J Fam Viol (2013) 28:823–831
DOI 10.1007/s10896-013-9544-7

RESPONSES TO INTIMATE PARTNER VIOLENCE

VHA Primary Care Providers' Perspectives on Screening Female Veterans for Intimate Partner Violence: A Preliminary Assessment

Katherine M. Iverson · Stephanie Y. Wells · Shannon Wiltsey-Stirman · Rachel Vaughn · Megan R. Gerber

Abstract Female Veterans experience intimate partner violence (IPV) at alarming rates. The Veterans Health Administration (VHA) requires foundational research to guide the development of policy and programs to detect IPV among women Veterans and provide interventions. This pilot study reports findings from in-depth qualitative interviews conducted with 12 VHA primary care providers treating female Veterans in the New England region. Although most providers indicated that they were not currently routinely screening for IPV, they expressed positive attitudes and beliefs about screening in VHA primary care settings. Themes also included the importance of a comprehensive health care response to IPV, such as interdisciplinary coordination of care and team-based approaches to detection and intervention. Barriers to routine screening were identified, as well as recommendations for training programs and clinical tools to inform the successful implementation of a standardized IPV screening and response program in VHA. Although preliminary, these findings represent an initial step in an essential line of research.

K. M. Iverson (✉) · S. Wiltsey-Stirman
Women's Health Sciences Division of the National Center for PTSD, VA Boston Healthcare System and Boston University School of Medicine, Boston, MA, USA
e-mail: Katherine.Iverson@va.gov

K. M. Iverson · S. Y. Wells · R. Vaughn
Women's Health Sciences Division of the National Center for PTSD, VA Boston Healthcare System, 150 S. Huntington Ave. (116B-3), Boston, MA 02130, USA

M. R. Gerber
VA Boston Healthcare System and Boston University School of Medicine, Boston, MA, USA

Keywords Women Veterans · Domestic violence · Screening · Qualitative research · Implementation · Veterans Health Administration

As women have come to occupy an increasing range of roles in the United States military over the past 30 years, the number of female Veterans has increased dramatically (Frayne et al. 2010; Street et al. 2009). Currently, women comprise approximately 15 % of all military service personnel and approximately 10 % of the total Veteran population, and are the fastest growing population of patients within the Veterans Health Administration (VHA; Frayne et al. 2010). It is increasingly understood that women Veterans represent a unique patient population in terms of health care needs and service use patterns (Frayne et al. 2010; Street et al. 2009). For example, women Veterans report more mental and physical health problems than civilian women (Batuman et al. 2011). These health disparities may be accounted for, in part, by women Veterans' greater exposure to various forms of interpersonal violence than civilian women (Kelly et al. 2011; Zinzow et al. 2007). Because VHA is the largest single provider of health care for women Veterans in the United States, it is critical to understand VHA providers' perspectives and practices in terms of addressing one of the most common forms of interpersonal violence experienced by women who have served in the military—intimate partner violence (IPV; Campbell et al. 2003; Campbell et al. 2008; Dichter et al. 2011; Merrill et al. 2006; Murdoch and Nichol 1995).

IPV refers to physical, or severe psychological psychological harm from a former or current intimate partner (Centers for Disease Control and Prevention [CDC] 2012). Epidemiological data indicate that lifetime IPV is more common among women Veterans than non-Veteran women

(Dichter et al. 2011) and research conducted with VHA samples suggest that IPV may be a particularly prevalent experience among female VHA patients. For example, one study found that 74 % of women seeking primary care within a large urban VHA facility reported lifetime physical IPV (Campbell et al. 2008). A more recent survey of female VHA patients in the New England region found that 29 % of women in an intimate relationship reported past-year physical, sexual, and/or severe psychological IPV (Iverson et al. 2013a). These findings are in the upper-range of what have been reported among other female health care samples (e.g., Nelson et al. 2012). Clearly, female VHA patients represent a vulnerable sub-population in terms of IPV risk.

The negative effects of IPV on women's short and long-term health are well documented. In terms of physical health problems, IPV is associated with high blood pressure, obesity, sexually transmitted diseases, gynecological problems, heart disease, stroke, asthma, stomach ulcers, arthritis, headaches, chronic pain, and other somatic symptoms (Campbell 2002; Coker et al. 2000; Dichter et al. 2011; Humphreys et al. 2011). Even low-severity violence and psychological aggression significantly increase the odds of adverse health outcomes, including pregnancy complications (Coker et al. 2002; McCauley et al. 1998). IPV also leads to and exacerbates serious mental health symptoms and conditions such as posttraumatic stress disorder (PTSD), depression, substance abuse, eating disorders, and suicidality (Campbell 2002; Coker et al. 2002; Dichter et al. 2011) that are relatively common among female VHA patients (e.g., Benda 2005; Maguen et al. 2010).

