Intimate partner violence affects 15–71% of women over their lifetime, resulting in significant stress, negative health effects, and negative economic effects. Features include physical and sexual abuse as well as psychological abuse and controlling behaviors such as reproductive coercion or stalking. Intimate partner violence can occur in both heterosexual and same-sex relationships, though the risk may be higher in lesbian, gay, bisexual, transgender, queer, or questioning couples. Pregnancy remains an especially risky time for escalating abuse and also provides a window of opportunity for screening and intervention. Victims experience many consequences of abuse, including physical injuries, traumatic brain injury, and chronic conditions such as headaches, insomnia, pelvic pain, depression, anxiety, and posttraumatic stress disorder. Homicide is an especially devastating consequence, with 40–45% of female victims killed by an intimate partner, and homicide remains an important cause of pregnancy-related death. Routine screening is recommended by the American College of Obstetricians and Gynecologists and the U.S. Preventive Services Task Force, and obstetrician–gynecologists (ob-gyns) should remain vigilant for signs of abuse in their patients. Often the cycle of abuse makes it difficult for women to break free, and ob-gyns should continue to provide supportive care regardless of a woman’s readiness to leave an abusive relationship.

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Intimate Partner Violence—Overall Definition

Intimate partner violence includes physical violence, sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner).

Physical Violence
Includes intentional use of physical force with the potential to cause death, disability, injury or harm. May include: hitting, pushing, punching, scratching, choking, shaking, burning, use of weapon(s) or restraints.

Sexual Violence
Includes any of the following acts, whether attempted or completed, and without the victim’s freely given consent, including cases in which the victim is unable to consent as a result of being too intoxicated through voluntary or involuntary use of alcohol or drugs:

1. Rape or penetration of victim—use of physical force to cause a person to engage in a sexual act against their will, includes forced or alcohol and drug-facilitated unwanted vaginal, oral, or anal insertion. Force includes both physical force and threats of force.
2. Victim was made to penetrate someone else—made to sexually penetrate a perpetrator or someone else without the victim’s consent.
3. Nonphysically pressured unwanted penetration—includes verbal pressure, intimidation, or misuse of authority to cause the victim to consent or acquiesce to being penetrated.
4. Unwanted sexual contact—includes intentional touching of the victim or making the victim touch the perpetrator either directly or through the clothing, on the genitalia, anus, groin, breast, inner thigh, or buttocks without the victim’s consent.
5. Noncontact unwanted sexual experiences—unwanted sexual experiences that are not of a physical nature that occur without a victim’s consent. Includes unwanted exposure to sexual situations (e.g., pornography), verbal or behavioral sexual harassment, threats of sexual violence to accomplish some other end, including unwanted filming, taking, or disseminating photographs of a sexual nature of another person.

Stalking
Includes a pattern of repeated unwanted attention and contact that causes concern for one’s own safety or the safety of someone else, including repeated unwanted phone calls, emails, or texts; leaving cards, flowers, letters, or other items when the victim does not want them; watching or following from a distance; spying; approaching or showing up in places where the victim does not want to see them; sneaking into the victim’s home or car; damaging the victim’s personal property; harming or threatening the victim’s pets; and making threats to physically harm the victim.

Psychological Aggression
The use of verbal and nonverbal communication with the intent to harm another person mentally or emotionally, and to exert control over another person. May include expressive aggression (name-calling, humiliating), coercive control (limiting access to transportation, money, friends and family; excessive monitoring of whereabouts), threats of physical or sexual violence, control of reproductive or sexual health (refusal to use birth control, coerced pregnancy termination), exploitation of victim’s vulnerability (immigration status, disability), exploitation of perpetrator’s vulnerability, and presenting false information to the victim with the intent of making them doubt their own memory or perception (mind games).

