



# Intimate Partner Violence and the Training of Healthcare Providers

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## Background

Intimate partner violence (IPV) is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other [1]. Reproductive coercion (RC) and sexual coercion (SC) are forms of abuse that intersect with IPV. They involve behaviors aimed to maintain power and control in a relationship related to reproductive health (i.e., birth control sabotage, pressuring someone to become pregnant or to terminate a pregnancy) or related to types of sexual violence, such as rape, threatening to end a relationship if a person does not have sex, intentionally exposing a partner to a STI or HIV, or retaliation by a partner if notified of a positive STD result [1].

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The prevalence of intimate partner violence (IPV), reproductive coercion, and sexual coercion in the USA is astonishingly high. According to Breiding et al., approximately 1 in 4 women have been physically and/or sexually assaulted by a current or former partner [2].

A substantial body of research has previously described the impact of IPV on women's health. IPV can most visibly lead to direct injury or death, or cause emotional and psychological distress. However, the impact of IPV is far more wide reaching. IPV has been associated with adverse obstetrical health outcomes, such as poor pregnancy, weight gain, chronic anemia, tobacco use, stillbirth, pelvic fracture, placental abruption, fetal injury, preterm delivery, and low birth weight [3–6].

In a systematic review of the impact of IPV on sexual health, IPV was consistently associated with sexual risk taking, inconsistent condom use, partner nonmonogamy, unplanned pregnancies, induced abortions, STIs, and sexual dysfunction [7]. In fact, in a study from Australia, IPV was found to be responsible for 7.9% of the overall disease burden for women aged 18–44; this is a larger risk factor for disease than elevated blood pressure, tobacco use, or obesity [8]. IPV costs the US economy \$12.6 billion dollars on an annual basis from hospitalizations, ED visits, and indirect costs to healthcare [9].

Given these staggering impacts on the individual IPV survivor, as well as society as a whole, the silent epidemic of intimate partner violence is being recognized as a public health crisis. As such, a public health framework for addressing IPV means that this is not just an issue for a specific “silo”—law enforcement, healthcare system, community service organizations, social services. Rather, every specialist and nonspecialist that may potentially come in contact with an IPV survivor should at least have a basic understanding of how to look for it, how to address it, and how to effectively communicate among partners in this work.

Obstetricians and gynecologists are in a unique position to screen and to provide support for women who experience IPV, due to the nature of the patient-physician relationship and the opportunities for intervention that occur during the course of pregnancy,

family planning, annual gynecological exams, and other women's health visits. However, according to LaPlante et al. [10], while 100% of OB/GYN residents surveyed felt prepared to counsel patients on smoking, diet, and exercise, only 9% felt prepared to counsel on IPV. Moreover, less than half felt prepared to ask their patients about reproductive coercion or contraceptive sabotage, give a referral, or call a hotline with a patient [11].

What is preventing providers from effectively addressing IPV? There are many barriers that have been identified:

- Comfort levels with initiating conversations with patients about IPV
- Feelings of frustration with patients when they do not follow a plan of care
- Not knowing what to do about positive disclosures of abuse
- Worry about mandatory reporting
- Lack of time

There are several ways to address these barriers:

1. Using tools like safety cards: Safety cards, such as the one available at Futures Without Violence, are easy-to-carry cards designed by IPV experts that can be used to facilitate screening. The safety card, titled, "Is your relationship affecting your health?," shifts the focus of screening from just checking off boxes as a part of taking the social history, to the reason why talking about healthy relationships matter, and why it should come from a healthcare provider. In addition, safety cards contain the number for a 24-hour hotline, and even if the patient is not currently experiencing IPV, extra cards can be given to be shared with patients' family and friends, thereby normalizing screening and empowering patients.
2. Simplifying the idea of reporting and documenting: most states do *not* mandate that you report intimate partner violence against a competent adult over the age of 18. The one exception to this would be if an act of violence occurred with deadly weapons, including firearms, knives, or burn injuries. A provider should document the response given to screening,

interventions used, and plans for follow-up, as one would for any issue that arises during an office visit.