Health care providers caring for women Veterans are often treating women who experience the health effects of cumulative trauma exposure and complex symptom presentations (Campbell et al. 2008; Kelly et al. 2011; Sadler et al. 2004). For example, a significant number of female Veterans have experienced physical, sexual, and emotional forms of childhood abuse (Kelly et al. 2011; Zinzow et al. 2007). These forms of childhood maltreatment are known risk factors for adverse health conditions and IPV in adulthood (Ehrensaft et al. 2003; Iverson et al. 2011b). Additionally, women Veterans report high rates of sexual harassment and assault during military service, referred to as "military sexual trauma" within VHA (Kimerling et al. 2010; Street et al. 2008). Military sexual trauma includes acts of sexual harassment and/or assault that may have been committed by any perpetrator (i.e., a fellow service member) and the definition is not limited to sexual trauma perpetrated by an intimate partner. Sexual assault, combat exposure, and other military-related stressors have a cumulative impact on women's mental health symptoms, including PTSD (Street et al. 2009; Zinzow et al. 2007), which may increase women's risk for future IPV (Iverson et al. 2011a; Iverson et al. 2013b). These cumulative trauma experiences may not only increase women Veterans' risk for IPV, but are also often associated with complex physical and mental health symptom presentations that can be time consuming to thoroughly assess and treat. All of these issues may create barriers to screening for IPV within VHA primary care settings due to competing demands on providers' time during routine visits.

The increase in women Veterans seeking VHA care, combined with increased recognition of women's unique health care needs, has led to significant system-wide changes to VHA health care for women (Yano et al. 2010). VHA primary care settings face challenges unique to a system that has predominantly served males. Availability of comprehensive care for women Veterans has rapidly expanded to meet the needs of this growing population. VHA defines comprehensive care as, "the provision of complete primary care and care coordination by one primary care provider at one site. The primary care provider should, in the context of a longitudinal relationship, fulfill all primary care needs…" (Department of Veterans Affairs 2010b, p. 2). Making comprehensive women's health care widely available has been challenging due to small caseloads at some sites (Yano et al. 2006). Additionally, many VHA providers have not been routinely caring for women during their VHA careers and lack the ability to provide gender-specific services (i.e., care that is dictated by gender, such as pelvic examinations and pap smears). Moreover, the prevalence of comorbid interpersonal trauma among women Veteran patients also creates challenges for delivery of comprehensive care as routine gender-specific examinations and procedures, such as pelvic exams, are often more difficult for these patients (Weitlauf et al. 2010). As a result, VHA has launched large-scale training programs to expand the capacity of providers to deliver comprehensive gender-specific care to women Veterans.

Concern that IPV is going under-detected among female VHA patients has led to recent calls for VHA to develop national IPV screening and response guidelines and programs (Sweeney et al. 2013). Consistent with new recommendations of the United States Preventative Task Force (2013), VHA primary care would be an ideal setting to begin systematically assessing for IPV since it is often the first point of contact for women Veterans entering VHA. Moreover, women who have experienced IPV identify primary care providers as the people from whom they would like to seek support for IPV and believe health care providers can help (Friedman et al. 1992; Hamberger et al. 1998).

Despite its relevance to the care of women Veterans, the barriers and facilitators to IPV screening among VHA primary care providers remain unknown. Researchers have long been interested in health care providers' experiences and perceived barriers to IPV screening among non-VHA health care providers (Elliott et al. 2002; Gerber et al. 2005; Waalen et al. 2000), but there is little work investigating VHA providers' attitudes, beliefs, and practices with regard to IPV screening. Given the unique characteristics and challenges of delivering women's health in VHA primary care settings, important differences may exist. To fill this gap in the literature and to help inform the successful implementation and adoption of IPV screening and response practice by VHA providers, this pilot study provides an initial qualitative assessment of VHA primary care providers' perspectives regarding IPV screening practices.

Method

Participants

Participants in this study were 12 primary care providers from the New England VA Healthcare System, which comprises Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut. All primary care providers, including physicians, nurse practitioners, and physician assistants, were eligible to participate as long as they treated female Veterans in a VHA primary care context. Participants had to participate in the research outside of their VHA work hours. There were no other exclusion criteria.

Nine participants were physicians and 3 were nurse practitioners. Participants were represented from primary care clinics within each of the six states that comprise the New England VA Healthcare System. The majority of participants were female (83.3 %), with the gender composition being fairly representative of the population of primary care providers treating women within the New England VA Healthcare System. Participants were an average of 42 ($SD=9.81$) years of age and had been practicing in the field, including any residency training, for an average of 15 ($SD=8.75$) years. On average, participants treated approximately 13 ($SD=12.21$) female Veteran patients per week. Only 1 participant reported having received any type of training relating to IPV within the past 6 months.

Procedures

Participants were recruited using informational letters sent via email to all primary care providers in the VA New England Healthcare System. The letter indicated that the study aimed to understand VHA providers' attitudes and beliefs regarding IPV screening practices with female Veterans. The informational letter included the following description of the procedures and inclusion criteria:

> "We are looking for primary care providers who work with female patients within the New England VA Healthcare System who will agree to participate in an audio taped interview over the phone…We are interested in conducting interviews from a variety of male and female primary care providers, including but not limited to those who work in Women's Health Clinics."

Interested providers called or emailed the first author to learn more about the study and schedule a 60-min phone interview. All interviews were conducted over the phone and audio-taped for transcription and coding purposes. To help protect participants' confidentiality, verbal informed consent was collected prior to conducting the audio-taped phone interviews because written informed consent forms would have been the only personally identifiable information collected in this study. Participants were informed that IPV was defined for the current study as physical, sexual, and psychological harm from a former or current intimate partner (CDC 2012).

