Evidence Brief: Prevalence of Intimate Partner Violence/Sexual Assault Among Veterans

Supplemental Materials

December 2021

U.S. Department of Veterans Affairs
Veterans Health Administration
Health Services Research & Development Service

Recommended citation: Parr NJ, Young S, Ward R, Mackey K. Evidence Brief: Prevalence of Intimate Partner Violence/Sexual Assault Among Veterans. Washington, DC: Evidence Synthesis Program, Health Services Research and Development Service, Office of Research and Development, Department of Veterans Affairs. VA ESP Project #09-199; 2021.

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APPENDIX A: SEARCH STRATEGY

SYSTEMATIC REVIEWS

1. Search for current systematic reviews **Date Searched: 08-05-21**			
A. Bibliographic Databases:	**#**	**Search Statement**	**Results**
MEDLINE: Systematic Reviews Ovid MEDLINE(R) ALL 1946 to August 04, 2021	1	Spouse Abuse/ OR Domestic Violence/ OR Battered Women/ OR Violence/ OR (((spouse OR spousal OR partner OR wife OR husband OR dating OR marital OR domestic) adj1 abuse) OR intimate partner violence OR ((domestic OR dating OR partner) adj1 violence) OR assaultive behavior$1 OR ((battered OR abused) adj (woman OR women)) OR ((psychological OR emotional OR physical) adj1 abuse) OR sexual partner$1 OR boyfriend OR girlfriend OR significant other OR couple OR romantic partner OR dyad).ti,ab.	113270
	2	Veterans/ OR Military Personnel/ OR (Veteran$1 OR armed forces OR military OR army OR navy OR marines OR air force OR active duty OR navy personnel OR naval personnel OR military personnel OR army person OR reservist OR reserve force OR coast guard OR soldier$1 OR sailor$1 OR army personnel OR air force personnel OR military OR submariner$1).ti,ab.	125516
	3	Prevalence/ OR Risk Factors/ OR (prevalence OR risk OR incidence OR rate$1 OR population OR statistics OR epidemiology OR statistical data).ti,ab.	6742062
	4	(systematic review.ti. or meta-analysis.pt. or meta-analysis.ti. or systematic literature review.ti. or this systematic review.tw. or pooling project.tw. or (systematic review.ti,ab. and review.pt.) or meta synthesis.ti. or meta-analy*.ti. or integrative review.tw. or integrative research review.tw. or rapid review.tw. or umbrella review.tw. or consensus development conference.pt. or practice guideline.pt. or drug class reviews.ti. or cochrane database syst rev.jn. or acp journal club.jn. or health technol assess.jn. or evid rep technol assess summ.jn. or jbi database system rev implement rep.jn. or (clinical guideline and management).tw. or ((evidence based.ti. or evidence-based medicine/ or best practice*.ti. or evidence synthesis.ti,ab.) and (((review.pt. or diseases category/ or behavior.mp.) and behavior mechanisms/) or therapeutics/ or evaluation studies.pt. or validation studies.pt. or guideline.pt. or pmcbook.mp.)) or (((systematic or systematically).tw. or critical.ti,ab. or study selection.tw. or ((predetermined or inclusion) and criteri*).tw. or exclusion criteri*.tw. or main outcome measures.tw. or standard of care.tw. or standards of care.tw.) and ((survey or surveys).ti,ab. or overview*.tw. or review.ti,ab. or reviews.ti,ab. or search*.tw. or handsearch.tw. or analysis.ti. or critique.ti,ab. or appraisal.tw. or (reduction.tw. and (risk/ or risk.tw.) and (death or recurrence).mp.)) and ((literature or articles or publications or publication or bibliography or bibliographies or published).ti,ab. or pooled data.tw. or unpublished.tw. or citation.tw. or citations.tw. or database.ti,ab. or internet.ti,ab. or textbooks.ti,ab. or	467370

		references.tw. or scales.tw. or papers.tw. or datasets.tw. or trials.ti,ab. or meta-analy*.tw. or (clinical and studies).ti,ab. or treatment outcome/ or treatment outcome.tw. or pmcbook.mp.))) not (letter or newspaper article).pt.	
	5	1 AND 2 AND 3 AND 4	37
	6	limit 5 to english language	37
CDSR: Protocols and Reviews EBM Reviews - Cochrane Database of Systematic Reviews 2005 to August 4, 2021	1	(Spouse Abuse OR Domestic Violence OR Battered Women OR Violence).kw.	23
	2	(((spouse OR spousal OR partner OR wife OR husband OR dating OR marital OR domestic) adj1 abuse) OR intimate partner violence OR ((domestic OR dating OR partner) adj1 violence) OR assaultive behavior$1 OR ((battered OR abused) adj (woman OR women)) OR ((psychological OR emotional OR physical) adj1 abuse) OR sexual partner$1 OR boyfriend OR girlfriend OR significant other OR couple OR romantic partner OR dyad).ti,ab.	47
	3	1 OR 2	61
	4	(Veterans OR Military Personnel).kw.	3
	5	(Veteran$1 OR armed forces OR military OR army OR navy OR marines OR air force OR active duty OR navy personnel OR naval personnel OR military personnel OR army person OR reservist OR reserve force OR coast guard OR soldier$1 OR sailor$1 OR army personnel OR air force personnel OR military OR submariner$1).ti,ab.	29
	6	4 OR 5	29
	7	(Prevalence OR Risk Factors).kw.	73
	8	(prevalence OR risk OR incidence OR rate$1 OR population OR statistics OR epidemiology OR statistical data).ti,ab.	7158
	9	7 OR 8	7166
	10	3 AND 6 AND 9	0

1. Search for current systematic reviews (limited to last 7 years) Date Searched: 08-05-21		
B. Non-bibliographic databases	**Evidence**	**Results**
AHRQ: evidence reports, technology assessments, U.S Preventative Services Task Force Evidence Synthesis	http://www.ahrq.gov/research/findings/evidence-based-reports/search.html Search: veteran; military; intimate partner violence	0
CADTH	https://www.cadth.ca Search: veteran; military; intimate partner violence	0

ECRI Institute	https://guidelines.ecri.org/ Search: veteran; military; intimate partner violence	0
HTA: Health Technology Assessments (UP TO 2016)	http://www.ohsu.edu/xd/education/library/ See Cochrane search above	0
NHS Evidence	http://www.evidence.nhs.uk/default.aspx Search: veteran; military; intimate partner violence	91
EPPI-Centre	http://eppi.ioe.ac.uk/cms/Default.aspx?tabid=62 Use browser search function [CNTL + F] for keyword search Search: veteran; military; intimate partner violence	0
NLM	http://www.ncbi.nlm.nih.gov/books Search: veteran; military; intimate partner violence	0
VA Products - VATAP, PBM and HSR&D publications	A. http://www.hsrd.research.va.gov/research/default.cfm B. http://www.research.va.gov/research_topics/ C. https://va.dimensions.ai/discover/publication Search: veteran; military; intimate partner violence Intimate Partner Violence, Health, and Health Care Among Female Veterans. January 2012-December 2016. https://www.hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141701684 Intimate Partner Violence: Patient Characteristics, Service Use and Experiences. October 2015-March 2019. https://www.hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141704480 Addressing Intimate Partner Violence Among Women Veterans: Evaluating the Impact and Effectiveness of VHA's Response. November 2019-April 2023. https://www.hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141706237 High Prevalence of Intimate Partner Violence among Women Veterans – Up to Age 55 – Using VA Primary Care. HSR&D Pub Brief. https://www.hsrd.research.va.gov/research/citations/PubBriefs/articles.cfm?RecordID=795 Overview of Intimate Partner Violence: Current State of Knowledge in Regard to Women Veterans. HSR&D Pub Brief. https://www.hsrd.research.va.gov/research/citations/PubBriefs/articles.cfm?RecordID=632	5

2. Search for systematic reviews currently under development (includes forthcoming reviews & protocols) **Date Searched: 08-05-21**		
D. Under development:	**Evidence:**	**Results:**
AHRQ topics in development (EPC Status Report)	Email Charli Armstrong carmstrong.src@gmail.com Email sent on 08-05	
PROSPERO (SR registry)	http://www.crd.york.ac.uk/PROSPERO/ Katherine Sparrow, Deirdre MacManus. A systematic review of the prevalence of intimate partner violence victimisation among military personnel. PROSPERO 2016 CRD42016038800 Available from: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42016038800 Sean Cowlishaw, Dzenana Kartal, Alyssa Sbisa, Isabella Freijah. Prevalence of intimate partner violence (IPV) victimization and perpetration in military and veteran populations: A systematic review of population-based studies. PROSPERO 2020 CRD42020199214 Available from: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42020199214 Gursimran Thandi, Deirdre MacManus, Nicola Fear, Simon Wessely. Risk factors associated with Intimate Partner Violence (IPV) perpetration in military populations. PROSPERO 2014 CRD42014010307 Available from: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42014010307	3

PRIMARY STUDIES

5. Search for primary literature **Date searched: 08-05-21**		
MEDLINE [Ovid MEDLINE(R) ALL 1946 to August 04, 2021]		
#	**Search Statement**	**Results**
1	Spouse Abuse/ OR Domestic Violence/ OR Battered Women/ OR Violence/ OR (((spouse OR spousal OR partner OR wife OR husband OR dating OR marital OR domestic) adj1 abuse) OR intimate partner violence OR ((domestic OR dating OR partner) adj1 violence) OR assaultive behavior$1 OR ((battered OR abused) adj (woman OR women)) OR ((psychological OR emotional OR physical) adj1 abuse) OR sexual partner$1 OR boyfriend OR girlfriend OR significant other OR couple OR romantic partner OR dyad).ti,ab.	113270
2	Veterans/ OR Military Personnel/ OR (Veteran$1 OR armed forces OR military OR army OR navy OR marines OR air force OR active duty OR navy personnel OR naval personnel OR military personnel OR army person OR reservist OR reserve force OR coast guard OR soldier$1 OR sailor$1 OR army personnel OR air force personnel OR military OR submariner$1).ti,ab.	125516

