

Middle-aged Women's Experiences of Intimate Partner Violence Screening and Disclosure: "It's a private matter. It's an embarrassing situation"



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BACKGROUND: National guidelines indicate that healthcare providers should routinely screen women of reproductive age for experience of intimate partner violence. We know little about intimate partner violence (IPV) screening and disclosure experience among women older than reproductive age.

OBJECTIVE: To examine the perspectives of middle-aged women who had experienced past-year IPV regarding IPV screening and disclosure in the healthcare setting.

DESIGN: Individual semi-structured qualitative interviews were conducted in-person as part of a larger study examining IPV screening and response services through the Veterans Health Administration.

PARTICIPANTS: Twenty-seven women aged 45–64 (mean age 53) who experienced past-year IPV and received care at one of two Veterans Affairs Medical Centers.

APPROACH: Interviews were digitally recorded and transcribed. Data were sorted and analyzed using templated notes and line-by-line coding, based on codes developed by the study team through an initial review of the data. Themes were derived from further analysis of the data coded for "screening" and "disclosure" for respondents aged 45 and older.

KEY RESULTS: Barriers to disclosure of IPV to a healthcare provider included as follows: (a) feelings of shame, stigma, and/or embarrassment about experiencing IPV; (b) screening context not feeling comfortable or supportive, including lack of comfort with or trust in the provider and/or a perception that screening was conducted in a way that felt impersonal and uncaring; and (c) concerns about privacy and safety related to disclosure. Provider demonstrations of care, empathy, and support facilitated disclosure and feelings of empowerment following disclosure.

CONCLUSIONS: Middle-aged women may benefit from routine IPV screening and response in the healthcare setting. Such interventions should be sensitive to concerns regarding stigma and privacy that may be prevalent among this population.

KEY WORDS: intimate partner violence; veterans; middle-aged.

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INTRODUCTION

Intimate partner violence (IPV), including physical, psychological, and sexual abuse by a current or former intimate partner, is a significant public health concern with both acute and chronic impacts on morbidity, mortality, and quality of life.¹ Screening for IPV in the healthcare setting can serve as a preventive strategy to educate patients about IPV and connect patients to supportive services to prevent further harm. Since 2013, and reaffirmed in 2018, the United States Preventive Services Task Force (USPSTF) has recommended routine screening of women patients of reproductive age, generally defined as younger than age 45.^{2,3} The recommendation is based on evaluation of evidence from randomized clinical trials (RCTs), which have been conducted primarily with pregnant or postpartum women, thus limited to women of reproductive age.⁴ The USPSTF concluded that a lack of evidence regarding the impact of routine IPV screening among women older than reproductive age precluded recommendations for this age group.

Experience of IPV, however, does not end at middle age. National survey data indicate that more than 4% of women aged 45–54 and more than 1% of women aged 55 or older experience *past-year rape, physical violence, or stalking* by an intimate partner.⁵ When including psychological forms of IPV and fear of partner, in addition to physical and sexual violence, national survey data of women veterans receiving primary care in the Veterans Health Administration (VHA) reveal more than 22% of women aged 45–64 reporting past-year IPV.⁶

Women military veterans in the USA experience elevated rates of lifetime IPV compared with women who have not

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served in the military.⁷ The VHA has implemented routine screening of women patients for IPV, without an upper age limit. Examination of the first 2 years of routinely collected and documented clinical IPV screening in VHA found that, although proportions of patients screening positive for past-year IPV declined with age, IPV exposure persisted beyond reproductive age with 9.1% of women aged 45–54, 6.6% of women aged 55–64, and 3.6% of women aged 65 or older reporting past-year psychological, physical, or sexual IPV.⁸

The exclusion of middle-aged and older women from RCTs evaluating the effectiveness of IPV screening and related research has left a void in knowledge about the needs, experiences, and preferences of this population.⁹ To help fill this knowledge gap, we examined qualitative interviews with middle-aged women who had experienced IPV in the prior year, about their experiences with, perceptions of, and recommendations for IPV screening and disclosure in the healthcare setting.