ADVERSE HEALTH EFFECTS

Victims of IPV may experience physical injuries related to battering, presenting with acute injuries, traumatic brain injury (TBI) (disrupted brain function resulting from a blow or jolt to the head), or unintended pregnancy or chronic conditions, such as headaches, insomnia, pelvic pain, sexual dysfunction, irritable bowel symptoms, depression, anxiety, and posttraumatic stress disorder (PTSD). Acute injuries are often seen in the emergency department, with patients presenting with injuries to the head, face, abdomen, and extremities, and can consist of scratches, contusions, lacerations, joint dislocations, bone fractures, strangulation, and head injuries.
Traumatic brain injuries result in altered or diminished consciousness, with impaired cognitive function and potential long-term impairment. Sometimes victims will present with accounts of how the injury occurred that are inconsistent with the injury pattern, or they may present in a delayed fashion or with multiple injuries in various stages of healing. Victims of IPV can also present with fear of or excessive distress during vaginal examinations, particularly if they are victims of sexual abuse. Another red flag concerning for abuse is an overly solicitous partner who can be threatening, intimidating, or controlling and may refuse to leave the patient unattended.

As many as 75% of women who experienced IPV had at least one partner-related TBI, and 50% had multiple partner-related TBIs. The TBI experienced by victims of abuse may also be more severe owing to the chronicity of the trauma and exacerbation by anoxia or hypoxia from strangulation, which may be unrecognized and untreated. A recent study demonstrated an association between partner-related TBI severity and alterations in memory and learning on functional magnetic resonance imaging. In a recent case–control study, women with IPV and probable TBI were more likely to have central nervous system symptoms (headaches, memory loss, blacking out, tinnitus, dizzy spells, seizures, vision and hearing problems, and difficulty concentrating) than women without IPV. In addition to acute care for traumatic injuries, women should be asked about dizziness, seeing stars or spots, disorientation, loss of consciousness, blacking out, and memory loss surrounding an incident.

Episodes of strangulation are indicative of severe abuse, and strangulation is a harbinger of escalating violence and potential homicide. Previous studies have demonstrated that nonfatal strangulation was reported in 45% of attempted homicides and 43% of homicides. In women experiencing a prior strangulation episode, there was a sixfold increased risk of experiencing attempted homicide in the future (odds ratio 6.7, 95% CI 3.9–11.49) and a sevenfold increased risk of homicide in the future (odds ratio 7.48, 95% CI 4.53–12.35). Strangulation is defined as pressure around the neck with enough force to block respiration or blood flow, more commonly with manual pressure from hands than with a ligature such as a cord or rope. Suffocation results from lack of oxygen due to obstruction of the upper airway or smothering. Often victims of strangulation will describe being “choked” or “choking.” Symptoms of

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**Box 2. Risk Factors for Intimate Partner Violence**

**Individual Risk Factors**
- Younger age
- Short-term relationships
- Intellectual disability
- Chronic mental illness
- Limited education
- Low income or socioeconomic status
- Indigenous status
- Drug and alcohol use disorder

**Relationship Risk Factors**
- Separated relationship status
- Marital disagreements
- Poor parenting practices
- Poor or disparate educational levels
- Negative attitudes toward women
- History of child abuse or witnessing IPV as a child
- Having other sexual partners

**Community Risk Factors**
- High levels of crime, poverty and unemployment
- Low social cohesion
- Lack of opportunities
- Lack of social services for IPV victims

**Social Risk Factors**
- Gender inequality
- Devaluation of women
- Cultural acceptance of IPV
- Social or religious support of IPV
- Laws against divorce

**IPV, intimate partner violence.**

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strangulation include breathing changes (dyspnea, hyperventilation, or asthma exacerbations) (85%), sore throat (60–70%), voice changes (50%), and difficulty swallowing. Victims may also have headaches, dizziness, blurry vision, and loss of bowel or bladder control. Long-term risks of strangulation include carotid artery dissection, hemorrhagic and ischemic stroke, and pulmonary edema, with increasing risks with multiple episodes of strangulation.23