In-depth semi-structured qualitative interviews were conducted with providers between February and June of 2012. The semi-structured interview included open-ended questions intended to elicit providers' experiences with screening and follow-up care for IPV with female VHA patients, perceived barriers and facilitators to screening, and training needs. For example, "What are your thoughts about whether or not VHA primary care providers should screen women patients for IPV?", "What do you think would help you and other providers in the VHA remember to screen and engage in screening practices?", and "What are some of the barriers you experience with regards to IPV screening and responding?" were a few of the questions asked. Perceived training needs were assessed with questions such as, "What types of educational interventions do you think are needed to improve VHA providers' readiness to address IPV?" Interviews were conducted by the first author until the research team had agreed that saturation had occurred during data collection (i.e., the researcher is no longer hearing new information during the interviews; Glaser and Straus 1967). Participants were compensated for their time with a $50 gift card to Amazon.com. All procedures for this study were approved by the Institutional Review Board at the VA Boston Healthcare System.

Data Analysis

Audio-recordings were transcribed verbatim. Transcripts were analyzed qualitatively using procedures informed by Grounded Theory methodology (Charmaz 2006). We first conducted open coding in which three investigators (authors 1, 2, and 4) separately identified key concepts emerging from the text, which were discussed together in consensus meetings, followed by the development of a preliminary codebook. The coding scheme facilitated systematic identification of ideas, as well as theoretically important concepts. After developing the preliminary codebook, each transcript was re-coded by two of the authors and consensus meetings were held weekly with the coders and first author to ensure agreement. Coded text segments were reviewed by investigators to condense broad codes into distinct themes. Subsequently, prominent themes and quotes exemplifying each were presented to the research team and refined through discussion.

Results

Analysis of the interview transcripts revealed five primary themes related to VHA primary care providers' perspectives regarding screening female Veterans for IPV victimization.

Theme 1: IPV Screening for Female VHA Patients Should be Routine

Participants expressed very positive attitudes toward IPV screening in VHA primary care settings, with many of the participants supporting screening for past and current IPV as a standard part of medical care. Eleven of the 12 participants indicated that IPV screening should be routine for women Veterans. The most salient reason for screening was the value of identifying an experience that may be impacting patients' health and being able to provide support. As one provider explained:

> I think it's one of those subjects that if you don't screen for it and start the conversation with the person, then you don't detect and don't treat. The downstream social consequences and medical complications are huge, so I think [IPV screening] has a lot of value.

Several providers advocated that IPV screening should be equated with other routine preventative health measures, such as conducting pap smears and screening for diabetes and depression. IPV screening was viewed as a clinical strategy that could increase early detection and possibly prevent future violence. For example, a provider stated:

> My whole goal is to help people be healthier and stay healthy before something bad happens. So, before someone's diabetes gets so out of control that they end up with kidney damage…we should try to prevent that from happening. It is all about keeping people healthy before something bad happens. So whether it is external injury—whether from a car accident or a person perpetrating it—it is all consistent with the same goals.

Providers also believed that IPV screening was consistent with their professional goals in providing holistic care for Veterans, such that:

> If it's happening to our Veterans we certainly need to know it. Our number one priority is helping the Veteran so we definitely need some sort of screening manual, screening paper, screening questions, or something like that to find out because we are here to take care of our Veterans.

Theme 2: There are Logistical and Educational Barriers to Screening

A primary aim of this study was to understand VHA providers' perceived barriers to screening for IPV among female patients, which were then conceptualized as either "logistical" or "educational" barriers. One of the most consistently mentioned logistical barrier was a perceived lack of time during clinical encounters. Primary care providers have only a short amount of time to meet with patients during routine visits. In particular, the presence of comorbid physical and mental health symptoms can make it difficult to assess a range of possible problems because, "If it's all left up to the provider and that encounter I think it may be pushed to subsequent visits because there's already so much stuff they're trying to do in that one encounter."

Providers also identified a lack of education pertaining to IPV as a significant barrier to screening. More specifically, the largest hindrance to IPV screening was a general lack of awareness and knowledge with respect to the prevalence and health consequences of IPV. One provider said it most succinctly:

> I think part of the not doing it is not knowing how common it is, how big of a problem it is and how often I should expect to be seeing it. It's just really not on my radar. It is so overshadowed by other mental health issues and substance abuse issues that, relative to those topics, IPV isn't really up there.

Providers' lack of IPV education has led some providers to feel uncomfortable screening and responding to IPV, as expressed by one provider, "[Barriers to screening are]…lack of training, lack of comfort level. So that would go along with the need for training…We need more face-to-face training so we could become more comfortable with that." Increasing providers' level of training may increase provider confidence and willingness to screen for IPV.