METHODS

As part of a larger study of women VHA patients' experiences with IPV, we enrolled 169 women from two VHA medical centers who had experienced past-year IPV to participate in structured interviews at baseline and again 6–9 months later (follow-up); a portion ($n = 50$) of participants also completed in-depth qualitative interviews at the follow-up period. Women VHA patients were recruited through several mechanisms, including provider referral, self-referral through flyers, in-clinic research staff recruitment in women's health primary care clinics, and direct mail outreach, and then screened for eligibility based on experience of any form of past-year IPV (see¹⁰ for more details on recruitment and participants). We purposively sought to include participants across a diverse age range to capture the experiences of middle-aged women. This paper reports on analysis of the qualitative interviews among the participants aged 45 and older.

Sample

Twenty-five participants from each site (total = 50) were selected on the basis of willingness to participate and diversity in demographics and IPV experience to participate in qualitative interviews. Among the interview participants, 27 were age 45–64 (mean age 53); none of the qualitative interview participants was older than age 64. Of the 27 middle-aged interview participants, 13 (48%) self-identified as black or African American, 10 (37%) identified as white, and 4 as another or two or more racial categories.

Data Collection

Qualitative interviews were guided by a semi-structured interview guide created by the research team with prompts about IPV screening, disclosure, and seeking and receiving help, in

the healthcare setting. Interviews were conducted by a trained and experienced member of the research team and ranged in length from 26 to 145 min, with a mean of 64 min. Participants received \$50 in cash at the completion of the interview. Interviews were audio-recorded and transcribed verbatim.

Data Analysis

Data were sorted and analyzed through templated notes and line-by-line coding of the transcripts. Team members completed templated notes for each interview, based on key topic areas for the study, producing a grid of case summaries. The team then generated a coding schema including a list of codes with definitions and exemplar quotes and refined the codebook through processes of analysis and discussion. Atlas.ti qualitative data management software (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany) was used for management and coding of transcribed interview data. Transcripts were coded according to the coding schema. To establish consistency in coding application, two members of the study team coded each transcript separately; the coding team met regularly to review and compare coded transcripts and to identify, discuss, and resolve any coding discrepancies.

To identify themes emerging from the data for this analysis, research team members reviewed the case summaries and coding report for text coded to “screening” or “disclosure” and filtered to participants aged 45 and older. Team members identified thematic categories and sought examples as well as outliers in the data; themes were refined through team discussion and data checking.

RESULTS

Participants spoke about barriers to disclosure of their IPV experience to healthcare providers. The barriers centered around three broad areas: (a) feelings of shame, stigma, and/or embarrassment about experiencing IPV; (b) screening context not feeling comfortable or supportive, including lack of comfort with or trust in the provider and/or a perception that screening was conducted in a way that felt impersonal and uncaring; and (c) concerns about privacy and safety related to disclosure. Women described experiences of being willing to disclose IPV to their healthcare team because the provider showed care, empathy, and support; they still felt embarrassed about sharing the experience but appreciated and valued the support that they received when doing so. Each theme is presented in more detail below, with examples from the interview transcripts.

Feelings of Shame, Stigma, and Embarrassment Inhibit Disclosure

Participants described feelings of shame and embarrassment, and concerns about stigma and judgment that served as barriers to their sharing about their experiences with IPV with

their healthcare provider. One participant, aged 48, referred to her IPV experience as a “dirty little secret”. Other participants expressed their concerns around stigma and judgment from others. For example, another participant, also aged 48, shared:

It's not something you run around and tell people. It's a private matter. It's an embarrassing situation. . . . People have a way of condemning you or belittling you or looking down on you in ways that they may not even realize that they do. . . . So you just don't talk about it because you don't wanna deal with all that.

Experience of IPV may also bring up feelings of self-blame, embarrassment, or shame, and a sense that one does not fit the image of someone experiencing abuse. In response to a question about what kept her from sharing details about her experiences of abuse with others, several years prior to the interview, a participant reflected on her feelings at the time:

A lot of embarrassment. I couldn't believe it was happening to me. I couldn't believe all the things that had happened and telling someone about that. This is not my first go-round. It's my second marriage. I am 47 years old [at the time]. I'm working. I'm making almost \$80,000 a year at that time and I'm having all these fucking issues. (50 years old)

In this case, the stereotype of someone experiencing IPV as a younger woman, with limited resources, conflicted with the survivor's experience and challenged her to both accept her own experience and then to share that with others.