3	Prevalence/ OR Risk Factors/ OR (prevalence OR risk OR incidence OR rate$1 OR population OR statistics OR epidemiology OR statistical data).ti,ab.	6742062
4	1 AND 2 AND 3	757
5	Limit 4 to English language	735
CINAHL		
#	**Search Statement**	**Results**
1	TI ((MH “Intimate Partner Violence”) OR (MH “Domestic Violence”) OR (MH “Battered Women”) OR (MH “Dating Violence”) OR (MH “Violence”) OR (((spouse OR spousal OR partner OR wife OR husband OR dating OR marital OR domestic) adj1 abuse) OR intimate partner violence OR ((domestic OR dating OR partner) adj1 violence) OR assaultive behavior$1 OR ((battered OR abused) adj (woman OR women)) OR ((psychological OR emotional OR physical) adj1 abuse) OR sexual partner$1 OR boyfriend OR girlfriend OR significant other OR couple OR romantic partner OR dyad)) OR AB ((MH “Intimate Partner Violence”) OR (MH “Domestic Violence”) OR (MH “Battered Women”) OR (MH “Dating Violence”) OR (MH “Violence”) OR (((spouse OR spousal OR partner OR wife OR husband OR dating OR marital OR domestic) adj1 abuse) OR intimate partner violence OR ((domestic OR dating OR partner) adj1 violence) OR assaultive behavior$1 OR ((battered OR abused) adj (woman OR women)) OR ((psychological OR emotional OR physical) adj1 abuse) OR sexual partner$1 OR boyfriend OR girlfriend OR significant other OR couple OR romantic partner OR dyad))	65722
2	TI ((MH “Veterans+”) OR (MH “Military Personnel+”) OR (Veteran$1 OR armed forces OR military OR army OR navy OR marines OR air force OR active duty OR navy personnel OR naval personnel OR military personnel OR army person OR reservist OR reserve force OR coast guard OR soldier$1 OR sailor$1 OR army personnel OR air force personnel OR military OR submariner$1)) OR AB ((MH “Veterans+”) OR (MH “Military Personnel+”) OR (Veteran$1 OR armed forces OR military OR army OR navy OR marines OR air force OR active duty OR navy personnel OR naval personnel OR military personnel OR army person OR reservist OR reserve force OR coast guard OR soldier$1 OR sailor$1 OR army personnel OR air force personnel OR military OR submariner$1))	49890
3	TI ((MH “Prevalence”) OR (MH “Risk Factors+”) OR (prevalence OR risk OR incidence OR rate$1 OR population OR statistics OR epidemiology OR statistical data)) OR AB ((MH “Prevalence”) OR (MH “Risk Factors+”) OR (prevalence OR risk OR incidence OR rate$1 OR population OR statistics OR epidemiology OR statistical data))	1391173
4	1 AND 2 AND 3	347

APPENDIX B: EXCLUDED STUDIES

Exclude reasons: 1=Ineligible population, 2=Ineligible intervention, 3=Ineligible comparator, 4=Ineligible outcome (including duplicative prevalence estimate), 5=Ineligible timing, 6=Ineligible study design, 7=Ineligible publication type, 8=Outdated or ineligible systematic review.

Citation	Exclude Reason
Beckham JC, Feldman ME, Kirby AC, Hertzberg MA, Moore SD. Interpersonal violence and its correlates in Vietnam Veterans with chronic posttraumatic stress disorder. *J Clin Psychol*. 1997;53(8):859-869. doi:10.1002/(sici)1097-4679(199712)53:8<859::aid-jclp11>3.0.co;2-j	E4
Begić D, Jokić-Begić N. Aggressive behavior in combat veterans with post-traumatic stress disorder. *Mil Med*. 2001;166(8):671-676.	E4
Bossarte RM. Challenges associated with the use of policy to identify and manage risk for suicide and interpersonal violence among Veterans and other Americans. *Adm Policy Ment Health*. 2018;45(4):692-695. doi:10.1007/s10488-018-0882-x	E7
Calhoun PS, Van Voorhees EE, Elbogen EB, et al. Nonsuicidal self-injury and interpersonal violence in U.S. Veterans seeking help for posttraumatic stress disorder. *Psychiatry Res*. 2017;247:250-256. doi:10.1016/j.psychres.2016.11.032	E4
Dao J. Preventing domestic violence in families of Veterans. *J Clin Psychiatry*. 2013;74(10):974-980. doi:10.4088/JCP.12124co1c	E7
Dichter ME, Haywood TN, Butler AE, Bellamy SL, Iverson KM. Intimate partner violence screening in the Veterans Health Administration: Demographic and military service characteristics. *Am J Prev Med*. 2017;52(6):761-768. doi:10.1016/j.amepre.2017.01.003	E4
Dichter ME, Sorrentino A, Bellamy S, Medvedeva E, Roberts CB, Iverson KM. Disproportionate mental health burden associated with past-year intimate partner violence among women receiving care in the Veterans Health Administration. *J Trauma Stress*. 2017;30(6):555-563. doi:10.1002/jts.22241	E4
Gerlock AA, Grimesey J, Sayre G. Military-related posttraumatic stress disorder and intimate relationship behaviors: a developing dyadic relationship model. *J Marital Fam Ther*. 2014;40(3):344-356. doi:10.1111/jmft.12017	E4
Gobin RL, Green KE, Iverson KM. Alcohol misuse among female Veterans: Exploring associations with interpersonal violence and mental health. *Subst Use Misuse*. 2015;50(14):1765-1777. doi:10.3109/10826084.2015.1037398	E4
Iverson KM, Mercado R, Carpenter SL, Street AE. Intimate partner violence among women Veterans: previous interpersonal violence as a risk factor. *J Trauma Stress*. 2013;26(6):767-771. doi:10.1002/jts.21867	E4
Iverson KM, Vogt D, Dichter ME, et al. Intimate partner violence and current mental health needs among female Veterans. *J Am Board Fam Med*. 2015;28(6):772-776. doi:10.3122/jabfm.2015.06.150154	E4
Iverson KM, Stirman SW, Street AE, et al. Female Veterans' preferences for counseling related to intimate partner violence: Informing patient-centered interventions. *Gen Hosp Psychiatry*. 2016;40:33-38. doi:10.1016/j.genhosppsych.2016.03.001	E1
Iverson KM, Dardis CM, Pogoda TK. Traumatic brain injury and PTSD symptoms as a consequence of intimate partner violence. *Compr Psychiatry*. 2017;74:80-87. doi:10.1016/j.comppsych.2017.01.007	E4

Mahoney CT, Iverson KM. The roles of alcohol use severity and posttraumatic stress disorder symptoms as risk factors for women's intimate partner violence experiences. *J Womens Health (Larchmt)*. 2020;29(6):827-836. doi:10.1089/jwh.2019.7944	E4
Makaroun LK, Brignone E, Rosland AM, Dichter ME. Association of health conditions and health service utilization with intimate partner violence identified via routine screening among middle-aged and older women. *JAMA Netw Open*. 2020;3(4):e203138. Published 2020 Apr 1. doi:10.1001/jamanetworkopen.2020.3138	E4
Maskin RM, Iverson KM, Vogt D, Smith BN. Associations between intimate partner violence victimization and employment outcomes among male and female post-9/11 veterans. *Psychol Trauma*. 2019;11(4):406-414. doi:10.1037/tra0000368	E4
Miller TW, Veltkamp LJ. Family violence: clinical indicators among military and post-military personnel. *Mil Med*. 1993;158(12):766-771.	E7
Montgomery AE, Sorrentino AE, Cusack MC, et al. Recent intimate partner violence and housing instability among women Veterans. *Am J Prev Med*. 2018;54(4):584-590. doi:10.1016/j.amepre.2018.01.020	E4
Murdoch M, Polusny MA, Hodges J, O'Brien N. Prevalence of in-service and post-service sexual assault among combat and noncombat Veterans applying for Department of Veterans Affairs posttraumatic stress disorder disability benefits. *Mil Med*. 2004;169(5):392-395. doi:10.7205/milmed.169.5.392	E4
Portnoy GA, Haskell SG, King MW, Maskin R, Gerber MR, Iverson KM. Accuracy and acceptability of a screening tool for identifying intimate partner violence perpetration among women Veterans: A pre-implementation evaluation. *Womens Health Issues*. 2018;28(5):439-445. doi:10.1016/j.whi.2018.04.003	E4
Sayers SL, Farrow VA, Ross J, Oslin DW. Family problems among recently returned military Veterans referred for a mental health evaluation. *J Clin Psychiatry*. 2009;70(2):163-170. doi:10.4088/jcp.07m03863	E4
Tiet QQ, Finney JW, Moos RH. Recent sexual abuse, physical abuse, and suicide attempts among male Veterans seeking psychiatric treatment. *Psychiatr Serv*. 2006;57(1):107-113. doi:10.1176/appi.ps.57.1.107	E4

Note. Excluded studies from the original ESP review[1] are not represented.

APPENDIX C: EVIDENCE TABLES

CHARACTERISTICS OF INCLUDED SYSTEMATIC REVIEWS

Characteristics of the Kwan et al[2] systematic review and meta-analysis are presented in the Literature Overview section of our Evidence Brief.

OUTCOME DATA OF INCLUDED SYSTEMATIC REVIEWS

All outcome data from Kwan et al[2] relevant to our current systematic review and meta-analysis are presented in the Results section of our Evidence Brief.