Victims of IPV are also more likely to experience somatization, with clinical presentations of internalized stress. Somatization can lead to physical symptoms such as chronic pain as well as other anxiety disorders, substance use disorder, and suicide. Often, survivors of IPV can manifest avoidance behaviors or extreme anxiety associated with pelvic examinations. Studies have also shown that women with a lifetime history of IPV have increased rates of self-reported poor health, emotional distress, suicidal thoughts, and suicide attempts.24 Victims of IPV are at increased risk for mental health disorders including depression, anxiety, and PTSD.14 Posttraumatic stress disorder occurs in 31–84% of IPV survivors and is increased in settings with perceived lack of support.25 In a recent systematic review of IPV and suicidality, the authors found a strong and consistent association between IPV and suicidality.26

Intimate partner violence can also exert negative health effects on the family, with children experiencing physical, psychological, and social effects related to exposure to violence. It is estimated that up to 10 million children witness IPV each year in the United States,27 and these children may be more likely to continue the intergenerational cycle of violence as adults (either as perpetrators or victims). Childhood exposure to IPV has been linked with increased violent behavior and adjustment problems, including internalizing (depression and anxiety) and externalizing problems (delinquency and violence perpetration).28 The effects of witnessing violence are complex and may have a dose–response relationship, with children witnessing multiple episodes of IPV and multiple episodes of abuse more likely to experience adverse effects.27 Additionally, maternal posttraumatic stress reactions can further adversely affect their children.29 Expanding current knowledge on the effects of IPV within families will allow for improved assessments and treatments aimed at breaking the intergenerational cycle of violence.

Intimate partner violence remains a significant risk factor for homicide, with intimate partners committing 14% of all homicides in the United States in 2007.30 Women are killed by intimate partners at twice the rate of men, with 40–45% of female homicide victims killed by an intimate partner.30 From 2001 through 2012, 6,410 women were murdered in the United States by an intimate partner using a firearm, and women are at increased risk of homicide when abusers have access to firearms.31 Women are most at risk for homicide after separation or after leaving a violent relationship, and homicide remains a leading cause of pregnancy-associated death, particularly in postpartum teenagers and women experiencing abuse during pregnancy.32

PREGNANCY

Pregnancy may be an especially risky time for victims of IPV, with the potential for escalating severity and frequency of violence.17 The prevalence of IPV in pregnancy is estimated to be between 4% and 20%,17,33 and has been associated with adverse effects, including miscarriage, bleeding, preterm birth, low birth weight, stillbirth, neonatal death, substance use disorder, depression, and somatic disorders.34,35 Pregnancy is an opportune time for assessment and intervention owing to regularly scheduled appointments and a woman’s heightened concern for her unborn child. Regular screening is recommended in pregnancy—at the initial prenatal visit, at least once per trimester, and at the postpartum visit.14 Repeated screening in pregnancy is associated with higher prevalence rates and increased opportunities for interventions, and screening in pregnancy is effective at increasing identification of IPV.36

Intimate partner violence effects in pregnancy include direct physical attacks that can result in fetal injuries or placental abruption, preterm labor, and prelabor rupture of membranes. Common injuries in pregnancy include those to the breasts, abdomen and uterus; maternal injuries can also include abdominal organs such as the liver and spleen, pelvic fractures, and retroperitoneal hematomas. Abdominal trauma during late pregnancy is more likely to directly injure the uterus and fetus or cause a placental abruption owing to the expansion of the uterus into the maternal abdomen after the 12th week. Psychological abuse and intimidation and sexual abuse can also be seen in pregnancy, and abusive partners may use force and intimidation to control access to health care, medications, nutrition, and financial resources, resulting in some abused women presenting late for prenatal care. Intimate partner violence may also increase postpartum, with a recent study demonstrating an increase in IPV postpartum, with increased stress and depression.37