Lack of Comfort with and Trust in the Relationship with the Provider Inhibits Disclosure

Given the context of shame, embarrassment, and concerns about negative judgment from others, participants noted that disclosing experience of abuse to a healthcare provider was contingent upon their feeling comfortable with and trusting of a provider, a feeling that tended to develop over time in the relationship with their provider. Participants noted that they would be more likely to share their experiences of IPV with a provider with whom they had a relationship and that having frequent staff turnover inhibited their ability to develop such relationships and, thus, feel comfortable disclosing:

They've gotta do something about the retention so that you can build some sort of relationship with your provider to where you would feel comfortable answering those questions in a genuine way. (55 years old)

Another participant explained that she needs to develop a “human” connection with a provider before she would feel comfortable opening up; in her view, having multiple visits over time with the same provider helps build trust and foster readiness to disclose:

They've got to show me that they're a human being first before I would even go there. . . . If I got a new primary physician tomorrow and if he asked me about that, I probably wouldn't tell him anything. But once I had seen him a couple of times, then I would, at some point. . . . It's like I've got to wait to test them. To see whether, do I want to trust this person with this? (64 years old)

Although lack of relationship and comfort with a provider as a barrier to disclosure emerged as a key theme in several of the participants' narratives, for one participant, her close relationship with her care team served as a *barrier* to disclosure. Noting that she had not been asked by her provider or clinical staff about experiences with violence or abuse, this participant said she would not disclose her experiences to them if they did ask:

If they was to [ask me about violence or abuse in my relationship], I wouldn't say anything. . . . Because I'm friendly with them and I wouldn't tell them anything. . . . It's like, I've been knowing them, seeing them, about ten years. . . . I would never tell. (59 years old)

In this case, concern about anticipated stigma may be elevated due to lack of perceived anonymity and/or judgment from providers with whom she has a long-standing relationship.

Perceptions That Questions Are Asked Only to Fulfill Obligations Inhibit Disclosure

In addition to feeling comfortable and safe in the relationship with the screening provider, participants noted the importance of *how* screening questions are presented to their willingness to share. Participants spoke about experiences in which healthcare providers or staff asked them about experiences with IPV in ways that they felt were “cold” or impersonal. Participants described the body language and approach of clinical staff asking the screening questions as implying that they did not genuinely care about the response:

The whole time, her head was down typing or writing and it was like, why are you asking me these questions? It's not like you even care as to what the answer is. You're just doing it because this is something you have to do. You have to ask these questions. (46 years old)

Sensing that the clinician is asking out of obligation rather than a concern for the patient's well-being may decrease a patient's willingness to disclose and potentially contribute to

distrust in the provider's intentions in inquiring about IPV:

Well, they always ask 'Do you feel like hurting someone or do you feel like someone's gonna hurt you' but they don't really go past that. And they tell you they ask you that because they have to ask you that. ...The message I get is you don't give a damn whether it is or not. You only doing it because it's a part of your job description that you have to do it. ...So if something was going on, I wouldn't fucking tell you because you don't really care. (49 years old)

Concerns About Lack of Privacy or Safety Inhibit Disclosure

For some participants, concerns about disclosure centered on the possibility of others, including partners, finding out about their disclosures, which may be experienced as a threat to privacy and/or safety. These women spoke, for example, about their partners being present at their appointments and, even if not present in the room, concerns about their knowing about the disclosure. One participant, aged 50, explained:

One of the reasons [I don't disclose to my healthcare provider] is that most of the time when I go to women's health, my husband is right outside.

Some participants were reluctant to disclose IPV due to concerns about IPV experiences being documented in the medical record. As one 48-year-old woman observed:

My provider, everything I say to her goes on the record... She's mandated to put everything in the record, she says.... That's a huge alarm. You're gonna put that in a record of the VA with me? No you're not, because I'm not gonna tell you any of it.

This participant was willing to share her IPV experience with her healthcare provider but concerned about the information being available for others to see.

Disclosure to a Supportive and Caring Clinician Can Feel Validating and Empowering, Although Feelings of Shame and Embarrassment May Persist

Participants also noted conditions under which IPV screening can be beneficial and increase the likelihood of disclosure. The patient-provider relationship, including the longevity of the relationship, can enable readiness to disclose. A participant who described her experience disclosing to her provider noted that her willingness to share was facilitated by the fact that she had already established a years-long relationship with that provider. In speaking about what it felt like to her after

disclosing, she said:

It felt good. I felt embarrassed, but it probably was the right time for me to let somebody know what was going on with me.

