A Chat with Our Experts

How intimate partner violence affects women Veterans

Dr. Katherine Iverson is a clinical psychologist and researcher in the Women's Health Division of the National Center for PTSD. She is also a researcher at the Center for Healthcare Organization and Implementation Research (CHOIR); both centers are located at the VA Boston Healthcare System. In addition, she is an associate professor of psychiatry at Boston University School of Medicine. Her research focuses on women's health and trauma—in particular, interpersonal violence and intimate partner violence. In 2014 she received the Presidential Early Career Award for Scientists and Engineers (PECASE) for her research into the effects of violence on women's health and associated health care needs.

VARQU spoke with Iverson about the work she is doing with women Veterans who have experienced intimate partner violence, and those who have sustained a traumatic brain injury as a result of a violent encounter with an intimate partner.

KEY POINTS:

• Women Veterans who experience IPV are much more likely to have a diagnosis of depression or PTSD, compared with their male counterparts.
• Women Veterans are at higher risk for IPV, compared with women who have not served in the military.
• Women are often strangled or sustain blows to the head during assaults by intimate partners, yet that type of head trauma is often not recognized as a cause of TBI.
• The first step to helping women who have experienced interpersonal violence is to develop programs in the VA that will screen for IPV and identify those Veterans who can benefit from treatment.

Welcome, Dr. Iverson. Can you tell us about the presentation that you gave in December 2017 at the National Institutes of Health on intimate partner violence and TBI in women Veterans?

It was definitely an honor to be invited to this event on understanding TBI and violence among women. The overall goal of the NIH conference was to understand gaps in knowledge as it relates to the issue of TBI experienced by women. There's been a lot of focus on the issue of TBI following sports injuries, as you've surely seen in the media, and a lot of focus on military personnel. But often the samples are male-dominated. So, it is not too often that people look at the health issues of women that result in concussion and more severe forms of TBI.

Some of my recent work focuses on women Veterans who experience TBI as a result of intimate partner violence. In my clinical work I found that women are often strangled or choked by intimate partners during their assaults. Or they are...
might be badly punched or elbowed to the head, face, or neck, or have their head bashed against the wall. Unfortunately, this kind of head trauma isn’t uncommon, yet it often isn’t detected by women or the health system as being a cause of TBI. But it is actually quite prevalent among women who have experienced IPV.

**Do women experience TBI differently than men?**

There is research to suggest that women may experience more severe symptoms following TBI. My colleagues and I at VA Boston have done some studies in this area. We were able to look at Operation Enduring Freedom/Operation Iraqi Freedom Veterans who were evaluated for TBI within the VA and found to have confirmed deployment-related TBI. We compared men and women on their current health symptoms using the neurobehavioral symptom inventory, as well as their psychiatric diagnoses from their VA medical records. We did find—this was published in *Women’s Health Issues*, in 2011—across the board, women did report significantly more severe health symptoms than their male partners when adjusting for demographic variables and blast exposure, including more severe cognitive symptoms, affective symptoms, vestibular symptoms, and somatosensory symptoms.

Another thing that we found was women were much more likely to have diagnoses of depression, in particular, as well as PTSD with comorbid depression, than their male counterparts. One of the take-homes was that while fewer OEF/OIF women overall experienced TBI during deployment, we need to be careful not to ignore these women or minimize what they’ve experienced. Because when they do experience TBI, they appear to have worse psychosocial symptoms and a more complex clinical presentation.

**Is IPV more prevalent in women Veterans than the general population?**

There is research being done by our colleagues in VA on that question, especially that of my wonderful collaborator Dr. Melissa Dichter at the Center for Health Equity Research and Promotion. She has documented that women Veterans are at higher risk for IPV compared to women who have not served in the military. We know from our studies that IPV is not only common for women Veterans across the lifespan, but that some of the forms of violence that they experience are quite severe. So they are a vulnerable population in terms of experiencing IPV. We just don't know why that is.

There are probably a lot of reasons for that and I think it's complicated. For one thing, women Veterans may simply have more risk factors for IPV. We know in general that having parents who have experienced IPV, witnessing violence in the home, and being a victim of childhood sexual abuse or childhood physical abuse puts you at higher risk for IPV later in life. We also know that people who've had these adverse experiences in childhood are more likely to go into the military. So that's one potential explanation, but it hasn't been studied empirically.

And then there are issues related to the military and the training environment—being trained in using violence—that may be playing a role in terms of conflict. Also, women Veterans and women who serve in the military are more likely to partner with or marry other service members or Veterans, who are a population that is at higher risk of using IPV. It's complicated; we are not really sure of the exact reasons why that is the case. Regardless, there are many opportunities to intervene within health care systems, such as VA.