QUALITY ASSESSMENT OF INCLUDED SYSTEMATIC REVIEWS

Assessed SR: Kwan 2020[2]				
Guiding Questions	**Reviewer 1**	**Reviewer 2**	**Consensus**	**Comments**
1. Eligibility Criteria				
1.1 Did the review adhere to pre-defined objectives and eligibility criteria?	PY	PY	PY	PROSPERO registration number listed, but protocol not found.
1.2 Were the eligibility criteria appropriate for the review question?	Y	Y	Y	
1.3 Were eligibility criteria unambiguous?	Y	Y	Y	
1.4 Were all restrictions in eligibility criteria based on study characteristics appropriate (*eg,* date, sample size, study quality, outcomes measured)?	Y	PY	PY	Restricted to studies that used validated tools to measure IPV perpetration, which could result in over-representation of measurements with CTS, which has some issues with validity and reliability. Likely still appropriate given that these issues have been addressed/quantified for the CTS.
1.5 Were any restrictions in eligibility criteria based on sources of information appropriate (*eg*, publication status or format, language, availability of data)?	Y	Y	Y	Restricted to published English Language articles; likely limits generalizability to military populations in primarily English-speaking countries.
Concerns regarding specification of study eligibility criteria (LOW/HIGH/UNCLEAR)	*Low*	*Low*	*Low*	*Rationale for concern: No major concerns.*
2. Identification and Selection of Studies				
2.1 Did the search include an appropriate range of databases/electronic sources for published and unpublished reports?	Y	Y	Y	
2.2 Were methods additional to database searching used to identify relevant reports?	Y	Y	Y	
2.3 Were the terms and structure of the search strategy likely to retrieve as many eligible studies as possible?	PY	PY	PY	
2.4 Were restrictions based on date, publication format, or language appropriate?	Y	Y	Y	
2.5 Were efforts made to minimize error in selection of studies?	Y	Y	Y	

Concerns regarding methods used to identify/select studies (LOW/HIGH/UNCLEAR)	*Low*	*Low*	*Low*	*Rationale for concern: No major concerns.*
3. Data Collection and Study Appraisal				
3.1 Were efforts made to minimize error in data collection?	NI	NI	NI	
3.2 Were sufficient study characteristics available for both review authors and readers to be able to interpret the results?	Y	Y	Y	
3.3 Were all relevant study results collected for use in the synthesis?	Y	Y	Y	
3.4 Was risk of bias (or methodological quality) formally assessed using appropriate criteria?	Y	Y	Y	
3.5 Were efforts made to minimize error in risk of bias assessment?	Y	Y	Y	
Concerns regarding methods used to collect data/appraise studies (LOW/HIGH/UNCLEAR)	*Low*	*Low*	*Low*	*Rationale for concern: Limited concerns overall; unclear whether data abstraction was checked by a second reviewer.*
4. Synthesis and Findings				
4.1 Did the synthesis include all studies that it should?	PY	PY	PY	
4.2 Were all pre-defined analyses reported or departures explained?	PY	PY	PY	
4.3 Was the synthesis appropriate given the nature and similarity in the research questions, study designs and outcomes across included studies?	Y	Y	Y	
4.4 Was between-study variation (heterogeneity) minimal or addressed in the synthesis?	PY	PY	PY	
4.5 Were the findings robust (*eg,* as demonstrated through funnel plot or sensitivity analyses)?	PY	PY	PY	
4.6 Were biases in primary studies minimal or addressed in the synthesis?	PY	PY	PY	Addressed limitations of CTS.

Concerns regarding synthesis and findings (LOW/HIGH/UNCLEAR)	*Low*	*Low*	*Low*	*Rationale for concern: Protocol does not appear to be locatable by PROSPERO ID, so cannot tell for certain whether there were departures from pre-defined analyses (a protocol that is likely this review's but having a different ID (CRD42016038800) was located, and predefined analyses align); magnitude of heterogeneity or residual heterogeneity not reported, but relevant subgroup analyses were performed or subgroup estimates from studies were reported.*
5. Risk of Bias in the Review				
5.1 Did the interpretation of findings address all of the concerns identified in Domains 1 to 4?	Y	Y	Y	
5.2 Was the relevance of identified studies to the review's research question appropriately considered?	Y	Y	Y	
5.3 Did the reviewers avoid emphasizing results on the basis of their statistical significance?	Y	Y	Y	
Risk of bias in the review (LOW/HIGH/UNCLEAR)	*Low*	*Low*	*Low*	*Rationale for risk of bias: Overall very few concerns. Reasonable inclusion criteria, comprehensive search, adequately described results, and appropriately contextualized findings.*

Abbreviations. NI=no information; PY=probably yes; Y=yes.

CHARACTERISTICS OF INCLUDED PRIMARY STUDIES

Primary study characteristics are presented in Table 1 of our Evidence Brief.

OUTCOME DATA OF INCLUDED PRIMARY STUDIES

A data table of prevalence estimates used in meta-analyses is available upon request by contacting ESP.CC@va.gov.

QUALITY ASSESSMENT OF INCLUDED PRIMARY STUDIES

Author Year	External validity: Target Population 1. Was the study's target population a close represent-ation of the national population in relation to relevant variables (*eg,* age, sex, occupation)?	External validity: Sampling Frame 2. Was the sampling frame a true or close represent-ation of the target population?	External Validity: Random Selection 3. Was some form of random selection used to select the sample or was a census undertaken?	External Validity: Non-response Bias 4. Was the likelihood of non-response bias minimal (*ie,* ≥75% response rate or no significant demo-graphic difference between responders and non-responders)?	Internal Validity: Source of Information 5. Were data collected directly from the subjects (as opposed to a proxy)?	Internal Validity: Case Definition 6. Was an acceptable case definition used in the study?	Internal Validity: Study Instrument 7. Was the study instrument that measured the parameter of interest shown to have reliability and validity?	Internal Validity: Survey Modality 8. Was the same mode of data collection used for all subjects?	Internal Validity: Count Reports 9. Were the num. and denom. for the parameter of interest appropriate?	Overall Risk of Bias
Bartlett 2018[3] (male/GFK sample)	Yes Panel used random digit dialing and address-based sampling to generate nationally representative sample of the US pop, with subpopulation of Veterans.	No Current study re-sampled Veteran sub-pop, but only those who endorsed trauma exposure (2175/3157)	Yes Random selection used.	Yes Response rate was 76.38%	Yes Responses completed by participants	Yes Past-year violence or aggression by intimate partner	Yes Used HARK instrument, which is recommended by the Institute of Medicine due to sensitivity and specificity	Yes Participants were contacted and enrolled in various ways, but all completed the survey online (with provided internet access and hardware if needed)	Yes Proportions are weighted, so we can't double check calculations, but they appear consistent	Moderate Study is likely to overestimate prevalence of IPV due to limitation of sampling to Veterans who endorsed trauma exposure
Bartlett 2018[3] (female/New England VA cohort)	No Target population was limited to the New England region.	Yes Sampled randomly from a database of Veterans in the region.	Yes Random selection used.	No Only 70.73% of Veterans from an initial survey agreed to be recontacted,	Yes Responses completed by participants	Yes Past-year violence or aggression by intimate partner	Yes Used CTS-2 tool, which is widely used, validated, and aligned with CDC	Yes Participants completed mail-in surveys	No Numerators and denominators don't match proportions (no mention of	High Study is likely to underestimate the prevalence of IPV due to limitation of sample to New

				and only 79.8% of those who agreed to be recontacted completed the survey.			definition when using severe psychological/ emotional aggression definitions (which the authors did)		survey weighting)	England region and high nonresponse; sample has higher proportion of White Veterans than national population
Bennett 2019[4]	No Target population was limited to the Midwest and to Veterans with identified military sexual trauma	No Limited to a single center in the VHA.	Yes Census of pts treated for index military sexual trauma at the participating VHA.	No Only 103/160 Veterans who completed screening had sufficient data for analysis and only 86 had IPV data. No analysis of pts with vs without missing data	Yes Responses completed by participants	Yes Lifetime IPV	No It's unclear which questionnaire included IPV screening and what questions the screening used.	Yes Participants completed structured interviews in person.	Yes Provides counts of pts who did vs did not experience lifetime IPV	High Limitation of sample to Veterans who experienced military sexual trauma likely to have resulted in overestimate of the national prevalence of IPV.
Brignone 2018[5]	Yes The study used data from as many VHA systems/sites as possible	No It's unclear how evenly distributed the 13 VHA sites were	Yes Census of women treated at participating VHA sites	No Study does not report the number of pts who were left out of the analysis due to missing IPV data	Yes Responses completed by participants	Yes Lifetime or past-year IPV	Yes Used the E-HITS instrument, which researchers validated against the CTS-2	Yes Participants completed in-person screening with a healthcare provider	Yes Numerators and denominators are provided and/or can be calculated from available information	Moderate Likely direction of potential bias is unclear. No comparisons are made between demographics of the included VHA networks and the national population of Veterans or between patients included vs excluded from the analysis
Campbell 2005[6]	No Target population was predominantly	Yes Sampled randomly from a women's VA clinic	Yes Random selection used	Yes Response rate was 88%	Yes Responses completed by participants	No May underestimate sexual IPV prevalence	Yes Used the Sexual Experiences Survey and	Yes Participants completed written surveys in-	No Proportion and denominator are reported,	High High proportion of low-income and racial or ethnic

	racial and ethnic minority, low-income Veteran women population in the Midwest					due to method of reporting and case definition; sexual assault was measured, which does not include all forms of sexual IPV	incident report forms	person at medical appointments	but not numerator	minorities compared to national population of Veterans likely to have resulted in overestimate of the national prevalence of IPV.
Campbell 2008[7]	No Target population was predominantly racial and ethnic minority, low-income Veteran women population in the Midwest	Yes Sampled randomly from a women's VA clinic	Yes Random selection used	Yes Response rate was 88%	Yes Responses completed by participants	Yes Lifetime physical IPV	Yes Study used CTS, which is validated/reliable for physical IPV	Yes Participants completed written surveys in-person at medical appointments	No Only proportion is provided (no numerator)	High High proportion of low-income and racial or ethnic minorities compared to national population of Veterans likely to have resulted in overestimate of the national prevalence of IPV.
Caralis 1997[8]	No Target population was women treated at the VA	No Sampling frame only included women attending Miami VA clinics	No Study used convenience sampling (recruited pts attending clinic)	Yes 78.7% completion rate	Yes All women were interviewed in person	No Study combines physical and sexual IPV without assessing psychological IPV	No Study used the Abuse Assessment Screen, which appears to be valid or abuse but unclear validity for IPV specifically	Yes All participants were interviewed	No Study reports denominators and proportions, but not denominators	High Likely direction of potential bias is unclear given minimal information about the demographics and characteristics of the target population and sampling frame.
Cerulli 2014[9] "Examining"	Yes Target population was male	No Study only sampled from male Veteran population in	Yes Random selection used.	No Response rate was 27%. No analysis of differences	Yes Responses completed by participants	No Study reported "any IPV," but questions only	No Study used its own, unvalidated	Yes All participants interviewed by phone	Yes Numerators and denominators are provided	High Likely direction of potential bias is unclear. No