She went on to describe her provider's response to her disclosure:

She was...consoling. Like another woman; you're talking to another woman. She was hurt that it was happening to me... like, no woman should be going through what you be going through. ...She listened. ... And she was concerned. She was very concerned. (55 years old)

An example from one participant demonstrated how providers can support and encourage women experiencing IPV, even in a new clinical relationship. The participant described that the provider asked about her relationship experiences in a way that demonstrated genuine care, facilitating her willingness to disclose and leading to her feeling supported and cared for:

What really ultimately made me open about it was the question. ...I think had she not asked me, then I probably would have never brought it up as well. So I think it's basically the question, just the fact that she asked. ...It was my first time ever seeing her as a doctor. ... And when she called me back [to the room], she patted my knee and asked me how I was and how are things at home. ...I know we're doctor/patient, but she didn't ask me like a doctor/patient. She asked me as if she was a friend that I have known for years. And it was the pat on the knee and [asking] "okay, how are you?" I didn't feel like I was in the clinic. I didn't feel like I was interrogated. It just felt my best friend asking me, "Okay, what's going on with you?" And that's how I feel about her. She's that type of person where you feel like okay, I can talk to you about whatever. And that's how it started. I love her for that. She's a great doctor. ...I feel like I'm going in and I'm talking to people who honestly care who have been my friends for a lifetime and I'm able to be open and honest. So I think it's the person, I think it's the way the questions are set up, and I think it's the presentation. Because everybody is in their own bubble and if you make things where people feel like they're more interrogated, then we're less likely to say anything. Because it's like okay, how are you going to look at me, what are you going to write about me, what are you going to think about me, what are you going to say about me. All these things run through your head, so then it makes you worry about what you're gonna say out your mouth. But if you have that right person, it makes it comfortable to

talk about it. Because believe it or not, we all wanna talk about it but it has to be the right person. (48 years old)

In the two examples above, participants reflected on the positive aspects of their clinical interactions feeling more personal, as talking to “another woman” or a “friend,” rather than what they thought of as a more clinical and less personal doctor/patient interaction.

A provider's care and concern can further be demonstrated by being prepared to offer resources and support in response to disclosure of IPV.

I thought it was quite apropos, the fact that she had information on hand to give me. So it wasn't just oh, so what's going on with your life? Oh, so this is – oh, you poor thing. She offered possible solutions if needed and I thought that was – like I said, I didn't need it but that she had them available, okay, she's serious. She cares. (46 years old)

Although providers may not be able to, and may not need to, provide services to assist patients experiencing IPV, they can inquire about and respond in ways that convey genuine care, as well as having information on hand about resources to promote safety and healing.

DISCUSSION

In many ways, the findings from this study based on qualitative interviews with women in middle age parallel existing knowledge based on research with younger (reproductive age) women. For example, prior research has found that barriers to disclosure include not feeling comfortable with the provider or particular healthcare encounter as well as feeling shame and stigma around the IPV experience, and that a healthcare provider's non-judgmental and supportive approach facilitates disclosure.^{11–14}

Insights from interviews with middle-aged women, whose experiences with and perspectives on IPV disclosure are rarely studied, also reveal particular considerations for this population. Today's middle-aged women grew up as children, adolescents, and young adults in an era that predated widespread Internet and social media use; there were no reality television shows, podcasts, Facebook, Twitter, and Instagram feeds through which people exposed their personal lives broadly to the public or a large group of acquaintances. Further, social recognition of and attention to IPV (more commonly referred to in earlier days as “wife abuse,” “battered women,” or “domestic violence”) began to emerge in the 1970s and 1980s, when the oldest of today's middle-aged women were already into adulthood; social discourse and attention expanded only after the 1994 O.J. Simpson trial.¹⁵ The now well-known #MeToo movement that encourages sharing of stories

of gender-based violence—largely, still, focused on sexual harassment and non-partner sexual violence more so than IPV—has become popularized only since 2017. Today's middle-aged women were raised by parents whose generation saw violence within families as a “private family matter” to be kept “behind closed doors.”