Studies assessing the effects of different interventions in pregnancy have produced mixed results, with some evidence that counseling interventions may be more effective than resource cards, no evidence that counseling was superior to standard care, and limited evidence that mentoring was superior to counseling.36 However, there
were a small number of good-quality studies on which to base these conclusions. Supported referrals may also be helpful, with the health care provider or social worker calling a shelter or IPV program for the patient or having the patient call from the clinic. This can increase the chances of patients following through with referrals and provide them additional support and comfort.4

SPECIAL POPULATIONS

Intimate partner violence may also be increased in lesbian, gay, bisexual, transgender, queer, or questioning couples, with sexual minority respondents reporting rates of IPV at least as high as those in heterosexual couples. The risk may be highest in bisexual women (61%) compared with lesbian women (44%) and heterosexual women (35%), as reported in the 2010 National Intimate Partner and Sexual Violence Survey.38 Rates of some form of sexual violence were also higher in bisexual and lesbian women than in heterosexual women, with 46% of bisexual women and 13% of lesbian women reporting rape in their lifetime.38 Bisexual women were also more likely to experience rape at an earlier age (11–17 years) and to experience stalking compared with heterosexual women.38 It is important to ensure that IPV prevention programs reach out to and support victims regardless of sexual orientation and ensure access to culturally sensitive services.

Adolescent girls are at increased risk for dating violence, which increases their risk of alcohol and drug use disorder, sexually transmitted infection, early sexual intercourse, multiple partners, unintended pregnancies, depression, suicidal ideation, and adult IPV victimization.39 Adolescent women reporting IPV are also more likely to be engaging in risky behaviors and less likely to have healthy behaviors.40 Between 10 and 20% of college students experience sexual assault, and 7% of women in the U.S. 2010–2012 National Intimate Partner and Sexual Violence Survey were victims of IPV before the age of 18.5 Experiencing IPV is more common in undergraduate sexual minorities and negatively affects performance, including grade point average and perceived academic difficulties.41

Rates of IPV in the military and in veteran populations may be affected by unique stressors such as deployments, separations, and relocations, as well as stressors related to combat. Additionally, the positive effects of universal health care and social support services within the Military Healthcare System and Veterans Health Administration must also be considered. A recent systematic review and meta-analysis reports a prevalence of lifetime IPV of 25.4–85.9% and a past-year IPV prevalence of 12–25% in military populations, both higher than the rates found in civilian population studies (37% lifetime IPV and 6.6% current IPV).42 However, in the largest study of pregnant women in the Military Healthcare System, the rates of abuse were not increased, with lifetime abuse reported by 14.5% of women and current abuse reported by 1.5%.43 In studies evaluating female veterans, past-year IPV rates in range from 8.7% to 18.5%43–46 and are associated with increased mental health morbidity47,48 and high rates of health care utilization.49

Other groups with increased rates of violence include immigrants, who may also face language barriers and fears about deportation. Women with disabilities and developmental delays are also at risk owing to reliance on their partners and families for care, as are elderly women, who are often abused by partners or adult children.50

ROLE OF OBSTETRICIAN–GYNECOLOGISTS

As women’s health care practitioners, obstetrician–gynecologists are in a unique position to identify, support, and treat women in abusive relationships. It is recommended that health care providers screen women for abuse at periodic intervals, including at routine annual examinations, during pregnancy, and at new-patient visits. Physician responsibilities are outlined in Box 3 and include screening and identification of IPV, documentation and reporting (if required by state law), and supportive assessment of the patient’s readiness to leave the relationship.17 Physicians should also assess the immediate safety of the patient and any children, help her establish a safety plan, and provide referrals and resources. Often victims of IPV are fearful or not yet ready to leave an abusive relationship. Ongoing compassionate care and support are important to help patients work toward leaving their abusers.