3. Knowing the basics of risk reduction strategies: Even though healthcare providers may not be experts in IPV, understanding the basic concepts behind risk reduction strategies can be helpful. These include forming safety plans specific to the patient's situation, recommending discrete methods of contraception, providing the office phone (so that it can't be traced) to contact local community resources, and even providing blank envelopes to conceal emergency contraceptive pills.
4. "Warm referrals" to social work: Providers should not stop at an order in EMR; go a step further to characterize the IPV situation as thoroughly as possible for the social worker, as one would for consulting any expert. This ensures that the transition from the provider's care in the office to resources in the community.

Providers need easily accessible training materials to learn about the above elements so that addressing IPV is demystified. Futures Without Violence is one place to start, where providers can order as many safety cards as they need and can access numerous helpful guides.

SAIF (Screen-Assess-Intervene-Follow Up) is a workshop built on the backbone of Futures Without Violence safety cards, in order to break down the barriers as described above. In the following sections, the contents of the SAIF curriculum will be described, followed by discussion of effective strategies of training students and healthcare providers in an interactive classroom setting.

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## **SAIF Curriculum Content**

The Screen-Assess-Intervene-Follow Up (SAIF) curriculum to address intimate partner violence is a project developed by healthcare providers in training, for healthcare providers in training (resident physicians and medical students). In particular, it was created with obstetricians and gynecologists in mind. However, this can be broadly applied to anyone who works with potential

IPV survivors. The curriculum is at most 2 hours in length, and does not require specialized pre-training in IPV for the organizer or leader in order to be meaningful.

The learning objectives are:

- Understand the scope of the problem for intimate partner violence (IPV), reproductive coercion, and sexual coercion.
- Understand the health impacts of IPV.
- Identify barriers to managing IPV and address them.
- Learn to screen, assess, intervene, and follow up on IPV

After 30–40 minutes of discussing the scope of the problem and the barriers to care in addressing intimate partner violence, the SAIF curriculum breaks down the daunting and sensitive task of addressing IPV into discrete and practical parts that are easy to remember. Much of the content is based on a second edition of the guide, *Addressing Intimate Partner Violence, Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic and Reproductive Health Care Settings* by Dr. Linda Chamberlain and Rebecca Levenson at Futures Without Violence [12], but has been rearranged for a workshop format. The core contents of the workshop are shared in the following sections.

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## Screen

### Framing Statements

The first step of screening is hardest to take. Providers may feel awkward asking probing questions about their patient’s relationship and current and/or past history of physical, emotional, or sexual trauma. One way to circumvent this is to use the language of *healthy relationships*: “I want to ask you questions about your relationship because your relationship can really affect your health.”

Statements such as “I ask all my patients these questions about healthy and safe relationships because it can have such a large impact on your health” can also normalize the conversation and

clearly demonstrate that this is an important health topic to address during a visit to the healthcare provider.

## **Limits of Confidentiality**

When addressing an issue as sensitive as IPV, it's important to reassure the patient at the start of the encounter that everything discussed is confidential. However, there are situations in which the provider is mandated to report, such as abuse of a minor, or injury with a firearm, knife, other deadly weapons, and burns. Mandated reporting criteria may differ slightly from state to state.

These limits of confidentiality should be addressed at the beginning of the clinical encounter, because if a patient discloses an event that requires reporting and the provider follows through with mandated report without first informing them of the limits of confidentiality, it may extinguish any hope of a therapeutic alliance. Survivors of IPV are in a relationship where there is an unequal power dynamic, and their agency may be taken away from them. If the provider takes steps to report against the wishes of the survivor, agency is further eroded away and there cannot be a therapeutic alliance.

## **Screening Questions**

It can be jarring and uncomfortable to jump into a screening question for intimate partner violence during the clinical encounter. Often this part of the history is in the midst of questions on substance use and sexual history which further creates an atmosphere of an inquisition of sorts. To alleviate these challenges, one can utilize the safety card as a simple information handout like any other found in the clinic, paired with the phrase, "we like to give everyone these cards" to normalize the screening process.