In addition to a culture of not disclosing experiences of IPV, today's middle-aged women may not have been acculturated to thinking about IPV as an issue to address in the healthcare setting. Although efforts towards healthcare attention to and routine screening for IPV have been discussed in the literature for 20 years, implementation of these practices has been slow and middle-aged women today may have received years of adult healthcare without ever having been asked about IPV. Middle-aged women, then, may be more surprised by and less prepared to respond to such inquiries than younger women who may have had issues of relationship health and violence raised with them in their adolescence or assume this to be a standard topic in adult healthcare. Recognition of these generational factors is not meant to suggest that today's younger generations are free from challenges with IPV disclosure; rather, that the older generation may have particular contextual considerations.

Age-related developmental factors may also influence how middle-aged women experience and think about IPV disclosure.¹⁶ Middle-aged women may perceive that they should “know better” or “grow out of” IPV experiences, as reflected by some of the participants in this study—they may feel added stigma related to their age or stage in life. Middle-aged women may face barriers also related to the stage of their social relationships—they may have been in the relationship with their abusive partners for years or decades, potentially with shared children and/or financial factors that add complications to relationship dissolution and help-seeking. Older women in this age group, in particular, may have started feeling age-related concerns about upcoming dependence and social isolation that can complicate considerations of IPV disclosure and help-seeking among older women.¹⁷

The current findings support established best practices for patient-centered IPV screening and response among a younger population of women, including ensuring privacy (e.g., only screening alone), respect for the patient's self-determination in receipt of follow-up services or actions, and providing universal education about IPV dynamics and resources even if a patient does not choose to disclose IPV experience. In addition, this study highlights the critical importance of attending to the clinical relationship and interpersonal dynamics in the encounter to minimize feelings of shame, stigma, and embarrassment that may serve as barriers to disclosure and help-seeking.

Participants noted the importance of feeling as though their provider cared about their lives and, especially when addressing the sensitive topic of IPV, as though they were treated as a whole person rather than as an anonymous “patient.” There is a common—and sometimes recommended—practice of

prefacing IPV screening with a statement that it is a routine part of clinical care (e.g., “we ask all women...”). While this practice is designed to minimize stigma by signaling that IPV is common and that the patient is not being singled out or targeted for such inquiry, it may have the unintended consequence of making patients feel as if the provider asking the questions does not actually care about their experience. In particular, language indicating that the questions are required (“we have to ask...”) may convey a lack of care and interest. Instead, it may be important for the provider to express that she cares about the patient’s life holistically and that services are available to provide support for IPV-related needs.

LIMITATIONS

Participants in this study were recruited from VHA medical centers and may not reflect a broader population of women seeking healthcare. Further, this study did not include men or others not identifying as women (e.g., non-binary), who may also experience IPV. Participants self-identified to the research team as having experienced past-year IPV; however, women experiencing the most severe forms of IPV may have been precluded from participation due to concerns about safety or lack of independence from abusive partners. The semi-structured qualitative interview approach allowed participants to elaborate on concepts meaningful to their own stories and identities and allowed us to identify themes that emerged from the data rather than imposing predetermined concepts. With this approach, we are not able to identify how many people have particular experiences; however, the purpose of this study was to uncover perspectives of a range of middle-aged women, rather than the scope or prevalence of each perspective.

CONCLUSIONS AND IMPLICATIONS

In conjunction with data demonstrating substantial rates of IPV experience among middle-aged and older women receiving VHA care,^{6, 7} the findings from this qualitative study of women patients who had experienced recent IPV hold implications for policy, practice, and research on IPV screening and response in the healthcare setting. The findings suggest that women beyond childbearing age desire and may benefit from healthcare screening for IPV. RCTs of the impact of such screening that include middle-aged and older women are needed to inform potential revisions to the USPSTF recommendations. Expanding routine screening to this older age group may lead to support and services to help women escape and heal from violence.

Middle-aged women experiencing IPV may be under-identified and underserved in healthcare settings due to emphasis on women of childbearing age. Understanding the experiences and needs of middle-aged and older women is critical for ensuring that interventions can be

tailored to meet their needs. Women, especially those in middle age, may feel particular sensitivity around perceptions of stigma and judgment related to IPV, requiring careful attention to the interpersonal dynamics in IPV screening and response that supports disclosure and pathways towards safety and healing.

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Compliance with Ethical Standards:

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