The American College of Obstetricians and Gynecologists recommends that the routine assessment process include screening in a private setting away from the patient’s partner, family, and friends.17,50 Normalizing statements should be used at the beginning of the assessment to reinforce that screening is part of routine practice, with professional interpreters used as needed. Health care providers should discuss limits of confidentiality before screening or assessments, including information about any mandatory reporting requirements and reporting requirements for minors exposed to or witnessing violence. Additional information is available at https://www.acf.hhs.gov/sites/default/files/fysb/state_compendium.pdf. All staff should be trained regularly to identify and care for victims of IPV, and offices should keep take-home safety and resource information in offices and in private areas such as
Box 3. The Physician’s Responsibility in Addressing Intimate Partner Violence and Domestic Violence

- Implement universal screening
- Acknowledge the trauma
- Assess immediate safety of patient and children
- Help establish a safety plan
- Review options
- Offer educational materials and a list of community and local resources (including toll-free hotline)
- Provide referrals
- Document interactions
- Provide ongoing support at subsequent visits

Box 4. Protocols for a Routine Intimate Partner Violence Assessment

- Screen for IPV in a private and safe setting with the woman alone and not with her partner, friends, family, or caregiver.
- Use professional language interpreters and not someone associated with the patient.
- At the beginning of the assessment, offer a framing statement to show that screening is done universally and not because IPV is suspected. Also, inform patients of the confidentiality of the discussion and exactly what state law mandates that a physician must disclose.
- Incorporate screening for IPV into the routine medical history by integrating questions into intake forms so that all patients are screened whether or not abuse is suspected.
- Establish and maintain relationships with community resources for women affected by IPV.
- Keep printed take-home resource materials such as safety procedures, hotline numbers, and referral information in privately accessible areas such as restrooms and examination rooms. Posters and other educational materials displayed in the office also can be helpful.
- Ensure staff receives training about IPV and that training is regularly offered.

Intimate Partner Violence

It is important to remember that IPV can occur in any patient; thus, screening is recommended at routine appointments, and regular screening is recommended in pregnancy. Screening for IPV identifies women with a lifetime history of violence and also those currently in abusive relationships, with the goal being to support and refer victims to social services and other interventions to improve outcomes. Intimate partner violence is a complex social relationship rather than a disease process; therefore, some of the classic screening criteria do not directly apply. Screening is recommended by the U.S. Preventive Services Task Force as well as the American College of Obstetricians and Gynecologists, the Association of Women’s Health, Obstetricians and Neonatal Nurses, the American Medical Association, the American Academy of Family Physicians, and the Agency for Healthcare Research and Quality. Before 2013, the U.S. Preventive Services Task Force did not recommend screening for IPV owing to a lack of effective screening instruments and a lack of evidence that screening improved outcomes. Current guidance from the U.S. Preventive Services Task Force recommends that clinicians screen for IPV in reproductive-aged women and refer women who screen positive to support services with a grade of B (high certainty that the net benefit is moderate or that there is moderate certainty that the net benefit is moderate to substantial). These recommendations are based on the evidence that screening instruments can identify abused women and that there is evidence of benefit when abused women are referred for ongoing support services, with overall small risk of harm due to screening and intervention for IPV. The U.S. Preventive Services Task Force notes that, although screening identifies abused women, the published trials do not show reductions in violence or improved quality of life over 3–18 months and that counseling and home visitation programs reduced violence in pregnant and postpartum women.

A recent large randomized controlled trial evaluated the effects of screening compared with no screening and found reduced IPV recurrence, PTSD, and alcohol problems and improved quality of life and mental health in both screened and nonscreened women, though all women received information on local resources for abused women. For women who screen positive, counseling interventions reduced IPV, improved birth outcomes, and reduced pregnancy coercion. Generally, studies indicate low levels of harm from IPV screening and that women may prefer self-completed screening over face-to-face screening. Available screening tools with high diagnostic accuracy are shown in Table 1. Health care providers should screen with framing statements that acknowledge the effects of abuse on women’s...
health and that screening is routine. Health care providers should address privacy and confidentiality and disclose any mandatory reporting requirements. Example screening questions are include: “Do you feel safe in your current relationship?”; “Has your current partner ever threatened you or made you feel afraid? (Threatened to hurt you or your children if you did or did not do something, controlled who you talked to or where you went, or gone into rages?)”; and “Has your partner ever hit, choked, or physically hurt you? (Hurt includes being hit, slapped, kicked, bitten, pushed, or shoved).” The components of effective ongoing support services recommended by the U.S. Preventive Services Task Force are shown in “Box. Components of Effective Ongoing Support Services for Intimate Partner Violence” by Curry et al (Available at: http://dx.doi.org/10.1001/jama.2018.14741).53