The title of the safety card is "Is your relationship affecting your health?" The content of the card goes on further to ask, "Is my partner or the person I am seeing kind to me and respectful of

my choice? Is my partner willing to talk openly when there are problems? Does my partner give me space to spend time with other people?" On the next side, attributes of unhealthy relationships are described: "Are there times my partner or the person I'm seeing shames or humiliates me, makes me feel bad about myself, or controls where I go and how I spend my money? Ever hurts or scares me with their words or actions? Makes me have sex when I don't want to? Keeps me from seeing my doctor or taking my medications?" [12].

These questions can start a conversation about what a healthy or an unhealthy relationship looks like. Although at first glance the concept of a respectful, healthy relationship may seem obvious, the healthcare provider may in fact be the first person to be talking about healthy relationships in such explicit manner. This act itself can be an intervention.

There are numerous other tools that have been used in IPV screening. Many, like the safety card, purposely ask broad questions regarding an intimate relationship, while others focus on specific actions. An example of a screening tool that asks pointed questions is HITS (Hurt, Insult, Threaten, and Scream):

- How often does your partner physically *Hurt* you?
- How often does your partner *Insult* or talk down to you?
- How often does your partner *Threaten* you with physical harm?
- How often does your partner *Scream* or curse at you?

Each question is answered in a 5-point scale (1 = never, 2 = rarely, 3 = sometimes, 4 = fairly often, 5 = frequently). In previous research, a HITS cut off score 10 or greater was used to classify participants as "victimized" [13, 14]. The downside of this tool is that it may be too narrowly focused on physical forms of IPV and neglects to screen for sexual or reproductive coercion.

The advantage of such directed survey tools is that they could also be utilized in paper format in the waiting room—similar to PHQ2 for depression screening. Given concerns about who could be accompanying the patient in the waiting room, there are different methods (such as color-coded stickers) to signal a positive screen in a clandestine manner.

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## How Often, When, Where

Following guidelines from the American College of Obstetricians and Gynecologists (ACOG), every patient should be screened at least annually, and in particular in the following kinds of visits:

- Obstetrical visits
  - First prenatal visits
  - At least once per trimester
  - Postpartum visits
- Gynecologic visits
  - Annual visits
  - Sexually transmitted illnesses screening visits
  - Repeat pregnancy test requests
  - Family planning visits

Because violence can escalate or be unmasked during pregnancy (as a particularly vulnerable situation for a patient), there should be repeat screenings at least once per trimester even if the initial screen on a new OB visit is negative.

Lastly, it's important to note the physical space in which the screening takes place. Patients must be screened in private, without family members or friends present, even if the patient appears to give permission for them to stay in the room. It goes without saying that if translation is required, family members or friends cannot be used to translate.

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## Assess

It's important to have an idea of how to initially respond, even if there appears to be dismissal or resistance from the patient, and move the conversation forward. Being prepared with this step—the initial assessment—can allow providers to also be more comfortable with screening in the first place.

Different types of IPV may be disclosed (physical or emotional abuse, sexual coercion, reproductive coercion), and



oftentimes more than one form of IPV is occurring concurrently. Characterization of IPV is therefore essential to address the issue holistically.

### **Negative Response (Does Not Endorse IPV Situation)**

A negative response to screening is still an opportunity to raise awareness and to empower the patient to reach out to friends and family who may be experiencing IPV. Patients can keep the safety card that was used to start the conversation and pass it along to someone they want to reach out to. Using this framework of helping others also normalizes the conversation about healthy relationships.

### **Unclear Response**

At times, a patient may not disclose an IPV relationship, but something may feel “off.” It’s important to convey to the patient that the provider’s door is open for future conversations. The goal of screening is not to force a disclosure, but to start the conversation. Like in a negative response, safety cards should be handed out so that patients can learn about the harmful effects of IPV and risk-reduction strategies without needing to disclose.

The safety card also contains the number for the National Domestic Violence Hotline, available 24/7 (1-800-799-SAFE), as well as a crisis text line (text “START” to 741741) where trained counselors are available. Such methods can be another way for the survivor to seek assistance in safety planning, resources, and support at a time of their own choosing.