Theme 3: Educational Trainings Specific to Identifying IPV Would Facilitate IPV Screening

Consistent with the aforementioned barriers to screening, most participants reported a strong need for education and formal training on IPV that includes specific guidelines for how to screen for IPV (e.g., what questions to ask and how to ask the questions). One provider described the essential training components as:

> If we are going to do it [IPV screening], people need to be trained how to do it. People need to be trained to look

> a patient in the eye, look away from the computer and let them know you're listening, ask carefully and in a meaningful way.

Overall, providers believed that receiving initial and ongoing educational opportunities would serve as a key facilitator to increased IPV screening practices among women Veterans.

In terms of the type of training format desired, providers expressed their preference for in-person, interactive, and "hands-on" training as opposed to online trainings, which are often the norm within VHA. For example, in regards to best methods of receiving training, one provider said, "I think it's something that would need to be like an official training, versus the online trainings." Additionally, providers identified specific training needs, including the importance of role-play and practice, and provided other examples of what they believed would be helpful in terms of formal training on IPV screening and responding, such as a focus on building communication skills that convey empathy for patients:

> One thing I know from the past is the importance of communication skills training, which did cover these more challenging issues such as violence…being trained how to ask the questions and how to support the patient, how to be empathic. It is critical.

Theme 4: Care Should be Coordinated and Team-Based

The majority of participants stressed the importance of coordination of care between primary care providers, VHA providers of other disciplines (i.e., social workers and psychologists), and community agencies. Although participants consistently indicated the belief that primary care providers, and nurses working within the primary care context, play an essential role in terms of identifying IPV and its impacts on patients' health, providers indicated that they would prefer to refer identified patients to social work or mental health for more rigorous assessment and treatment planning. For example, one provider felt that, "Primary care would be more of a screening place and triage place. I don't personally see primary care as the best place to treat this kind of complicated issue." In general, VHA social workers and other mental health providers were believed to be more appropriately trained with regard to the issues most relevant to IPV survivors (e.g., safety concerns, mental health needs, and logistical considerations such as housing or legal matters). Another provider elaborated:

> I am very comfortable with suspecting abuse or IPV and some of the physical symptoms might be like the medical model of it, but I am much less comfortable with what I'd do once the person told me about it and what I'd do if I thought the children were in danger, things like that I actually have no idea, I'd probably call a social worker or a psychiatrist or psychologist here, but that's where I fall apart.

Similarly, participants indicated that the VHA's focus on team-based approaches to care is an important component of primary care within VHA that can facilitate IPV screening and response efforts. Patient Aligned Care Teams (Department of Veterans Affairs 2010a), or patient-centered, multi-disciplinary teams, were seen as critical to caring for IPV victims using a team-based approach. One provider explained that the team approach helped not only in terms of providing resources, but also in terms of the support that providers could offer one another around this challenging clinical issue:

> I think the team can facilitate [IPV screening] because if you have a patient you're concerned about…I think having a team that is on board with you in that feeling it's important, you have people to go to and ask about resources and ask what they've done in similar situations and even to bring them in on the discussion. So I think that the team, definitely to the extent that the team is on board with you and thinks the issue is important, can be a facilitator.

Theme 5: Provide us with Clinical Tools to Make IPV Screening Easy and Systematic

Participants indicated a desire for various tools and resources to increase consistency and efficiency of IPV screening practices by VHA providers. VHA has an extensive clinical reminder dialogue system. These clinical reminders are embedded within patients' electronic medical records and they prompt the provider to assess for various health risks or conditions at specified time points (e.g., annual pap smear). A brief IPV screening tool embedded within the electronic medical record template as a clinical reminder or administered via paper-and-pencil were identified as methods of making screening more standardized and acceptable for providers as indicated by one provider's statement, "I think we need some sort of guideline as to how to ask the question. It's going to have to be a clinical reminder just like PTSD." The clinical reminder system was typically considered a potential facilitator for many of the participants, as stated by one provider as:

> It may make sense to have a template that prompts you, you know, like some kind of validated questionnaire type of situation. And it would be helpful if the tool could be pulled up as a women's health template. Then it would be documented the way it should be documented and all the right questions are asked.

In addition to clinical reminders that incorporate evidence-based screening tools, participants also discussed the utility of note templates to assist with documentation (i.e., extent of documentation of screening and risk assessment results) and increase provider accountability.

Discussion

While prior studies have examined primary care providers' attitudes, barriers, and practices regarding screening for IPV in non-VHA settings, to our knowledge the current study is the first assessment of these issues among VHA primary care providers. Our qualitative findings provide important insights into VHA primary care providers' subjective experiences and recommendations for informing the implementation of systematic IPV screening and response programming within VHA.

Participants consistently expressed positive attitudes about screening female patients for IPV in the VHA primary care context (Theme 1). All but one participant expressed the opinion that VHA primary care providers should be routinely screening female Veterans for IPV and providing appropriate care and referrals. Similarly, consistent with work examining patients' perspective on IPV screening (Petersen et al. 2004), many participants indicated that they believe direct inquiry is important because patients will be more likely to disclose such experiences in the context of a routine screening program with a provider with whom they have an ongoing relationship as opposed to expecting patients to spontaneously disclose IPV experiences.