**What are some typical symptoms of IPV that women might experience?**

Well, in addition to the physical symptoms that I mentioned earlier related to physical injury, there may be gastrointestinal (stomach) problems and sexual health problems. And then we often see a lot of mental health symptoms. Depression is extremely common, as is PTSD. So of course we want to be able to recognize and treat those conditions and symptoms, in addition to addressing any ongoing IPV.

What we find depends on the woman's history and the nature of the abuse she experienced. Anyone who has worked with women who have experienced chronic IPV knows that they can be colossally self-invalidating and critical of themselves. Sometimes a woman might learn to distrust her feelings about things. If you've been put down enough and told that you are crazy, you can start feeling like that. So I think an important part of what clinicians can do is validate for women that their experiences are legitimate; that they don't deserve to be treated like that; that it's not their fault; and that there are programs that can help.

**For Veterans who are in the VA health system and are experiencing IPV, what is the first touch-point for them?**
If they have a provider that they feel comfortable with, like a primary care or mental health provider, we'd encourage them to talk to their provider about it. There has been a tremendous effort in VA to educate providers about IPV. They are being encouraged to talk with their patients about IPV and let them know that help is available both within and outside VA. An increasing number of VAs across the country have what's called an IPV coordinator. These coordinators are tasked with educating providers about IPV, teaching them how they can screen for IPV, and how they can provide supportive responses for women who disclose IPV. Some IPV coordinators are available to do assessment and intervention for women who disclose IPV. They really are the experts on connecting with community services.

But every position works differently at every VA. I would definitely encourage women Veterans, physicians, and other health care providers to find out if they have an IPV coordinator at their VA—to connect with them, and ask them to come in to talk to the clinic staff. They should also find out if they can make referrals for individuals who have experienced IPV. IPV coordinators are just a wonderful resource that I think will continue to evolve over time. VA providers can also contact the national IPV Assistance Program for more information. The manager for this program is Dr. LeAnn Bruce.

Can you talk about the research that you are doing to promote a health care-based response to IPV?

Part of what I do in terms of my research agenda is, first, understanding the scope of IPV. How often do we see it in our patient population? What types of IPV do we most often see? How does it impact women's health? We know that it impacts their health in many ways. Women who experience IPV are twice as likely to attempt suicide. They are two to four times more likely to have diagnoses of PTSD and depression and to use alcohol—perhaps as a way of coping with the IPV they experience.

We know that IPV is prevalent in this population, we know it is impacting their health, so the next question becomes is there something that we can do as a health care system to tackle this issue? We know that women who experience IPV use a lot of health services. They use a lot of primary care services, for example, at higher rates than women who haven't experienced IPV. So that becomes an important opportunity within primary care to possibly identify women who are experiencing IPV and connect them with health and social services that they may need. Oftentimes the IPV is not what they are coming in for, but it is impacting their health over time, in many different ways. Yet, patients and providers may not make that connection.

We have an important opportunity to identify and help these women, especially in VA, where we have an integrated health care system that has very accessible mental health and social work services. I think we are in a very good position to safely and sensitively identify women who experience IPV—asking them about these experiences, educating, and supporting them. Just by asking these questions we are educating women that this is an important health issue for which help is available. If women feel ready to disclose IPV, we can offer them additional services, both within the VA and with our community partners. VA has Women's Health Services and the IPV Assistance Program, and Women’s Mental Health Services, [all of which] work very closely with important partners in the community, such as the National Domestic Violence Hotline, to make more resources available for male and female Veterans who have experienced IPV.

In terms of future research on IPV, can you tell us what you are working on?

We have a new project funded by VA Health Services Research and Development that we started a few months ago, that we are really excited about. There are many things that we can do as an integrated health care system to address IPV. Some of it is education and basic information, but also I have been interested in developing a brief counseling intervention for women who disclose IPV within VA. We have developed a modular-based intervention: there are six different topics ranging from safety planning and self-care, to connecting with resources in the community, to asking for social support, to understanding the effects of IPV. These are all modules or topics that women can decide to focus on in counseling.

We know that not every woman needs the same thing; every situation is different. Some women may need extensive safety planning, and other women may not need that at all. They may be more interested in getting treatment for mental health symptoms related to abuse that may have already ended. So we have to figure out how we tailor interventions to the needs of the woman sitting in front of us, and how to make it acceptable and feasible to deliver in VA. We are not a domestic violence shelter; that's not the role that we play in VA. But we can play a very important role in helping women understand symptoms that they experience, to recognize IPV, to know where to seek help, to get help for their own symptoms so that they can make decisions that are best for themselves and their children. Essentially, we focus on enhancing the tremendous strengths and resilience that women Veterans already have.

Right now we are getting a lot of feedback from women Veterans and VA providers on how best to use the intervention. We will be testing it in two VA medical centers, here at the VA Boston Healthcare System and at the VA Connecticut Healthcare System in West Haven. We are hopeful that this intervention will ultimately enhance care and health outcomes for our women Veterans.

Questions about the R&D website? Email the Web Team.