	Veterans in the US	upstate New York		between responders and non-responders.		assessed sexual and physical IPV	questions for screening			comparison of respondents to non-respondents. No validation of study questionnaire/ instrument. Use of psychological + sexual IPV may underestimate any IPV by leaving out physical IPV (though not by much, as psychological IPV generally accompanies other forms)
Cerulli 2014[10] "Exploring"	Yes Target population for the study was all men US Veterans	No Only 8 states participating in the BRFSS surveyed IPV status in 2006; not representative of the Midwest or Northwest	Yes Random selection used (random digit dialing)	No Study does not report response rate or comparison between responders and non-responders	Yes Responses answered directly by participants	Yes Lifetime IPV	No Study used a single question to assess IPV, developed by BRFSS researchers	Yes All participants surveyed over the phone	No Numerator not provided (just denominator and proportion)	High Likely direction of potential bias is unclear. No comparisons are made between demographics of Veterans in the included states and the national population of Veterans or between respondents vs non-respondents. Study question used to assess IPV was not validated.
Combellick 2019[11]	No Target population was limited to Veterans during	No Only included Veterans served at New England, Indianapolis,	Yes Took a census of eligible women Veterans and	No Only 1,094/9,912 Veterans responded/ consented to	Yes Responses answered directly by participants	Yes IPV in the last 12 months (score of 7+ on E-HITS evaluated)	Yes Study used E-HITS, which has been validated in	Yes All participants completed written surveys	Yes Numerators and denominators are provided and match	High Likely direction of potential bias is unclear.

	Operation Enduring Freedom, Operation Iraqi Freedom, and/or Operation New Dawn	Los Angeles, and Durham VHAs; unclear how well these systems represent national population	randomly sampled men	participate and no comparison between responders and non-responders			Veteran populations		reported proportions	OEF/OIF/OND Veterans are likely to be younger than the national population of Veterans, and therefore more likely to report IPV than older veterans. However, no comparisons are made between demographics of Veterans in the included VHA networks and the national population of Veterans or between respondents vs non-respondents.
Coyle 1996[12]	No Target population was women veterans in the Baltimore VAMC area	Yes Surveys mailed to all women who received care in the previous 6 months	Yes Study took a census of all pts treated in the study period	No Study had a 52% response rate and respondents served longer on average than non-respondents	Yes Surveys were completed by participants	No Sexual IPV outcome was defined as rape by spouse or partner. Sexual abuse by spouse/ partner was also reported, but reportedly less common despite a less stringent definition.	No Study used ad-hoc questionnaire	Yes All participants completed mail-in surveys	No Numerators specific to abuse by spouse/ partner were not reported, just proportions and denominators	High Likely direction of potential bias is unclear given missing demographic info on race, ethnicity, and LGBTQ+ identity. Unclear how unvalidated survey instrument may have biased results.
Creech 2017[13]	No Target population was limited to women	Yes Sampled from all women Veterans on the roster who	Yes Invited participants were	No Survey response rate was 27%	Yes Responses were completed by participants	Yes Past-year IPV	Yes Used the CTS-2	Yes Participants were first contacted by mail and	Yes Numerators and denominators are provided	High Likely direction of potential bias is unclear.

	Veterans in current intimate relationships who served during Operation Enduring Freedom, Operation Iraqi Freedom, and/or Operation New Dawn	resided within a VISN	randomly selected					provided with a link to an online survey	and match reported proportions	OEF/OIF/OND Veterans are likely to be younger than the national population of Veterans, and therefore more likely to report IPV than older Veterans. However, no comparisons are made between respondents vs non-respondents.
Creech 2021[14]	No Target population was limited to pregnant Veterans	Yes Selected based on medical record entries indicating that Veteran was pregnant from 15 VHA hubs across the country	Yes Study attempted to take a census of all pregnant Veterans	No Only 38% of eligible patients participated in parent study (https://www.liebertpub.com/doi/10.1089/jwh.2018.7628), and only 71.3% of participants in the parent study were included in analysis, likely due to missing data from IPV screen; no comparison of responders vs non-responders provided	Yes Responses completed by participants	Yes Past-year IPV	Yes Study used E-HITS, which has been validated in Veteran populations	Yes All participants completed phone interviews	Yes Numerators and denominators reported	High Direction of potential sources of bias is difficult to predict without comparison between responders and non-responders.
Dardis 2017[15]	Yes Panel used random digit	Yes All women Veterans in	Yes Random	Yes Response rate was 75%	Yes Responses	Yes Followed CDC	Yes Used HARK instrument,	Yes All participants	Yes Numerators and	Low

	dialing and address-based sampling to generate nationally representative sample of the US pop, with subpopulation of Veterans.	the panel were invited to complete the survey	selection used.		completed by participants	recommended IPV definition (*ie*, physical, sexual, psychological aggression and stalking from a past or current intimate partner)	which is recommended by the Institute of Medicine due to sensitivity and specificity	completed a web-based survey	denominators provided	
Dichter 2011[16]	Yes Target population for the study was all women US Veterans	No Only 8 states participating in the BRFSS surveyed IPV status in 2006; not representative of the Midwest or Northwest; no indication if rural and urban populations are adequately represented	Yes Random selection used (random digit dialing)	No Study does not report response rate or comparison between responders and non-responders	Yes Responses answered directly by participants	Yes Lifetime IPV	No Study used a single question to assess IPV, developed by BRFSS researchers	Yes All participants surveyed over the phone	Yes Numerator and denominators are provided; proportions are adjusted for sample design and non-response, but are close to crude proportions.	High Likely direction of potential bias is unclear. No comparisons are made between demographics of Veterans in the included states and the national population of Veterans or between respondents vs non-respondents. Study question used to assess IPV was not validated.
Dichter 2014[17] and 2015[18]	No Target population was women Veterans seeking care at a single VA center	Yes Study attempted to recruit all women visiting/ seeking care at the center	No Study used convenience sampling (waiting room and flyer recruitment)	No Total number of women approached not reported, so nonresponse cannot be assessed	Yes Responses completed by participants	Yes Lifetime IPV	Yes Study used CTS-2	Yes All participants completed in-person interviews	Yes Denominators and numerators not all reported in 2014 study, but they are available in 2015 and proportions align	High Likely direction of bias is unclear. Study limited to care-seeking patients, which would typically result in overestimate of prevalence. In this case, it might have resulted in

										an underestimate if pts with IPV experiences avoided the triggering interview. Also unclear how demographics of sampling frame compared to national population of Veterans
Dichter 2017[19] "IPV, Unhealthy alcohol use"	No Target population was women Veterans treated at 2 regional VA centers	Yes Universal IPV screening was used, and records used were consecutive	Yes Appears to be a census (describes time period and consecutive records)	Yes 92.7% of participants had complete IPV data	Yes Responses completed by participants	Yes Past-year IPV	Yes Study used E-HITS, which has been validated in Veteran populations	Yes All participants completed paper surveys	Yes Numerators and denominators reported; proportions match	High Likely direction of bias is unclear given minimal information on demographics of sample.
Dobie 2004[20]	No Target population was women Veterans seen for care at the VA Puget Sound HCS	Yes Surveys mailed to all women who received care over a 1-year period	Yes Study took a census of all pts treated in the study period	No Study had a 65% response rate and 62% completion rate; no comparisons made between respondents and non-respondents	Yes Surveys were completed by participants	Yes Lifetime physical IPV (study language may be misleading, as it presents results as "domestic violence by a partner" but only measured physical IPV; however, it is included in our meta-analysis as-measured, and not as-labeled).	No Study used unvalidated survey question	Yes All participants completed mail-in surveys	Yes Numerators and denominators reported and match reported proportions	High Unclear how well regional population of women Veterans generalizes to the national population. Unclear how survey questions may have biased results.

Dutra 2012[21]	No Limited to male partners/ spouses of female Vietnam Veterans	Yes Veteran-partner dyads were sampled from the nationally representative NVVRS and NSVG studies	No Sampling methods not specified (likely not random)	No Response rate not reported	No Data were collected from partners/ spouses, but the methods are unclear. Veterans might have been present or nearby for the interviews, which could have affected the results. Double checked more detailed paper for interview methods.	Yes Past-year physical IPV	Yes Used the CTS, which has been validated for physical violence	Yes All participants completed in-person interviews	No Only proportions and denominators are provided	High Likely direction of potential bias is unclear. Limitation of sample to partners of Vietnam Veterans with PTSD would like result in an overestimate of the national prevalence of IPV, but if Veterans were nearby for partner interviews, the estimated prevalence would likely be an underestimate of the true prevalence in the target population.
Gondolf 1991[22]	No Study limited to partners/ spouses of Veterans in treatment for alcoholism	No Study only included pts from 1 center and only some of their partners/ spouses	No Study did randomly select 50 Veteran-partner pairs, but the Veterans had to provide consent to have their partners/ spouses participate. In this sense, it was not a true random sample of partners/ spouses.	Yes All partners/ spouses of the Veterans who consented to their participation appear to have responded.	No Data were collected from partners/ spouses, but the methods are unclear. Veterans might have been present for the interviews, which could have affected the results.	Yes Any past-year physical IPV	Yes Study used CTS, which is validated/ reliable for physical IPV	No Method of data collection not described for partners/ spouses	Yes Numerators and denominators reported	High Likely direction of potential bias is unclear. Limitation of sample to partners of Veterans in treatment for alcoholism would like result in an overestimate of the national prevalence of IPV, but Veterans had to consent to their spouse's participation and may have been present for the interview, which

										likely resulted in an underestimate of the true prevalence in the target population.
Huston 2019[23]	Yes Panel used random digit dialing and address-based sampling to generate nationally representative sample of the US pop, with subpopulation of Veterans.	Yes All women Veterans in the panel were invited to complete the survey	Yes Random selection used.	Yes Response rate was 34.7% but there were no differences between participants and non-participants	Yes Responses completed by participants	Yes Followed CDC recommended IPV definition (*ie*, physical, sexual, psychological aggression and stalking from a past or current intimate partner)	Yes Used HARK instrument, which is recommended by the Institute of Medicine due to sensitivity and specificity	Yes All participants completed a web-based survey	Yes Numerators and denominators provided	Low
Iverson 2013[24] "Clinical Utility"	No Target population was limited to the New England region.	No Limited to Veterans who reported being in an intimate partner relationship over the past year	Yes Random selection used.	No Response rate was 63.5%, and responders were on average older than non-responders.	Yes Responses completed by participants	Yes Past-year violence or aggression by intimate partner	Yes Used CTS-2 tool, which is widely used, validated, and aligned with CDC definition when using severe psychological/ emotional aggression definitions (which the authors did)	Yes Participants completed mail-in surveys	Yes Numerators and denominators provided and reported proportions match	High Study has unclear direction of likely bias. Limitation of sample to Veterans who were in intimate partnerships over the last year would likely result in overestimate of IPV prevalence, while limitation of sample to New England region and high nonresponse would likely result in underestimate (sample has higher proportion of older White Veterans than national population)