Although participants advocated for routine IPV screening, several important logistical and educational barriers to screening in VHA primary care settings were also identified (Theme 2). First, replicating previous research with non-VHA providers (Ferris 1994; Minsky-Kelly et al. 2005; Sprague et al. 2012), time constraints were consistently noted as a major barrier to IPV screening within VHA, especially in light of the extensive list of screening programs that already exist (e.g., obesity, tobacco use, sexual trauma during military service, PTSD, depression, alcohol misuse, HIV). In addition to the more logistical challenge of time constraints, participants identified several concerns that can be understood as a general lack of education regarding IPV. For example, participants indicated that a lack of awareness and general knowledge pertaining to the prevalence and health effects of IPV contributed to inconsistent IPV screening practices among VHA providers. Providers' lack of education regarding IPV screening led to decreased confidence levels in their ability to appropriately and sensitively screen women for IPV. Although similar observations have also been documented among non-VHA providers (Davis and Harsh 2001; Guillery et al. 2012), this study extends these findings in a new population of providers that care for an important group of patients who are at heightened risk for IPV relative to civilian women (Dichter et al. 2011).

Complementing the findings regarding educational barriers to screening for IPV, participants consistently indicated that provision of education and training programs related to identifying and managing IPV among female Veteran patients is essential to facilitating IPV screening in VHA (Theme 3). Specifically, participants reported a need for basic education on IPV, such as information on prevalence, risk factors, and health consequences, to facilitate provider 'buy in' regarding the importance of screening women patients for IPV. Providers also requested in-person interactive training programs that provide specific guidelines on screening, assessment, referrals, and follow-up care. Role-play exercises, practice accompanied by feedback, and communication skills were identified as important components of educational training programs. Providers also suggested that education be ongoing and associated with specific protocols for caring for IPV survivors that would enhance providers' willingness and comfort level with IPV screening and response. This finding is in line with previous research showing that provider educational training sessions lead to increased knowledge and self-efficacy regarding screening, assessment, and referral practices with respect to addressing IPV in health care settings (Campbell et al. 2001; Hamberger et al. 2004; Thompson et al. 2000).

Coordination of care among VHA providers, including team-based approaches, and the ability to refer patients to relevant community resources were perceived as important facilitators to IPV screening (Theme 4). Participants generally believed that after a patient disclosed IPV, it was important that patients were seamlessly connected with mental health and social services within VHA as well as with community agencies serving IPV survivors. In particular, social workers were considered paramount in assessing patients' safety and the need for support services, including mental health treatments and shelters. One particularly promising approach to helping women Veterans who are impacted by IPV is the VHA PACT model, a new team-based multidisciplinary method of primary care delivery. PACT provides accessible, coordinated, comprehensive, patient-centered care, and is managed by primary care providers with the active involvement of other clinical and non-clinical staff, as well as the Veteran (Department of Veterans Affairs 2010a). These findings suggest that PACT has important implications for the development and implementation of guidelines for IPV screening and response programming within VHA since such programming can help make the referral process easy and seamless. Coordination of care with community resources was also viewed as critical, which is consistent with previous work showing that such coordination of care increases provider self-efficacy in terms of IPV screening (O'Campo et al. 2011). Indeed, prior work indicates that a planned care team approach along with close community collaboration is ideal for patients experiencing IPV in health care settings (Zink et al. 2007).

Finally, providers stated a strong desire for clinical tools, such as screening tools embedded within clinical reminders and note templates, to make IPV screening and responding efficient and acceptable to VHA providers (Theme 5). It is noteworthy that all of the participants in this study expressed openness to use of an IPV screening tool in their VHA practice since there are several IPV screening tools that have demonstrated clinical utility in health care settings (Rabin et al. 2009), including good accuracy detecting IPV among female VHA patients (Iverson et al. 2013a). Such screening tools can be paired with note templates to assist providers with risk assessment and appropriate documentation, as well as to facilitate coordination of care.

Although findings from this study illuminate factors that can lead to improvements in VHA and non-VHA health care for women Veterans, there are several limitations of this study. This was a pilot study with a small sample size. Although we cast a wide net in terms of recruitment (e.g., recruitment targeted all primary care providers in the VA New England Healthcare System, minimal exclusion criteria), there is a possibility of selection bias in our sample. For example, providers may have volunteered to participate in this study because they tended to have a more vested interest in transforming VHA care to include routine screening for IPV or have a specific interest in women's health. Similarly, it is possible that providers who had less knowledge of how to address IPV may have been more likely to respond to the recruitment materials. In addition, it was beyond the scope of the current study to evaluate systems or organizational differences between sites, such as the size of the facility, existence of freestanding women's health clinics at locations, and specific leadership characteristics. Similarly, we only interviewed primary care providers who were caring for women Veterans in the New England area and findings may not be representative of all VHA health care providers nationally.

These issues can be addressed in future research with a larger, more representative sample of VHA providers. Such research can also examine similarities and differences in attitudes and practices across different types of primary care providers (e.g., physicians compared to nurse practitioners or registered nurses) and explore the ways in which different types of training experiences impact providers' perceptions of their roles as health care providers with respect to addressing IPV. Although the proportion of female providers who participated in this study is representative of primary care providers who treat women in the New England VA Healthcare System, the subsample of male participants was too small to examine potential gender differences in the domains examined in this study. While the study resulted in a predominantly female sample, issues pertaining to providers' gender did not emerge as a major theme in the study findings. Despite these limitations, this study offers a unique perspective from an understudied group of providers.