Barriers to screening include the health care provider’s personal discomfort with discussing IPV; concern for misdiagnosis; lack of knowledge, education, or training; time constraints; lack of knowledge of referral options; and lack of protocols.62 Health care providers may have attitudes that create barriers, including fears of offending patients or disrupting their relationship with the patient and fear of the partner’s reaction and creating stress.62 Effective interven-

| Table 1. Screening Tools52,59–61 |
|-----------------|---|---|---|---|---|---|
| **Tool** | **Sensitivity** | **Specificity** | **PPV** | **NPV** | **Scale** | **Scoring** | **Description** |
| AAS | 93 | 55–99 | 33 | 97 | 5-items, dichotomous | 0–5 points | 5-item clinician administered, assesses sexual coercion, lifetime abuse, current abuse, abuse during pregnancy |
| HARK* | 81 | 95 |  |  | 4-items, dichotomous | 0–4 points | 4-item self-report survey, adapted from AAS |
| HITS* | 86–96 | 91–99 |  |  | 4-items, 5-point Likert | 4–20 points | 4-item self-report or clinician administered, assess frequency of IPV, excludes sexual abuse |
| E-HITS* |  |  |  |  |  |  | E-HITS includes additional item assessing frequency of sexual violence |
| OVAT | 86–93 | 83–86 | 75 | 97 | 4 items, dichotomous | 0–4 points | 4-item self-report, assesses ongoing physical and emotional IPV, excludes sexual abuse |
| PVS* | 49–71 | 80–94 | 47 | 94 | 3-items | Positive if any positive response | 3-item clinician administered, assesses physical and nonphysical violence and current safety, excludes sexual abuse |
| STaT | 80–96 | 75–92 |  |  | 3 items, dichotomous | 0–3 points | 3-Item clinician administered, excludes sexual abuse. Improved sensitivity and specificity if 2 items positive |
| WAST* | 47–89 | 89–96 | 55 | 94 | 8 items, 3-point Likert | Positive if “a lot of tension” or “great difficulty” | 8-item self-report instrument, assesses tension, arguments, physical violence, emotional and sexual abuse |

PPV, positive predictive value; NPV, negative predictive value; AAS, Abuse Assessment Screen; HARK, Humiliation, Afraid, Rape, Kick instrument; HITS, Hurt, Insult, Threaten, Scream; E-HITS, Extended HITS; OVAT, Ongoing Violence Assessment Tool; PVS, Partner Violence Screen; STaT, Slapped, Threatened, and Throw; WAST, Women Abuse Screening Tool; IPV, intimate partner violence.

Data are %.

* Rated as accurately detecting IPV in the past year among adult women by the U.S. Preventive Services Task Force.52
for victims of IPV. All 50 states require reporting of child abuse; however, state laws vary regarding reporting requirements for IPV. Most states require reporting of specific injuries and wounds. Some states require reporting of injuries caused by weapons such as firearms, knives, or other sharp objects or injuries resulting from criminal activity or general violence. Additional information is available at http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Compendium%20Final.pdf.

Mandatory reporting of IPV is controversial. Laws requiring reporting of IPV are aimed at identifying and protecting victims; however, this may place victims in danger of retaliation or increased abuse. Mandatory reporting also supersedes a women’s autonomy and could negatively affect the patient–physician relationship and decrease disclosure of abuse by patients. In states with mandatory reporting, patients should be provided information about requirements for mandatory reporting and limitations on confidentiality. Generally, state laws provide immunity from civil or criminal liability for filing reports of abuse if completed in good faith.