### **Positive Response**

The very first and foremost step when faced with a positive disclosure is to simply pause and *believe*. At first glance, the concept may seem too obvious or simple. Countless stories of IPV survivors

share a commonality in not being believed, which further makes disclosures difficult, for the fear of not being believed. Survivors encounter dismissive attitudes from people who are supposedly there to help them—including healthcare providers—who may consciously or subconsciously shift to victim blaming, even before a word is uttered by a survivor. Implicit biases and society's concept of what a "good victim" should look like—meek, innocent, waiting to be rescued—color one's perceptions, and when an IPV survivor does not seem to fit this picture, it is easy to be dismissive, even in part, or in subtle body language.

Therefore, it is of critical importance to acknowledge and to truly *hear* a positive disclosure, to explicitly express, "I believe you. I am here to support you without judgment." It's important to be comfortable with giving pause, and not rushing into the next steps to check off boxes or to call social work in a haste attempt to take a challenging case off of one's hands. Only with a careful, nonjudgmental, and validating stance, can one allow the door that's beginning to crack open to stay open.

The next steps are to characterize the IPV. If the nature of IPV that is disclosed is physical violence, there should be an assessment of immediate safety. The following questions must be asked:

- "Are you in immediate danger?"
- "Is your partner at the health facility now?"
- "Do you want to (or have to) go home with your partner?"
- "Do you have somewhere safe to go?"
- "Has the violence gotten worse or is it getting scarier? Is it happening more often?"

Through this initial assessment, necessary steps can be taken for the patient's immediate safety. Every clinic or hospital should have policies and plans in place to be able to escort the patient through an alternate route if the patient does not want to leave the clinic with the partner.

These series of questions should be followed by questions to assess the pattern of abuse:

- "How long has the violence been going on?"
- "Have you ever been hospitalized because of the abuse?"
- "Can you tell me about your most serious event?"

IPV is often not a one-time event. It is a pattern of abuse, and as such, once the immediate situation is discussed, the full history of the IPV relationship should also be explored.

Lastly, there are specific questions that should be asked regarding reproductive and sexual coercion:

- “Does your partner support you in using birth control?”
- “Does your partner ever refuse to use condoms when you ask?”
- “Have you ever hidden birth control from your partner?”
- “Does your partner support your decisions about if or when you want to have (more) children?”
- “Has your partner told you they would leave you if you didn’t get pregnant?”
- “Has your partner told you they would have a baby with someone else if you didn’t get pregnant?”
- “Does your partner force you to have sex when you don’t want to?”
- “Are you afraid your partner would hurt you if you told them that you had an STI and they needed to be treated too?”

When discussing sexual coercion, it should be noted that patients may not respond to the use of the term “rape” because of the perception that perpetrators of rape are strangers, and not an intimate partner. More general terms such as “forced sex” or “sex when you don’t want to” may be more appropriate.

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## Intervene

Once the provider has assessed the situation, there are basic interventions that can be done in partnership with the clinic, hospital, or community resources and a social worker to help navigate those resources.

Many of these interventions are “risk reduction strategies,” that is, actions that can be taken to decrease the chance of physical harm, and discrete methods of contraception for those experiencing reproductive coercion.

## Safety Planning

A safety plan is a set of actions that can help lower the risk of physical harm from the abusive partner. The plans should be tailored to the survivor's individual situation, and be made for home, school, work place, or other locations that the survivor may frequent.

A sample safety plan may contain the following elements:

- Safety at home
  - Cash, extra keys, important documents
  - Escape plans
  - Who to call and where to go in a volatile situation
- Safety at work/public place
  - A copy of an order of protection
  - Knowledge by building security
- Safety plan involving children
  - Code words for calling 911 or escaping
  - Authorized persons to pick up from day-care
- Technology and safety
  - Don't forget phone bills
  - Use public computers (library, internet café, etc.)

Ideally, an expert in IPV should be conducting safety planning with the patient face-to-face. If this is not an option, there is a mobile application called myPlan. This app not only has elements similar to the safety card—screening questionnaire, assessment tool, educational resources on healthy relationships—but also a self-guided tool to craft a personalized safety plan. The app is pin-protected, and can masquerade as a different app at the touch of a button.

What follows are four risk reduction tips highlighted in the SAIF curriculum.