To date, the majority of the IPV screening literature has focused on providers caring for women outside of the VHA. This research has been critical to informing best practices for IPV assessment and response in health care settings, such as the importance of asking behaviorally specific questions about IPV and responding in a validating manner to women's responses while providing appropriate assessment, education, referrals, documentation and follow-up care (e.g., Family Violence Prevention Fund 2004; Salber and Taliaferro 2006). It is necessary to expand this research to include female VHA patients because of their increased risk for IPV compared to civilian women. Our results reveal that VHA providers identify IPV as an issue of high importance to the care of women Veterans. While policies and procedures to promote IPV identification and treatment programming within the VHA require significant development, given evidence that IPV screening and response programs can improve abused women's health and safety (Nelson et al. 2012), the potential benefits of doing so are immense.

Acknowledgements This work was supported by the Lynne Stevens Research Award from the Department of Family Medicine at Boston University School of Medicine awarded to Dr. Katherine Iverson. This work was also supported by the Department of Veterans Affairs, Veterans Health Administration, Health Services Research and Development Service as part of Dr. Iverson's Career Development Award (CDA 10–029) at the VA Boston Healthcare System. The views expressed in this article are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs. The authors are grateful to Dr. April Gerlock for her consultation on the interview guide, as well as the dedicated providers who participated in this study and all those who care for women Veterans.

References

Batuman, F., Bean-Mayberry, B., Goldzweig, C., Huang, C., Miake-Lye, I. M., Washington, D. L., et al. (2011). *Health effects of military service on women Veterans*. Washington DC: Department of Veteran Affairs.

Benda, B. B. (2005). Gender differences in predictors of suicidal thoughts and attempts among homeless veterans that abuse substances. *Suicide and Life-Threatening Behavior, 35*, 106–116.

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*, 1331–1336. doi:10.1016/S0140-6736(02)08336-8.

Campbell, J. C., Coben, J. H., McLoughlin, E., Dearwater, S., Nah, G., Glass, N., et al. (2001). An evaluation of a system-change training model to improve emergency department response to battered women. *Academic Emergency Medicine, 8*, 131–138. doi:10.1111/j.1553-2712.2001.tb01277.x.

Campbell, J. C., Garza, M. A., Gielen, A. C., O'Campo, P., Kub, J., Dienemann, J., et al. (2003). Intimate partner violence and abuse among active duty military women. *Violence Against Women, 9*, 1072–1092. doi:10.1111/j.1552-2712.2001.tb01277.

Campbell, R., Greeson, M. R., Bybee, D., & Raja, S. (2008). The co-occurrence of childhood sexual abuse, adult sexual assault, intimate partner violence, and sexual harassment: a mediational model of posttraumatic stress disorder and physical health outcomes. *Journal of Consulting and Clinical Psychology, 76*, 194–207. doi:10.1037/0022-006X.76.2.194.

Centers for Disease Control and Prevention. (2012). *Understanding intimate partner violence: Fact sheet*. Retrieved on March 21, 2013, from http://www.cdc.gov/violenceprevention/pdf/ipv_factsheet-a.pdf

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks: Sage Publications.

Coker, A. L., Smith, P. H., McKeown, R. E., & King, M. J. (2000). Frequency and correlates of intimate partner violence by type: physical, sexual, and psychological battering. *American Journal of Public Health, 90*, 553–559. doi:10.2105/AJPH.90.4.553.

Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., et al. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine, 23*, 260–268. doi:10.1016/S0749-3797(02)00514-7.

Davis, R. E., & Harsh, K. E. (2001). Confronting barriers to universal screening for domestic violence. *Journal of Professional Nursing, 17*, 313–320. doi:10.1053/jpnu.2001.28181.

Department of Veterans Affairs. (2010a). *Patient aligned care team: Overview*. Retrieved August 29, 2012, from http://www.va.gov/primarycare/pcmh

Department of Veterans Affairs (2010b). V*HA Handbook 1330.01, Health care services for women Veterans*. Washington, DC: Author. Retrieved on March 1, 2013, from https://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2246

Dichter, M. E., Cerulli, C., & Bossarte, R. M. (2011). Intimate partner violence victimization among women veterans and associated heart health risks. *Womens Health Issues, 21*, S190–S194. doi:10.1016/j.whi.2011.04.008.

Ehrensaft, M. K., Cohen, P., Brown, J., Smailes, E., Chen, H., & Johnson, J. G. (2003). Intergenerational transmission of partner violence: a 20-year prospective study. *Journal of Consulting and Clinical Psychology, 71*, 741–753. doi:10.1037/0022-006X.71.4.741.

Elliott, L., Nerney, M., Jones, T., & Friedmann, P. D. (2002). Barriers to screening for domestic violence. *Journal of General Internal Medidicne, 17*, 112–116.

Family Violence Prevention Fund. (2004). *National consensus guidelines on identifying and responding to domestic violence victimization in healthcare settings*. San Francisco: Author.