MANAGEMENT AND INTERVENTIONS

Current U.S. Preventive Services Task Force recommendations on screening for intimate partner violence state that women who screen positive should be referred to intervention services. Current evidence supports various interventions, including counseling, resource cards (an example is available from the National Domestic Violence Hotline at http://www.thenationalhotline.org/wp-content/uploads/sites/3/2015/05/Hotline-personalsafetyplan.pdf), home visitation, and referral to community services and mentoring. More comprehensive interventions involving support services with empowerment, home visitation, mentoring, and counseling are more effective in reducing violence, abuse, and harm to women.

When a patient acknowledges abuse, physician responsibilities include: 1) providing support and validation—listen without judgment, affirm that she is not to blame and that help is available; 2) provide information on the effects of abuse on her health and risks of escalating abuse; 3) assess immediate safety—review safety planning, inquire about safety of any children and presence of weapons in the home, and assess risk of suicide a homicide; 4) refer to local advocacy and support services, including the National Domestic Violence Hotline: (800) 799-SAFE, TTY (800) 787-3224; 5) report to law enforcement or social services agencies—know state requirements and laws regarding reporting (if mandatory reporting is required in your state, ensure familiarity with the laws and requirements). Partners and families can face significant consequences if children are taken (“abducted”) across international borders, because the Hague Convention allows the “left-behind” parent legal recourse, even if this parent is abusive. Patients in these situations should seek legal counsel and assistance. If patients disclose past abuse, provide support and offer referral to support services or advocacy services as needed. Should a patient deny abuse but concern remains, respect her response and let her know you are available if things should change; reassess for abuse at regular intervals and provide ongoing support. Additional resources are available in Box 5.

The trauma-informed approach to counseling and care increases health care providers’ awareness and understanding of how trauma affects victim’s lives and provides support while minimizing retraumatization in a safe environment. The focus of trauma-informed care is on resiliency, coping skills, building on individual strengths, listening to victims’ choices, and restoring power and control in victims’ lives. One of the main goals is to guide victims to understand that they have a choice in how they respond to situations and can choose when to leave an abusive relationship.

Continuing to provide

Box 5. Support and Resources

National Coalition Against Domestic Violence
http://www.ncadv.org
Online tool for creating a safety plan

National Domestic Violence Hotline
1-800-799-SAFE
TTY 1-800-787-3224
http://www.ndvh.org
Help with safety planning and crisis interventions
Text-trained counselors
www.crisistextline.org
Text “START” to 741741

Futures Without Violence
http://www.futureswithoutviolence.org
Posters, brochures, safety planning cards

National Health Resource Center on Domestic Violence
Supports health care providers improve responses to intimate partner violence; offers free, culturally competent materials appropriate for a variety of settings
www.endabuse.org/health
888-Rx-ABUSE (888-792-2837) Mon–Fri, 9 am–5 pm PST
TTY 800-595-4889
email: health@endabuse.org

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support and access to resources in a nonjudgmental fashion is also important, and, even if interventions do not reduce IPV victimization, awareness of resources and increased ability to seek safety is important.68

DISCUSSION

In conclusion, IPV is an important problem in women’s health. Continued vigilance and support of our patients and their families is the first step in addressing this epidemic. Obstetrician–gynecologists have the knowledge and the tools to make a difference. As women’s health practitioners, we are uniquely equipped to hear our patient’s stories and guide them on their journey of healing. We should always remember that, “It takes courage to change your life. Day in and day out, over and over, you have to decide to take the small brave steps that change your future.”69

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Implement an effective screening and intervention strategy for journal-based CME activity

Describe the spectrum of intimate partner violence


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In accordance with the College policy, all faculty and planning committee members have signed a conflict of interest statement in which they have disclosed any financial interests or other relationships with industry relative to article topics. Such disclosures allow the participant to evaluate better the objectivity of the information presented in the articles.

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Disclosure of Faculty and Planning Committee

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