Iverson 2015[25] "Accuracy"	No Target population was limited to the New England region.	No Limited to Veterans who reported being in an intimate partner relationship over the past year	Yes Random selection used.	No Response rate was 50.0%, and responders were on average older than non-responders.	Yes Responses completed by participants	Yes Past-year violence or aggression by intimate partner	Yes Used CTS-2 tool	Yes Participants completed mail-in surveys	Yes Numerators and denominators provided	High Study has unclear direction of likely bias. Limitation of sample to Veterans who were in intimate partnerships over the last year would likely result in overestimate of IPV prevalence, while limitation of sample to New England region and high nonresponse would likely result in underestimate (sample has higher proportion of older White Veterans than national population)
Iverson 2015[26] "TBI"	No Target population was limited to the New England region.	No Limited to Veterans who reported being in an intimate partner relationship over the past year	Yes Random selection used.	No Response rate was 71%; study reports no difference in demographics between those who did vs did not return surveys, but there's no comparison between those with complete vs incomplete data	Yes Responses completed by participants	Yes Past-year or lifetime violence or aggression by intimate partner	Yes Used CTS-2 tool	Yes Participants completed mail-in surveys	No Not all numerators reported (just proportions and denominators)	High Study has unclear direction of likely bias. Limitation of sample to Veterans who were in intimate partnerships over the last year would likely result in overestimate of IPV prevalence, while limitation of sample to New England region and high nonresponse would likely result

										in underestimate (sample has higher proportion of older White Veterans than national population)
Iverson 2017[27] "IPV"	No Target population was limited to recently separated Veterans	Yes Study sampled from a database that included all recently separated Veterans	Yes Random selection used	No No reporting of response rate at baseline; response rate at T2 was 64.2% without comparison between responders and non-responders	Yes Responses completed by participants	Yes 6-month IPV	Yes Study used the CTS-2	Yes Participants completed paper/written surveys	Yes Numerators are reported and denominators can be calculated. Proportions appear accurate, though 2 estimates may be off by <0.5%	High Likely direction of potential bias is unclear. Recently separated Veterans are likely to be younger than the national population of Veterans, and therefore more likely to report IPV than older Veterans. However, no comparisons are made between respondents vs non-respondents.
Iverson 2020[28]	No Target population was limited to women Veterans wo experienced TBI and served during Operation Enduring Freedom, Operation Iraqi Freedom, and/or	No Sampling frame only included Veterans who completed comprehensiv e TBI screening	Yes All eligible pts were invited to participate (census)	No Survey response rate was 16.2%	Yes Responses were completed by participants	Yes Lifetime IPV	Yes Used the HARK	No Participants had option to complete web or mail-in paper surveys	No Numerators and denominators are provided and/or calculable, but do not always match reported proportions (seems likely that proportions are taken from pool of pts with	High Likely direction of potential bias is unclear. OEF/OIF/OND Veterans are likely to be younger than the national population of Veterans, and therefore more likely to report IPV than older Veterans.

	Operation New Dawn								available data for each demographic or IPV category, but missingness is not reported).	However, no comparisons are made between respondents vs non-respondents or mail-in vs web-based survey respondents.
Kimerling 2016[29]	Yes Target population was women Veterans in the US	Yes Study sampled from women Veterans who had at least 1 visit to the VHA in 2011	Yes Random, representative selection used	Yes 84% participation rate	Yes Responses completed by participants	Yes Past-year IPV	Yes Used the HARK	Yes Interviews conducted over the phone	Yes Proportions are weighted, so we can't double check calculations, but they appear consistent and numerators and denominators are provided	Low
Luterek 2011[30]	No Target population was Veterans attending VA Puget Sound outpatient mental health clinics or specialty PTSD clinics	Yes Sampled from database of eligible Veterans in the region	Yes Participants were randomly selected	Yes Response rate was 43%, but no significant demographic differences were found between responders and non-responders	Yes Interviews were completed by participants	No Case definition only refers to physical abuse and spouses (not including, non-married partner and sexual/ psychological abuse)	No Study used TLEQ, which is validated for trauma exposures but not specifically IPV (questions related to IPV appear minimal)	Yes All participants completed in-person interviews	No Proportions and denominators are reported, but not numerators	High Limitation of sample to Veterans in treatment for general mental health and/or PTSD likely to have resulted in overestimate of the regional prevalence of IPV. Unclear how well regional population of women Veterans generalizes to the national population. Additionally, "spousal physical abuse" likely

										underestimates IPV.
Portnoy 2020[31]	Yes Panel used random digit dialing and address-based sampling to generate nationally representative sample of the US pop, with subpopulation of Veterans.	Yes All women Veterans in the panel were invited to complete the survey	Yes Random selection used.	No Study limited to women who responded at multiple time points (34% response rate)	Yes Responses completed by participants	Yes Followed CDC recommended IPV definition (*ie*, physical, sexual, psychological aggression and stalking from a past or current intimate partner)	Yes Used the MST-2, MSA, and CTS-2	Yes All participants completed a web-based survey	Yes Numerators and denominators provided	Moderate Study is likely to overestimate prevalence of IPV due to introduction of reporting bias in requirement that women respond at multiple time points.
Rosenfeld 2018[32]	No Target population was women age 18-44 who received care at the VA	Yes Study sampled from women age 18-44 who had at least 1 visit to the VHA in a 12-month period	Yes Random, representative selection used	Yes Response rate was only 28%, but there were no statistical differences in demographics between participants and non-participants	Yes Responses completed by participants	No Case definition was women who experienced reproductive coercion, which is a type of IPV, but under-estimates the overall prevalence	No Study did not report validation of interview questions	Yes Computer-assisted phone interviews used for all participants	Yes Numerators and denominators are provided and/or can be calculated from available information	High Likely direction of potential bias is unclear. Young age range of the survey would likely result in overestimate of national prevalence of IPV, but strict limitation of case definition would likely result in underestimate.
Sadler 2003[33]	No Target population was women Veterans who served in the Vietnam, post-Vietnam, and the Persian Gulf eras; excluded	Yes Selected from national registries of VA women from target eras	Yes Random selection used	No Only 558/2172 selected Veterans completed interviews; responders were older on average than non-responders	Yes Responses completed by participants	No Outcome definition was rape by a spouse or partner during military service	No Study instrument was an ad-hoc questionnaire	Yes All participants completed computer-assisted phone interviews	Yes Numerators and denominators reported	High Study likely underestimated the true prevalence of lifetime sexual IPV. Surveyed Veterans were older than the national population due to

	older Veterans at time study was conducted and is outdated now that OIF/OEF/OND Veteran population has grown.									target population and demographics of responders. Additionally, case definition is more limited in scope and time period than sexual IPV.
Savarese 2001[34]	No Target population was spouses/ partners of men Veterans of the Vietnam War who screened positive for PTSD	Yes Veteran-partner dyads were sampled from the nationally representative NVVRS study	No Sampling methods not specified (likely not random)	Yes Response rate of the sub-sample was 80%	No Veterans might have been nearby for the interviews, which could have affected the results if spouses who experienced IPV were did not feel safe/had concerns that their partners (Veterans) would hear their answers.	Yes Past-year psychological and/or emotional IPV	Yes Used the CTS, which has been validated for male-perpetrated violence	Yes All participants completed in-person interviews	Yes Denominators and numerators are reported and proportions align	High Likely direction of potential bias is unclear. Limitation of sample to partners of Vietnam Veterans with PTSD would like result in an overestimate of the national prevalence of IPV, but if Veterans were nearby for partner interviews, the estimated prevalence would likely be an underestimate of the true prevalence in the target population.

Abbreviations. BRFSS=Behavioral Risk Factor Surveillance System; CDC=Center for Disease Control and Prevention; COMFORT=Center for Maternal and Infant Outcomes and Research in Translation; CTS=Conflict Tactics Scale; denom.=denominator; DoD=US Department of Defense; E-HITS=Extended-Hurt, Insulted, Threaten, Scream; GfK=Growth from Knowledge; HARK=Humiliation, afraid, rape, kick; IPV=intimate partner violence; LGBTQ+=lesbian, gay, bisexual, transgender, queer; MSA=military sexual assault; MST=military sexual trauma; NSVG=National Survey of the Vietnam Generation; num.=numerator; NVVRS=National Vietnam Veterans Readjustment Study; OEF/OIF/OND=Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn; pts=patients; PTSD=posttraumatic stress disorder; subpop.=subpopulation; TBI=traumatic brain injury; TLEQ=Traumatic Life Events Questionnaire; US=United States; VA=Veterans' Affairs; VAMC=Veterans' Affairs medical center; VHA=Veterans' Health Administration; WOMAN=Women's Overall Mental Health Assessment of Needs.

STRENGTH OF EVIDENCE FOR INCLUDED STUDIES

Strength of evidence ratings are presented in the Results section of our Evidence Brief.

APPENDIX D: PEER REVIEW DISPOSITION

Comment #	Reviewer #	Comment	Author Response
Are the objectives, scope, and methods for this review clearly described?			
1	1	Yes	None.
2	2	Yes	None.
3	3	Yes	None.
4	4	Yes	None.
5	6	Yes	None.
6	7	Yes	None.
7	8	Yes	None.
Is there any indication of bias in our synthesis of the evidence?			
1	1	No	None.
2	2	No	None.
3	3	No	None.
4	4	Yes - Inherent bias in the availability of research reviewed not in the researchers presentation of the available research.	None.
5	6	No	None.
6	7	No	None.
7	8	No	None.
Are there any published or unpublished studies that we may have overlooked?			
1	1	No	None.
2	2	No	None.
3	3	No	None.
4	4	No	None.
5	6	No	None.
6	7	No	None.
7	8	No	None.
Additional suggestions or comments can be provided below.			