Risk reduction tip #1:

- Offer use of a private phone in clinic so that the survivor can make the call to an advocacy program without the number being traced by their partner.

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Risk reduction tip #2: Sexually transmitted infection (STI) notification.

- Disclosing a positive STI result can escalate violence in a volatile IPV relationship. Instead of asking the patient to disclose the positive result, the provider can offer to have the health department call the partner anonymously, saying that someone the partner has slept with in the past year has (name of STI) and the partner needs to be treated.

Risk reduction tip #3: The IUD

- Some controlling partners may monitor bleeding patterns and menstrual cycles.
- The safest option may be the copper T IUD (Paragard) as it does not change their cycles.
- Consider cutting strings short in the cervical canal so that the device can't be detected by partner.
- Difficult IUD removal is preferable to an IPV situation becoming more dangerous.

Risk reduction tip #4: Emergency contraception

- Emergency contraception (EC) comes in a large box with bold lettering and can easily be discovered.
- Consider strategies such as giving them an envelope so that remove the EC from package and conceal it.

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## Follow-Up

At least one follow-up appointment (or referral) with a healthcare provider, social worker, or IPV advocate should be offered after disclosure. An important aspect of setting up a follow-up appointment is that many clinics or hospital systems have automated reminder calls regarding upcoming appointments, which may not be safe to leave as a voicemail on a survivor's phone. Therefore, it

is critical that the patient's phone numbers are reviewed while the patient is with the provider to ensure that it is a safe number to call or leave a message. Similarly, automated letters to home addresses must not be overlooked. The following clarifying questions are suggested:

- “Is there a number or address that is safe to use to contact you?”
- “Are there days or hours when we can reach you alone?”
- “Is it safe for us to make an appointment reminder call?”

When the patient returns to the office, review the medical record. Let the patient know that you are still concerned for their health and safety and ask the following questions:

- “Have you sought counseling, a support group or other assistance?”
- “Has there been any escalation in the severity or frequency of the abuse?”
- “Have you developed or used a safety plan?”
- “Have you informed any family or friends about the abuse?”
- “Have you talked with your children about the abuse and what to do to stay safe?”

## **Documentation**

In most states, there are no specific requirements for documentation of a clinic encounter related to IPV. Take note of the mandatory reporting rules of your state.

Routinely, the following should be documented:

- Confirmation that the patient was screened for IPV and reproductive/sexual coercion
- Patient response to screening
- Documentation of resources provided (such as safety cards)
- Any referrals provided

## SAIF Curriculum Design and Implementation

As discussed thus far, the content of the SAIF curriculum focuses on the practical steps, and the integration of a specific tool—the safety card—to address IPV. As such, the content presented in the previous section is not something that can be effectively conveyed via a handout or a dry PowerPoint presentation. There are seven key elements to the curriculum to increase its meaningfulness and utility.

1. Flipped classroom methods: The concept of flipped classroom has taken off in recent years, predominantly in undergraduate medical education. In the flipped classroom approach, there are pre-class materials such as articles or videos that the participants should review prior to the workshop. The first few minutes of the workshop quickly review these basic materials, so that the rest of the session can focus on discussions and hands-on activities that build on the basics. SAIF incorporates audience response systems to review basic concepts within the first few minutes. This way, the speaker can also gauge how prepared and knowledgeable the participants are. The concepts polled were:
  - (a) Have you ever met a patient experiencing IPV?
  - (b) Definition of IPV
  - (c) Health impacts of IPV
  - (d) Prevalence of IPV
  - (e) Impact of speaking to patients about IPV
2. Hands-on practice with Safety Cards and role-playing: Becoming familiar with the Futures Without Violence Safety Cards is at the crux of the SAIF workshop. As such, almost 10 minutes are spent on pairing up and taking turns going through the cards, practicing screening, framing statements, risk reduction strategies outlined on the cards, and the hotline.
3. Video of an example clinical encounter versus actor: Woven into role playing exercise is a video of a clinical encounter

using the safety card, available from Futures Without Violence. The participants have an opportunity to compare how they use the safety cards with another provider interacting with a standardized patient. Group discussions take place with critiques of the video.