Ferris, L. E. (1994). Canadian family physicians' and general practioners' perceptions of their effectiveness in identifying and treating wife abuse. *Medical Care, 32*, 1163–1172.

Frayne, S. M., Phibbs, C. S., Friedman, S. A., Berg, E., Ananth, L., Iqbal, S., et al. (2010). *Sourcebook: Women Veterans in the Veterans Health Administration. Volume 1. Sociodemographic characteristics and use of VHA care*. Washington, DC: Women's Health Evaluation Initiative, Women Veterans Health Strategic Health Care Group, Veterans Health Administration, Department of Veteran Affairs.

Friedman, L. S., Samet, J. H., Roberts, M. S., Hudlin, M., & Hans, P. (1992). Inquiry about victimization experiences: a survey of patient preferences and physician practices. *Archives of Internal Medicine, 152*, 1186–1190. doi:10.1001/archinte.1992.00400180056008.

Gerber, M. R., Leiter, K. S., Hermann, R. C., & Bor, D. H. (2005). How and why community hospital clinicians document a positive screen for intimate partner violence: a cross-sectional study. *BMC Family Practice, 6*, 48–56.

Glaser, B. G., & Straus, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Publishing Company.

Guillery, M. E., Benzies, K. M., Mannion, C., & Evans, S. (2012). Postpartum nurses' perceptions of barriers to screening for intimate partner violence: a cross-sectional survey. *BMC Nursing, 11*, 2–8. doi:10.1186/1472-6955-11-2.

Hamberger, L. K., Ambuel, B., Marbella, A., & Donze, J. (1998). Physician interaction with battered women: the women's perspective. *Archives of Family Medicine, 7*, 575–582.

Hamberger, L. K., Guse, C., Boerger, J., Minsky, D., Pape, D., & Folsom, C. (2004). Evaluation of a healthcare provider training program to identify and help partner violence victims. *Journal of Family Violence, 19*, 1–11.

Humphreys, J., Cooper, B. A., & Miaskowski, C. (2011). Occurrence, characteristics, and impact of chronic pain in formerly abused women. *Violence Against Women, 17*(10), 1327–1343. doi:10.1177/1077801211425216.

Iverson, K. M., Gradus, J. L., Resick, P. A., Suvak, M. K., Smith, K. F., & Monson, C. M. (2011a). Cognitive-behavioral therapy for PTSD and depression symptoms reduces risk for future intimate partner violence among interpersonal trauma survivors. *Journal of Consulting and Clinical Psychology, 79*, 193–202. doi:10.1037/a0022512.

Iverson, K. M., Jimenez, S., Harrington, K. M., & Resick, P. (2011b). The relative contribution of three forms of childhood maltreatment on intimate partner violence reported by female and male victims of rape and or robbery. *Violence and Victims, 26*, 73–87.

Iverson, K. M., King, M. W., Resick, P. A., Gerber, M. R., Kimerling, R., & Vogt, D. (2013a). Clinical utility of an intimate partner violence screening tool for female VHA patients. *Advance online publication. Journal of General Internal Medicine. doi:*. doi:10.1007/s11606-013-2534-x.

Iverson, K. M., Litwack, S. D., Pineles, S. L., Suvak, M. S., Vaughn, R., & Resick, P. A. (2013b). Predictors of intimate partner violence revictimization: the relative impact of distinct PTSD symptoms, dissociation and coping strategies. *Journal of Traumatic Stress, 26*, 102–110.

Kelly, U. A., Skelton, K., Patel, M., & Bradley, B. (2011). More than military sexual trauma: interpersonal violence, PTSD, and mental health in women veterans. *Research in Nursing and Health, 34*, 457–467. doi:10.1002/nur.20453.

Kimerling, R., Street, A. E., Pavao, J., Smith, M. W., Cronkite, R. C., Holmes, T. H., et al. (2010). Military-related sexual trauma among Veterans health administration patients returning from Afghanistan and Iraq. *American Journal of Public Health, 100*, 1409–1412. doi:10.2105/AJPH.2009.171793.

Maguen, S., Ren, L., Bosch, J. O., Marmar, C. R., & Seal, K. H. (2010). Gender differences in mental health diagnoses among Iraq and Afghanistan Veterans enrolled in Veterans affairs health care. *American Journal of Public Health, 100*, 2450–2456. doi:10.2105/ajph.2009.166165.

McCauley, J., Kern, D. E., Kolodner, K., Derogatis, L. R., & Bass, E. B. (1998). Relation of low-severity violence to women's health. *Journal of General Internal Medicine, 13*, 687–691. doi:10.1046/j.1525-1497.1998.00205.x.

Merrill, L. L., Stander, V. A., Thomsen, C. J., Crouch, J. L., & Milner, J. S. (2006). Premilitary intimate partner violence and attrition from the U. S. Navy. *Military Medicine, 171*, 1206–1210.

Minsky-Kelly, D., Hamberger, L. K., Pape, D. A., & Wolff, M. (2005). We've had training, now what? Qualitative analysis of barriers to domestic violence screening and referral in a health care setting. *Journal of Interpersonal Violence, 20*, 1288–1309. doi:10.1177/0886260505278861.

