment
  - Depression, prior trauma, PTSD
  - Functional Impairment and medical comorbidities – ADLs/IADLs
  - Social isolation and loneliness -- strong personal relationships are a primary protective factor

# Barriers to IPV Disclosure

- Confidentiality
- Financial stability
  - Reliant on their partner's benefits
  - Caregiver responsibilities prevent them from gaining/maintaining employment
- Shame, fear of being a burden
- Fear of retaliation – ex. being placed in a nursing home
- Disability that impacts ability to report/be believed
- Cultural or spiritual differences
- Emotional abuse decreases self-efficacy
- Powerlessness and helplessness
- Concerns for housing
- Personal/Community reputations
- Concerns about DCS involvement
- Concerns about APS involvement

General self-efficacy operationalized: Schwarzer & Jerusalem, 1995, 2000

IPV, invalidation and self-efficacy; Iverson, Shenk & Fruzzetti, 2009

Iverson, Danitz et al., 2021

# Legal Considerations

- Caregiving responsibilities may be formally established; POAs, guardian.
- Vulnerable Adult Abuse Laws
  - Designed to protect vulnerable individuals, however there are possible unintended consequences to caregivers.
  - Elder abuse laws can discourage caregivers from exiting IPV relationships
    - Fear of exiting being criminalized as “abandonment” and/or “neglect”, specifically if determined that the vulnerable adult experienced harm “intentionally” or due to “negligence” as a result. (A.R.S 46-455, 46-451, 13-3601)

# Caregivers Engaging in IPV Behaviors

Dementia related behaviors can trigger violence from the caregiver, in addition to other pre-existing triggers if the IPV preceded dementia.

For the individual experiencing dementia, there may be:

- Increased risk for physical injury and neglect
- Increased risk for death and medical complications
- Increased need for in-home support
- Abuse is less likely to be reported

# IPV *Prior* to Onset of Dementia

In relationships with longstanding IPV, physical violence may decrease but may be replaced by worsening psychological and emotional abuse

The sooner the IPV starts in the relationship, the higher the likelihood that the person experiencing the abuse will be/feel less able to exit the relationship and/or protect themselves.

Caregivers experiencing prior IPV are more likely to:

- Feel burdened and less motivated to serve in a caregiving role
- Give more negative descriptions of caregiving experiences
- Psychological trauma/fear from past experiences interfere with changes in the Caregiver's role
- Difficulty making decisions for the individual or responding to disruptive/inappropriate behaviors
- Have difficulty accepting/seeking support
- Have difficulty pursuing placement when warranted
- Have higher risk for burnout
- Internalize the behaviors as a personal attack

# IPV *After* Onset of Dementia

Caregivers are more likely to:

- Adjust and cope more effectively
- Be receptive to support from peers and professionals
- Show the person empathy and have a desire to help them
- Mourn the loss of their previous relationship
- More willing/comfortable with setting limits and making decisions for their partner, even if the partner does not agree
- Feel more inclined to continue caregiving, described more balanced or positive caregiving experiences
- If perceived as something outside the partner's control, partner-caregivers are less likely to report IPV, and often feel a greater obligation to remain in the relationship.

# IPV and Dementia-Related Behaviors

Dementia-related aggressive behaviors;

- Physical: Hitting, kicking, grabbing, choking, physical intimidation
- Psychological: Insults, cursing, threatening, yelling
- Sexual: Assault, unwanted touching/grabbing
  
- The behaviors may be more common during ADLs or other close contact, or if the individual is experiencing another trigger (overstimulation, feeling scared).
- The behaviors communicate the person's distress.

**When these behaviors are directed towards an intimate partner, it meets criteria for IPV**



# IPV & Mandated Reporting

## DCS:

- “When a parent, guardian or custodian inflicts or allows the infliction of physical, sexual or emotional abuse, neglect, exploitation or abandonment.”
  - If a child witnesses IPV behaviors, it is reportable to DCS

## APS

- Vulnerable adult – over 18yo and unable to protect themselves from abuse, neglect or exploitation by others because of a physical or mental impairment, including incapacitation.
- Age alone is insufficient to determine if an individual is a vulnerable adult – there must also be traits of vulnerability/incapacitation (A.R.S. §46-451, A.R.S §13-3623).
  - If they are not a vulnerable adult, you do not have to report it to APS

DCS/APS is often helpful in providing additional supportive services

\*This information is specific to Arizona – laws vary by state\*

# Intervention

- First, initiate emergency services, as needed
- Then explore: Was there IPV prior to the dementia?

If no:

- Seek the causes of the agitation (ex. Frustration, pain, boredom etc.)
- Family education about dementia and behavioral interventions
- Mental health care and caregiver support to prevent burnout
- Resources and additional assistance within the home (HHA, respite, home-based primary care etc.)
- Educate on nursing home placements or ALFs (plant the seed early, view it as a process)
- Safety planning and treat injuries, as needed
- File APS/DCS reports as indicated

If yes:

- Dementia interventions are unlikely to improve the situation
- Existing triggers for violence are exacerbated
- Feelings of helplessness and vulnerability may escalate the individual's violence
- Provide education to the caregiver re: the behaviors, and consider working towards separating the couple, if willing – ex. Nursing homes/ALFs
- Safety planning and treat injuries, as needed
- File APS/DCS reports as indicated

# Resources

## Community Options

- Alzheimer's Association
- Caregiver support groups (AARP, Arizona Caregiver Resource Line etc.)
- Foundation for Senior Living
- Area Agency on Aging
- Brain Injury Alliance of Arizona
- Office of the Attorney General's Task Force Against Senior Abuse (TASA)
- National Domestic Violence Hotline; P: 1800-799-7233, [www.thehotline.org](http://www.thehotline.org)
- Community DV programming – Catholic Charities, Jewish Family & Children's Services



## VA Healthcare System

- Caregiver Support Program
  - Caregiver Coaching and other supportive programming
  - Possible financial benefits and respite
  - P: 1855-260-3274
  - P:602-277-5551 x 7777 – Will help with application
- Neuropsychology assessments and treatment recommendations
- Home-based primary care
- PACT Medical and Social Work Services
- Home Health Aids
- Adaptive equipment
- Contracted Nursing Homes, Respite, Adult Day Healthcare (pending benefits eligibility and safety)

*For Mental Health Appts please call 602.222.2752 Option 3  
For Medical Appts please call 602.222.6550 Option 2 then 4*

# Intimate Partner Violence Assistance Program (IPVAP)

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IPVAP Coordinator Amanda Kraker, LCSW  
P: 602-277-5551 ext. 2680.

## Building Relationship Health and Safety

VA Can Help



Contact Your VA Coordinator  
Intimate Partner Violence Assistance Program  
[www.socialwork.va.gov/IPV/Coordinators.asp](http://www.socialwork.va.gov/IPV/Coordinators.asp)

The National Domestic Violence  
**HOTLINE**  
1.800.798.SAFE (72531) • 1.800.787.5524 (ITV)

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