Comment #	Reviewer #	Comment	Author Response
1	1	This report provides a good overview of the current state of literature regarding IPV/SA prevalence among Veterans. There are particular points that I believe warrant some additional attention/discussion/clarification, as detailed below.	None.
2	1	The estimated prevalence rate of IPV/SA among Veteran men is much higher for past-year than lifetime experience, suggesting wide variation in measurement across studies (given that lifetime experience would include past-year). The variation is noted but it might be helpful to more specifically note this disparity and address the difference in measurement more specifically that would account for this.	Thank you for this comment. We have added detail in the main text, noting the higher lifetime prevalence and that it may result from methodological variation across studies (including the use of ad hoc measures in those studies providing lifetime estimates).
3	1	Regarding the recommendation that: "Future research on the scope of IPV/SA among Veterans should collect data in safe and secure environments… Assessing IPV/SA in a safe and comfortable environment, potentially outside of participants' homes" – more is needed on this: what is considered "safe and secure"? What are the limitations of the current studies on this? Much of the data are collected in healthcare settings that, depending on the specific context, may or may not feel safe and secure. It is not clear to the reader how an environment would be determined to be safe or secure for a respondent.	Thank you for this useful comment. We have considerably revised the future research section based on peer review feedback and clarification that the most relevant recommendations and considerations would be those that apply to prevalence assessed in clinical settings.
4	1	There is a lack of attention to the important difference between clinical screening and survey research. For example, the comment about "providing respondents the option of answering assessments face-to-face with a trusted provider or privately using a computer-, table-, or smartphone-based assessment" may be more relevant to clinical screening than research surveys (especially regarding "provider"). This distinction is also relevant to the discussion of "burdensomeness" of assessments – in a clinical setting, a shorter tool, like the HARK, may work best. In research, depending on the scope of the study, a longer tool may be beneficial and not burdensome.	See response to comment 3.

Comment #	Reviewer #	Comment	Author Response
5	1	Furthermore, there are well-documented barriers to disclosure in clinical settings or reporting with documentation other than for research purposes (e.g., reporting to a military authority) and research has found much higher rates of IPV disclosure in survey research than clinical screening data. Prior literature (e.g., Dichter ME, Haywood TN, Butler AE, Bellamy SL, Iverson KM. Intimate partner violence screening in the Veterans Health Administration: demographic and military service characteristics. American journal of preventive medicine. 2017 Jun 1;52(6):761-8.) has cautioned against interpreting IPV disclosure documented in clinical screening as prevalence. Given that this report uses data from studies that include both survey research and clinical data sources, this issue should be addressed in the report.	See response to comment 3. Additionally, regarding the distinction of survey vs clinically-derived estimates, in the present review we generally grouped the former into the "random/population" sample type category and the latter into the "convenience" category, then carried out sensitivity analyses to explore differences in prevalence estimates. Although these analyses were only possible for lifetime IPV estimates, and this categorization was also based on other factors than simply survey vs clinically-derived, the analyses do shed some light on the important consideration you bring up. We have also added an explicit mention of the potential misestimation of true prevalence when clinical IPV data is used, with the provided citation, to the Future Research section.
6	1	On page 10 – "objective measure such as military records" – I'm not sure that I would classify military records as "objective" (vs. a validated self-report measure). The military records are likely based on self-reporting of experience and impacted by decisions around recording / documenting these reports. I would suggest using language other than "objective" here given that there is still potential for bias or mis-/underrepresentation. The language of "objective" suggests that this data source is more factual than a "subjective" self-report measure; however, given the barriers to reporting experience to a source that would document in a military record, these records are likely to under-represent prevalence more so than the self-report measures.	Thank you for this comment. This language is used by the authors of the included review on perpetrated IPV prevalence; therefore we have maintained it.
7	1	When multiple papers reported on the same sample/dataset (duplicative estimates), how did you determine which paper to include and which to exclude? For example, Dichter Haywood et al 2017 ("Intimate partner violence screening in the Veterans Health Administration: Demographic and military service characteristics"), Dichter Sorrentino et al 2017 ("Disproportionate mental health burden associated	As far as we are able to tell, both Brignone and Dichter Haywood break down estimates into similar or identical sociodemographic categories (in Table 1 and Table 3, respectively).

Comment #	Reviewer #	Comment	Author Response
		with past-year intimate partner violence among women receiving care in the Veterans Health Administration"), and BrigNone. et al 2018 ("Suicidal ideation and behaviors among women veterans with recent exposure to intimate partner violence") all use the same sample/dataset but only the BrigNone. article is included; the Dichter Haywood et al article, however, provides screening response data by demographic characteristics so might be most appropriate to include in this review.	
8	1	Page 21: "these metrics do not differentiate IPV/SA with a current partner vs a previous partner" – it would be helpful to clarify this statement with regards to methodological (or clinical) limitation. Given that it is common for people to experience ongoing IPV from a former partner, and that relationships may be fluid (i.e., in and out of relationship), it is not clear why differentiating the status of the relationship is particularly useful.	See response to comment 3.
9	1	Page 21: "it is clear that future research on IPV prevalence should account for risks of further IPV/SA as well as the impact disclosing and discussing IPV/SA may have on respondents" – it would be helpful to provide more discussion/clarification about this statement as well. There has been substantial research and literature on risks of revictimization and on impact of IPV/SA disclosure. These studies might not have met criteria for inclusion in this report but given their existence, the call for future research in this area may need to be reconsidered or justified.	See response to comment 3.
10	1	Page 22: "supplementing standardized assessments with a limited number of questions that more fully characterize the frequency and intensity of IPV/SA. For example, each standard item (eg, the HARK item Within the last year, have you been afraid of your partner or ex-partner?) could be accompanied by a prompt to complete a rating scale of how often in the last year this form of IPV occurred." This recommendation may also benefit from reconsideration	See response to comment 3.

Comment #	Reviewer #	Comment	Author Response
		or further discussion. It is not clear to me that knowing the frequency of experience (especially on something like being afraid) would be particularly helpful for anything or reflect the intensity or the impact of the experience, nor that respondents would be able to recall the frequency of such experience with precision.	
11	2	Overall this review is well-written and conducted. There were a few areas that I thought could be clarified or would benefit from minor edits.	None.
12	2	1. In some IPV literature past partners who perpetrate IPV after the relationship is over are included in estimates. It would be helpful to clarify how the current review defined IPV in regards to past partners.	Thank you for the comment. We have considerably revised the Future Research section and removed mention of the past vs current partner issue based on other reviewers' feedback. As another reviewer noted, it is not relevant to the aims of this review to distinguish past vs present partner IPV, and we made no attempt to do so.
13	2	2. It is unclear to me why the misclassification that can occur on the CTS/CTS2 would be a misclassification based on gender identity (p. 21, lines 31-33) rather than just a potential misclassification of aggression acted in defense as perpetration. People of all different gender identities could potentially act in self-defense. Please clarify or reword.	Thank you for this comment; we have clarified this sentence.
14	2	3. It appears that the recommendations made on p. 22 (lines 1-12) are primarily aimed at assessing experience of IPV. For example, do the authors have a brief measure of IPV perpetration they recommend?	Thank you for this question. We are not aware of a brief measure that covers all forms of perpetrated IPV.
15	3	The objectives, scope, and methods of the review were generally very clearly described. However, it would be helpful if the authors could clarify for what types of reasons they excluded 767 studies in the literature flowchart.	The 767 excluded studies were at the title/abstract screening stage; it is not uncommon to have many non-relevant search results and to exclude a large number of records during title/abstract screening. We conducted dual sequential title/abstract screening to ensure excluded records were appropriate for exclusion. Per the PRISMA guidelines, specific exclude reasons are provided at the full-text screening level only.
16	3	Additionally, it is not clear why the authors use the term sexual assault in addition to intimate partner violence. They do not define sexual assault, but they do define	Thank you for this comment. We have clarified the language in the Executive Summary and Background sections. The use of SA in the fashion noted is as a

Comment #	Reviewer #	Comment	Author Response
		IPV, and it appears that sexual assault falls within the umbrella of IPV when between two intimate partners. When the authors stated in the background (pg. 4) that "the prevalence of SA among Veteran intimate partners and non-partners is also not fully understood," it gave the impression that the authors were going to review sexual assault separately from IPV and were going to examine it between non-partners, but this was not the case since the authors later stated "excluding non-partner SA" on pg. 5. It would be helpful if the authors could clarify their use of SA and define it given the use of this term throughout the review.	result of the legislative language associated with this review.
17	3	I did not find bias beyond what is already mentioned by the authors in their limitations section. Overall, I believe this is a very important review that sheds light on how much more work is needed to understand IPV in the Veteran population.	None.
18	4	page ii line 4: Change Elizabeth Estabrooks title from Acting Executive Director to Deputy Director	Corrected.
19	4	page 1 line 10: Editorial change: add "both" in front of "women and men"	Changed.
20	4	page 2 line 22: REcommended change to LGBTQ+, Here and thorughout the report. The Center for Women Veterans uses LGBTQ+, as does the VA now. This is important inclusive language that the VA adopted in the Summer, and we would like to continue that here. If this study is not inclusive of transgender Veterans, there will need to be an explanation of why please. Otherwise, let's change this throughout to LGBTQ+ so that this Rapid Review reflects the intentional inclusivity of CWV and VA.	We did not exclude literature among gender minority Veterans but instead did not locate any prevalence estimates in this population. The studies we did find provided prevalence data among sexual minorities only (individuals self-identifying as lesbian, gay, or bisexual), and hence we felt it was more appropriate to use LGB because the available evidence provides no information on prevalence among transgender or queer/questioning Veterans (or Veterans with other sexual and/or gender minority identities).
21	4	page 3 line 49: Because transgender Veterans in particular are missing from this report, CWV would like the addition of a recommendation that identifies the need for inclusion of transgender Veterans in particular please.	Thank you for this suggestion, which has been implemented.