Murdoch, M., & Nichol, K. L. (1995). Women veteran's experiences with domestsic violence and with sexual harrassment while in the military. *Archives of Family Medicine, 4*, 411–418.

Nelson, H. D., Bougatsos, C., & Blazina, I. (2012). Screening women for intimate partner violence: a systematic review to update the U.S. Preventative Services Task Force recommendation. *Annals of Internal Medicine, 156*, 796–808.

O'Campo, P., Kirst, M., Tsamis, C., Chambers, C., & Ahmad, F. (2011). Implementing successful intimate partner violence screening programs in health care settings: evidence generated from a realist-informed systematic review. *Social Science & Medicine, 72*, 855–866. doi:10.1016/j.socscimed.2010.12.019.

Petersen, R., Moracco, K. E., Goldstein, K. M., & Clark, K. A. (2004). Moving beyond discolsure: women's perspective on barriers and motivators to seeking assistance for intimate partner violence. *Women & Health, 40*, 63–76.

Rabin, R. F., Jennings, J. M., Campbell, J. C., & Bair-Merritt, M. H. (2009). Intimate partner violence screening tools: a systematic review. *American Journal of Preventive Medicine, 36*, 439–445. doi:10.1016/j.amepre.2009.01.024.

Sadler, A. G., Booth, B. M., Mengeling, M. A., & Doebbeling, B. N. (2004). Life span and repeated violence against women during military service: effects on health status and outpatient utilization. *Journal of Womens Health, 137*, 799–811. doi:10.1089/jwh.2004.13.799.

Salber, P. R., & Taliaferro, E. (2006). *The physician's guide to intimate partner violence and abuse: A reference for all health care professionals* (2nd ed.). Volcano: Volcano Press.

Sprague, S., Madden, K., Simunovic, N., Godin, K., Pham, N. K., Bhandari, M., et al. (2012). Barriers to screening for intimate partner violence. *Women's Health, 52*, 587–605. doi:10.1080/03630242.2012.690840.

Street, A. E., Stafford, J., Mahan, C. M., & Hendricks, A. (2008). Sexual harassment and assault experienced by reservists during military service: prevalence and health correlates. *Journal of Rehabilitation Research and Development, 45*(3), 409–419. doi:10.1682/JRRD.2007.06.0088.

Street, A. E., Vogt, D., & Dutra, L. (2009). A new generation of women veterans: stressors faced by women deployed to Iraq and Afghanistan. *Clinical Psychology Review, 29*, 685–694. doi:10.1016/j.cpr.2009.08.007.

Sweeney, A. C., Weitlauf, J. C., Manning, E. A., Sze, J. A., Waldrop, A. E., & Hasser, C. (2013). Intimate partner violence: perspectives on universal screening for women in VHA care. *Women's Health Issues, 23*, 73–76.

Thompson, R. S., Rivara, F. P., Thompson, D. C., Barlow, W. E., Sugg, N. K., Maiuro, R. D., et al. (2000). Identification and management of domestic violence: a randomized trial. *American Journal of Preventive Medicine, 19*, 253–263.

U.S. Preventive Services Task Force. (2013). *Screening for intimate partner violence and abuse of elderly and vulnerable adults: U.S. Preventive Services Task Force recommendation statement.* AHRQ Publication No. 12-05167-EF-2. Retrieved August 28, 2013, from http://www.uspreventiveservicestaskforce.org/uspstf12/ipvelder/ipvelderfinalrs.htm

Waalen, J., Goodwin, M. M., Spitz, A. M., Petersen, R., & Saltzman, L. E. (2000). Screening for intimate partner violence by health care providers: barriers and interventions. *American Journal of Preventative Medicine, 19*, 230–237.

Weitlauf, J. C., Frayne, S. M., Finney, J. W., Moos, R. H., Jones, S., Hu, K., et al. (2010). Sexual violence, posttraumatic stress disorder, and the pelvic examination: how do beliefs about the safety, necessity, and utility of the examination influence patient experiences? *Journal of Women's Health, 19*(7), 1271–1280. doi:10.1089/jwh.2009.1673.

Yano, E. M., Bastian, L. A., Frayne, S. M., Howell, A. L., Lipson, L. R., McGlynn, G., et al. (2006). Toward a VA women's health research agenda: Setting evidence-based priorities to improve the health and health care of women Veterans. *Journal of General Internal Medicine, 21*, 93–101.

Yano, E. M., Hayes, P., Wright, S., Schnurr, P. P., Lipson, L., Bean-Mayberry, B., et al. (2010). Integration of women veterans into VA quality improvement research efforts: what researchers need to know. *Journal of General Internal Medicine, 25*(Suppl 1), S56–S61. doi:10.1007/s11606-009-1116-4.

Zink, T., Lloyd, K., Isham, G., Mathews, D. J., & Crowson, T. (2007). Applying the planned care model to intimate partner violence. *Managed Care, 16*, 54–61.

Zinzow, H. M., Grubaugh, A. L., Monnier, J., Suffoletta-Maierle, S., & Frueh, B. C. (2007). Trauma among female Veterans: a critical review. *Trauma Violence & Abuse, 8*, 384–400. doi:10.1177/1524838007307295.