4. Group discussions: Throughout the workshop, there are opportunities for the participants to share about their previous experiences with survivors of IPV, to voice the barriers they have faced and possible solutions.
5. Protected time: If the participants are medical residents (also called “house staff”), finding a block of time in their workday is exceedingly difficult. Any resident didactics or formalized training sessions run into the same issue, but for a topic as sensitive as IPV, such a workshop cannot be rushed, truncated, or interrupted. There should be break time built into the workshop so that participants can take a physical and emotional break from the subject. Other IPV training curriculums are often whole days or at least half days with multiple breaks and exercises built in to support the emotional wellbeing of their participants.
6. Location-specific hospital/community resources: Not knowing about what services are available at the hospital or community level is a significant barrier in itself. Thus, it is incredibly valuable to invite guest speakers from local community resources or hospital social work departments. Not only are their insights enriching to the conversation, the relationship-building that occurs through the workshop means that participants are now aware of their allies on a personal level, and therefore are able to refer their patients with confidence.
7. Pre-/post-surveys: Subjective and objective measurements must be made to validate the workshop, to continue to improve the educational experience based on feedback, and use the data collected to demonstrate the need for long-term sustainability of the workshop. Subjective measurements often involve surveying the participants through pre-/post-surveys.
  - (a) Ideally, obtaining a pre-workshop survey ahead of time would allow the speaker or workshop leader to have a sense of the backgrounds of the participants, but if that is



not feasible, administering the pre-workshop survey at the start of the workshop would be needed. The SAIF workshop then administered a post-workshop survey within 1 week of the workshop to gather changes in knowledge, opinions, self-reported behaviors, and feedback regarding the workshop. Six months later, another post-workshop survey was conducted, this time focused more on self-reported behaviors and experiences in the months following the workshop.

- (b) In addition, objective measurements of the impact of the workshop include number of patients screened, number of interventions offered, volume of referrals, and the change in patient experience as a result of a healthcare provider more attuned to this issue. While it is more challenging to collect such data, these objective measurements are often more illuminating and impactful to observe than subjective measurements from surveys of workshop participants.

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## Evaluation of the Workshop

Curriculum evaluation is an integral part of the training. As mentioned above, in order to assess the impact of this curriculum on the competence and comfort that providers have with IVP, SAIF workshop utilized pre-/post-workshop surveys. Fortunately, there are pre-existing, validated surveys, such as the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS), a 15-minute survey developed by the CDC and other experts in the field [15].

PREMIS comprehensively and reliably measures physician readiness to manage IPV, and has been validated (Cronbachs  $\alpha \geq 0.65$ ). It is broken down into four sections:

1. Background (3 questions)

- (a) Previous IPV training?
- (b) How prepared do you feel in managing IPV?
- (c) How much do you think you know about IPV?

2. Factual knowledge (8 questions)
3. Opinions and attitudes (27 questions)
4. Practical issues, i.e., resources available in clinic (13 questions)

The PREMIS should be administered as a pre-test prior to the start of the workshop. After the curriculum, the same PREMIS can be administered and collected as an immediate post-test. Three to six months after the curriculum, PREMIS can be re-administered for long-term follow-up. In order to allow for Wilcoxon signed-rank test, each participant should be self-assigned with an anonymous study ID which should remain consistent through the three surveys.

The immediate post-testing can be expanded with an acceptability survey to gather feedback. Potential questions to include are:

- Overall satisfaction
- Satisfaction with training materials/didactics
- Satisfaction with time allotted
- Would the participant recommend the curriculum to another provider
- Free text for comments

PREMIS is not a perfect tool. There are terminologies that are outdated (such as the word “batterer”) and many will find its length to be prohibitively long. For these reasons, SAIF curriculum modified PREMIS to choose questions that were felt to be most meaningful, while retaining the overarching structure of background, knowledge, opinions/attitudes, and practical issues.

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## Conclusion

The public health crisis of intimate partner violence requires a public health approach of multidisciplinary, concerted efforts to address IPV. Like any other public health issue, only when we address intimate partner violence together—and not in isolated silos—can we truly make an impact.

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