Comment #	Reviewer #	Comment	Author Response
22	4	page 4 line 50: Change from "survey" to "study." The language in the bill is "study."	Corrected.
23	4	page 6 line 30: Throughout the document I changed the numbers so that all numbers under 10 are spelled out. From "1" to "one."	ESP style conventions are to spell out numbers only when a number begins a sentence.
24	4	page 6 line 41: Change from "female" to "women."	Corrected.
25	4	page 7 line 33, 38: Change to LGBTQ+	See response to comment 20.
26	4	page 7 line 40: "2" to "two"	See response to comment 23.
27	4	page 10 line 5: "1" to "one"	See response to comment 23.
28	4	page 10 line 11: "2" to "two"	See response to comment 23.
29	4	page 10 line 16: "1" to "one"	See response to comment 23.
30	4	page 10 line 58: "3" to "three"	See response to comment 23.
31	4	page 14 line 17: "1" to "one"	See response to comment 23.
32	4	page 14 line 24: "2" to "two"	See response to comment 23.
33	4	page 14 line 25: "1" to "one"	See response to comment 23.
34	4	page 14 line 33: "3" to "three"	See response to comment 23.
35	4	page 14 line 34: "1" to "one"; "5" to "five"	See response to comment 23.
36	4	page 14 line 45: Change to LGBTQ+-identifying	See response to comment 20.
37	4	page 14 line 46: Change to LGBTQ+	See response to comment 20.
38	4	page 14 line 58: "2" to "two"	See response to comment 23.
39	4	page 15 line 4: "1" to "one"; "6" to "six"	See response to comment 23.
40	4	page 15 line 35: "1" to "one"	See response to comment 23.
41	4	page 15 line 37: "8" to "eight"	See response to comment 23.
42	4	page 15 line 39: "3" to "three"; "6"to "six"	See response to comment 23.
43	4	page 15 line 49: Change to LGBTQ+	See response to comment 20.
44	4	page 15 line 50: Change to LGBTQ+	See response to comment 20.
45	4	page 16 line 21: "2" to "two"	See response to comment 23.
46	4	page 16 line 40: "1" to "one"	See response to comment 23.
47	4	page 16 line 43: "8" to "eight"	See response to comment 23.
48	4	page 16 line 46: "6" to "six"	See response to comment 23.

Comment #	Reviewer #	Comment	Author Response
49	4	page 16 line 47: "3" to "three"	See response to comment 23.
50	4	page 16 line 54: Change to LGBTQ+	See response to comment 20.
51	4	page 16 line 56: Change to LGBTQ+	See response to comment 20.
52	4	page 17 line 42: "3" to "three"; "6"to "six"	See response to comment 23.
53	4	page 17 line 47: "1" to "one"	See response to comment 23.
54	4	page 17 line 53: Change to LGBTQ+	See response to comment 20.
55	4	page 17 line 55: Change to LGBTQ+	See response to comment 20.
56	4	page 18 line 34: "2" to "two"	See response to comment 23.
57	4	page 18 line 41: "3" to "three"	See response to comment 23.
58	4	page 18 line 46: "2" to "two"	See response to comment 23.
59	4	page 18 line 58: "1" to "one"	See response to comment 23.
60	4	page 19 line 18: "2" to "two"	See response to comment 23.
61	4	page 19 line 26: 1 to "one"	See response to comment 23.
62	4	page 20 line 28: Change to LGBTQ+	See response to comment 20.
63	4	page 21 line 36: Out of curiousity, did you examine how race and culture could impact the way a person responds to or answers the questions? Could the surveys/questions contain race/cultural bias that affect outcomes for individuals of different races and ethnicities?	This is a valuable question and research area. However, it may be best examined in primary research rather than a systematic review. We have acknowledged this possibility in the context of the next comment.
64	4	page 22 line 8: Consider a recommendation: identify assessment tools that are culturally appropriate and take into consideration race, ethnicity, gender and sexual identify (LGBTQ+ status).	Thank you for this comment; we have incorporated this suggestion.
65	6	As you will see in comments left in the report, Center for Women Veterans, and VA, uses LGBTQ+, not LGB when referencing the LGBTQ+ community, as it is a more inclusive phrase. CWV has used this for over a year, and VA has since July, 2021. We are requesting that this report align with CWV and VA language. This report, by using simply LGB limits the population, which may be perceived as excluding transgender Veterans and those who identify as Queer and beyond	See response to comment 20.

Comment #	Reviewer #	Comment	Author Response
		(identified by the + sign. In the report you have written a category of "Veterans of any Gender Identify," but this is insufficient in identifying that researchers were inclusive of transgender Veterans. I did notice that the librarian pulled a couple of papers on transgender Veterans, and I am aware that there are likely a paucity of of data sources related to transgender Veterans and IPV/SA. However, it is important that we state the attempts and identify this as a limitation and a a need for further research in the future please.	
66	7	The authors should be commended for a rigorously conducted systematic review focused on IPV/SA prevalence in a Veteran population that is well-synthesized and presented. My specific comments/concerns are as follows:	None.
67	7	1. While the authors well-describe their search methods, and investigated a number of different platforms (e.g., MEDLINE, CINAHL, AHRQ), I wondered why they did not search PsycInfo (or other psychology or social science databases); often IPV papers are published outside of the medical literature so I worry that they may have missed some key articles.	Thank you for this important observation; it is true that our search focused on databases indexing health, psychiatric, trauma, and public health literatures, and therefore may have missed research on IPV/SA published in psychological journals. However, because our interest was chiefly in epidemiological (prevalence) research – and not literature on predictors or outcomes of IPV/SA – it is likely that most relevant literature was captured by our search. Nevertheless, we have added a note to this effect in the Limitations.
68	7	2. The Executive Summary does not well-represent their overarching findings and conclusions and should be revised (e.g., there are differences in experiences of IPV/SA between women and men, and this difference is not reflected and should be).	We respectfully disagree that the Executive Summary does not well-represent findings and conclusions. We agree that there are observed differences in prevalence by gender identity, which are noted in Table ES1, however methodological and strength of evidence variation and differences in the amount of available evidence by gender complicate this picture.
69	7	3. Though the audience for this piece may implicitly understand, the background does not clarify why prevalence of IPV/SA might be important to study in Veterans in particular. In fact, the findings (greater percentage of women versus men with histories of IPV/SA, predominance of psychological abuse, etc) largely parallel what is found over and over in civilian	Thank you for this comment. The focus of the review was to synthesize evidence on IPV prevalence among Veterans, and not to compare prevalence, predictors/explanatory factors, or outcomes of IPV to civilians. As a rapid review, we focus the background information on a general overview of the issue and the reason(s) why the review was requested.

Comment #	Reviewer #	Comment	Author Response
		populations. There is no mention or reference to the huge body of literature examining IPV/SA prevalence in civilian populations and why (or whether) the authors expect rates to be different in Veterans.	
70	7	4. In addition to the above comment, the authors only very generally touch on what is fairly well-known differences in men and women's use of violence (e.g., men are more likely to use more severe violence and sexual violence, women often use violence in self-defense and yet the current measure do not allow for this contextual understanding). Some of this background context (which is well-described in the literature) is important background and context. Similarly, there is little justification for why they would look at sub-populations (including what is known currently in the literature).	See response to comment 69.
71	7	5. Methodologically, the biggest area of concern and confusion was the inclusion of the systematic review(s) and meta-analysis. First, the degree to which these articles are included (and why and how they are included) differs by section. On p. 10, the authors refer to 1 systematic review (and no meta-analyses) meeting inclusion criteria; in other sections, they refer to a meta-analysis and a systematic review and I believe in other sections two systematic reviews. Also, I am not used to seeing systematic reviews and meta-analyses being pulled into another systematic review in this way. Typically, I would expect that the existing reviews might be used to look for primary studies to be included in the current review. It is unclear to me the degree to which the authors just pulled in what others have published versus going back to the included studies and conducting their own analyses. This needs to be significantly clarified throughout the manuscript.	Thank you for this comment. As a rapid review, we do not duplicate recent, relevant, and high-quality systematic reviews. When the scope of a rapid review includes a research question addressed by one or more duplicative reviews, we summarize findings of the existing review(s). We have clarified in the Synthesis section that we conducted meta-analyses on experienced IPV prevalence, while the meta-analyses on perpetrated IPV were conducted by Kwan et al. and simply summarized by us.
72	7	6. On p. 14, lines 56-61 (and into the next page), I wonder if there is an error. The authors state that any lifetime IPV/SA for Veteran men was 12.6% but then report that past-year prevalence was 36.7%. These numbers do not make sense (pretty much always	See response to comment 2.

Comment #	Reviewer #	Comment	Author Response
		lifetime prevalence is higher than past year prevalence).	
73	7	7. Figures may be an efficient way to demonstrate their prevalence findings (more effective than the text alone).	Thank you for this suggestion. While we generally agree, given the many subsets of type and form of IPV, we felt a figure or set of figures presenting findings would be overly complex.
74	8	If there's any sense of the potential overlap and/or additional value of the other systematic reviews that were found to be underway, it would be helpful to note that. Very much appreciate ESP's work here under a rapid review mechanism.	Thank you for this comment. The information we were able to access on underway reviews is limited, therefore we cannot speak more to their content or methods. It is likely there will be some overlap, but this will largely depend on the timeline of those reviews, which is not clear from their registry information.
75	8	Page 6, Key Findings: bullet 1 (Veteran women and men, not Veterans women and men). 3rd bullet “perpetrated among Veteran men” is confusing and sounds like IPV among Veteran men vs. “by” – would recommend changing “among” to “by” for clarity.	Thank you for these suggestions, which have been implemented.
76	8	Lines 50-51, the present review was not about informing future VA research per se. Instead, it was requested in response to a Congressional mandate. While I can understand that you may not want to be that blunt here, I would focus this line on “to assess the impact of IPV/SA in the Veteran population and among Veteran partners” or some such since that was the purpose of the review going into our discussions with ESP. It may inform research as a side benefit but I think it may be problematic to make it sound like that was the primary purpose.	Thank you for this suggestion, which has been implemented.
77	8	Page 7, line 22, should probably spell out LGB on 1st use.	LGB is defined at first use (in the Synthesis section, page 7).
78	8	Page 8, bullet on line 30, am not familiar with the HARK tool and suspect other readers may not be either. Spelling out 1st use (unless it’s someone’s last name) and adding a link to a citation or resource would be helpful here. I am similarly not familiar with “planned missingness designs” so a citation or link to a resource would be helpful here as well (line 47).	Thank you for these suggestions. HARK is defined at first use in the main text, but we have included its definition in the Executive Summary as well. Based on other comments, we have removed the suggestion of planned missing designs.

Comment #	Reviewer #	Comment	Author Response
79	8	Page 9, line 14, so the challenge here is that the legislation indicates that a study must be done, and VA Central Office decided against that being primary data collection. And technically, research will not be funding the work but instead operations, which means we are doing evaluation work since operations funds cannot be used for research. It may be better to say that "Findings from this Evidence Brief will be used to respond to activities required by section 5305…" Of particular importance is the need for edits to lines 49-50 – the legislation does not specify a "baseline survey" but instead a "baseline study" – this is important because VA Central Office decided to interpret that as doing a bunch of secondary analyses of existing data as being responsive. No new primary data collection is being done. I have double checked the language in section 5305, and it does indeed say "baseline study" so if you could please make that change here, that would be important and helpful.	Thank you for these suggestions, which have been implemented.
80	8	Page 14, figure 1, was the large # of excluded papers (n=767) because they were papers of IPV/SA-only studies? I re-read the section on eligibility and exclusion a couple of times, and that is all I could glean and I could imagine readers wondering the same thing. I noted that the Literature Overview came after figure 1, so I thought at first that it may contain insights into the large exclusion group, but it focuses on included articles, so nothing in that section solves the issue I raise here. Just want to make sure it is clear to readers why such a large number of studies were exited out of the review.	See response to comment 15.
81	8	Table 1 is tremendous! Results are clearly written and important contributions. Really appreciated the methodological recommendations as well.	None.

APPENDIX E: RESEARCH IN PROGRESS

Status	Study Title	Study Design	Information Resources
In progress	A systematic review of the prevalence of intimate partner violence victimisation among military personnel	Systematic Review	CRD42016038800
In progress	Prevalence of intimate partner violence (IPV) victimization and perpetration in military and veteran populations: A systematic review of population-based studies.	Systematic Review	CRD42020199214
In progress	Risk factors associated with Intimate Partner Violence (IPV) perpetration in military populations.	Systematic Review	CRD42014010307

REFERENCES

1. Gierisch JM, Shapiro A, Grant NN, King HA, McDuffie JR, Williams JW. Intimate partner violence: Prevalence among U.S. military Veterans and active duty servicemembers and a review of intervention approaches. *Department of Veterans Affairs VA Evidence based Synthesis Program Reports.* 2013;08:08.
2. Kwan J, Sparrow K, Facer-Irwin E, Thandi G, Fear NT, MacManus D. Prevalence of intimate partner violence perpetration among military populations: A systematic review and meta-analysis. *Aggression & Violent Behavior.* 2020;53:101419.
3. Bartlett BA, Iverson KM, Mitchell KS. Intimate partner violence and disordered eating among male and female veterans. *Psychiatry Research.* 2018;260:98-104.
4. Bennett DC, Thomas EJ, Porter KE, Broman RB, Rauch SAM, Sexton MB. Context Matters: Posttraumatic Stress Disorder Symptom Associations With Military Sexual Trauma Event Characteristics and Dual Histories of Interpersonal Trauma. *Violence & Victims.* 2019;34(1):69-84.
5. Brignone E, Sorrentino AE, Roberts CB, Dichter ME. Suicidal ideation and behaviors among women veterans with recent exposure to intimate partner violence. *General Hospital Psychiatry.* 2018;55:60-64.
6. Campbell R, Raja S. The sexual assault and secondary victimization of female veterans: Help-seeking experiences with military and civilian social systems. *Psychology of Women Quarterly.* 2005;29(1):97-106.
7. Campbell R, Greeson MR, Bybee D, Raja S. 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 & Clinical Psychology.* 2008;76(2):194-207.
8. Caralis P, Musialowski R. Women's experiences with domestic violence and their attitudes and expectations regarding medical care of abuse victims. *South Med J.* 1997;90(11):1075-1080.
9. Cerulli C, Stephens B, Bossarte R. Examining the Intersection Between Suicidal Behaviors and Intimate Partner Violence Among a Sample of Males Receiving Services From the Veterans Health Administration. *American Journal of Mens Health.* 2014;8(5):440-443.
10. Cerulli C, Bossarte RM, Dichter ME. Exploring intimate partner violence status among male veterans and associated health outcomes. *American Journal of Mens Health.* 2014;8(1):66-73.
11. Combellick JL, Dziura J, Portnoy GA, Mattocks KM, Brandt CA, Haskell SG. Trauma and Sexual Risk: Do Men and Women Veterans Differ? *Womens Health Issues.* 2019;29 Suppl 1:S74-S82.
12. Coyle BS, Wolan DL, Van Horn AS. The prevalence of physical and sexual abuse in women veterans seeking care at a Veterans Affairs Medical Center. *Military Medicine.* 1996;161(10):588-593.
13. Creech SK, Macdonald A, Taft C. Use and Experience of Recent Intimate Partner Violence Among Women Veterans Who Deployed to Iraq and Afghanistan. *Partner Abuse.* 2017;8(3):251-271.
14. Creech SK, Pulverman CS, Kroll-Desrosiers A, Kinney R, Dichter ME, Mattocks K. Intimate Partner Violence Among Pregnant Veterans: Prevalence, Associated Mental

Health Conditions, and Health Care Utilization. *Journal of General Internal Medicine.* 2021;19:19.
15. Dardis CM, Shipherd JC, Iverson KM. Intimate partner violence among women veterans by sexual orientation. *Women & Health.* 2017;57(7):775-791.
16. Dichter ME, Cerulli C, Bossarte RM. Intimate partner violence victimization among women veterans and associated heart health risks. *Womens Health Issues.* 2011;21(4 Suppl):S190-194.
17. Dichter ME, Marcus SC, Wagner C, Bonomi AE. Associations Between Psychological, Physical, and Sexual Intimate Partner Violence and Health Outcomes Among Women Veteran VA Patients. *Social Work in Mental Health.* 2014;12(5/6):411-428.
18. Dichter ME, Wagner C, True G. Timing of Intimate Partner Violence in Relationship to Military Service Among Women Veterans. *Military Medicine.* 2015;180(11):1124-1127.
19. Dichter ME, Wagner C, Borrero S, Broyles L, Montgomery AE. Intimate partner violence, unhealthy alcohol use, and housing instability among women veterans in the Veterans Health Administration. *Psychological Services.* 2017;14(2):246-249.
20. Dobie DJ, Kivlahan DR, Maynard C, Bush KR, Davis TM, Bradley KA. Posttraumatic stress disorder in female veterans: association with self-reported health problems and functional impairment. *Archives of Internal Medicine.* 2004;164(4):394-400.
21. Dutra L, de Blank G, Scheiderer E, Taft C. Correlates of female Veterans' perpetration of relationship aggression. *Psychol Trauma.* 2012;4(3):323-329.
22. Gondolf EW, Foster RA. Wife assault among VA alcohol rehabilitation patients. *Hospital & Community Psychiatry.* 1991;42(1):74-79.
23. Huston JC, Grillo AR, Iverson KM, Mitchell KS, System VABH. Associations between disordered eating and intimate partner violence mediated by depression and posttraumatic stress disorder symptoms in a female veteran sample. *General Hospital Psychiatry.* 2019;58:77-82.
24. Iverson KM, King MW, Resick PA, Gerber MR, Kimerling R, Vogt D. Clinical utility of an intimate partner violence screening tool for female VHA patients. *Journal of General Internal Medicine.* 2013;28(10):1288-1293.
25. Iverson KM, King MW, Gerber MR, et al. Accuracy of an intimate partner violence screening tool for female VHA patients: a replication and extension. *Journal of Traumatic Stress.* 2015;28(1):79-82.
26. Iverson KM, Pogoda TK. Traumatic brain injury among women veterans: an invisible wound of intimate partner violence. *Medical Care.* 2015;53(4 Suppl 1):S112-119.
27. Iverson K, Vogt D, Maskin RM, & Smith, BN. Intimate partner violence victimization and associated implications for health and functioning among male and female post-9/11 Veterans. In. *Medical Care.* Vol 552017:S78-S84.
28. Iverson KM, Sayer NA, Meterko M, et al. Intimate Partner Violence Among Female OEF/OIF/OND Veterans Who Were Evaluated for Traumatic Brain Injury in the Veterans Health Administration: A Preliminary Investigation. *Journal of Interpersonal Violence.* 2020;35(13-14):2422-2445.
29. Kimerling R, Iverson K, Dichter M, et al. Prevalence of Intimate Partner Violence among Women Veterans who Utilize Veterans Health Administration Primary Care. *JGIM: Journal of General Internal Medicine.* 2016;31(8):888-894.
30. Luterek J, Bittinger J, Simpson T. Posttraumatic sequelae associated with military sexual trauma in female Veterans enrolled in VA outpatient mental health clinics. *J Trauma Dissociation.* 2011;12(3):261-274.

31. Portnoy GA, Relyea MR, Street AE, Haskell SG, Iverson KM. A Longitudinal Analysis of Women Veterans' Partner Violence Perpetration: the Roles of Interpersonal Trauma and Posttraumatic Stress Symptoms. *Journal of Family Violence.* 2020;35(4):361-372.
32. Rosenfeld EA, Miller E, Zhao X, Sileanu FE, Mor MK, Borrero S. Male partner reproductive coercion among women veterans. *American Journal of Obstetrics & Gynecology.* 2018;218(2):239.e231-239.e238.
33. Sadler A, Booth B, Cook B, Doebbeling BN. Factors associated with women's risk of rape in the military environment. *Am J Ind Med.* 2003;43(3):262-273.
34. Savarese VW, Suvak MK, King LA, King DW. Relationships among alcohol use, hyperarousal, and marital abuse and violence in Vietnam veterans. *Journal of Traumatic Stress.* 2001;14(4):717-732.