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WOMEN'S HEALTH CARE PHYSICIANS

# COMMITTEE OPINION

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## Committee on Health Care for Underserved Women

*This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.*

## Intimate Partner Violence

**ABSTRACT:** Intimate partner violence (IPV) is a significant yet preventable public health problem that affects millions of women regardless of age, economic status, race, religion, ethnicity, sexual orientation, or educational background. Individuals who are subjected to IPV may have lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and even death. Although women of all ages may experience IPV, it is most prevalent among women of reproductive age and contributes to gynecologic disorders, pregnancy complications, unintended pregnancy, and sexually transmitted infections, including human immunodeficiency virus (HIV). Obstetrician–gynecologists are in a unique position to assess and provide support for women who experience IPV because of the nature of the patient–physician relationship and the many opportunities for intervention that occur during the course of pregnancy, family planning, annual examinations, and other women’s health visits. The U.S. Department of Health and Human Services has recommended that IPV screening and counseling should be a core part of women’s preventive health visits. Physicians should screen all women for IPV at periodic intervals, including during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup), offer ongoing support, and review available prevention and referral options. Resources are available in many communities to assist women who experience IPV.

Intimate partner violence (IPV) is a pattern of assaultive behavior and coercive behavior that may include physical injury, psychologic abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and reproductive coercion (1). These types of behavior are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and is aimed at establishing control of one partner over the other (1). It can occur among heterosexual or same-sex couples and can be experienced by both men and women in every community regardless of age, economic status, race, religion, ethnicity, sexual orientation, or educational background. Individuals who are subjected to IPV may have lifelong consequences, including emotional trauma, lasting physical impairment, chronic health problems, and even death.

More than one in three women in the United States have experienced rape, physical violence, or stalking by an intimate partner in their lifetime (2). In the United States, women experience 4.8 million incidents of physical or sexual assault annually (3). However, the true prevalence of IPV is unknown because many victims are afraid to disclose their personal experiences of violence. Intimate

partner violence caused 2,340 deaths in 2007; of this number, 1,640 were female and 700 were male (4).

### Patterns of Intimate Partner Violence

Intimate partner violence encompasses subjection of a partner to physical abuse, psychologic abuse, sexual violence, and reproductive coercion. Physical abuse can include throwing objects, pushing, kicking, biting, slapping, strangling, hitting, beating, threatening with any form of weapon, or using a weapon. Psychologic abuse erodes a woman’s sense of self-worth and can include harassment; verbal abuse such as name calling, degradation, and blaming; threats; stalking; and isolation. Often, the abuser progressively isolates the woman from family and friends and may deprive her of food, money, transportation, and access to health care (5). Sexual violence includes a continuum of sexual activity that covers unwanted kissing, touching, or fondling; sexual coercion; and rape (6). Reproductive coercion involves behavior used to maintain power and control in a relationship related to reproductive health and can occur in the absence of physical or sexual violence. A partner may sabotage efforts at contraception, refuse to practice safe sex, intentionally

expose a partner to a sexually transmitted infection (STI) or human immunodeficiency virus (HIV), control the outcome of a pregnancy (by forcing the woman to continue the pregnancy or to have an abortion or to injure her in a way to cause a miscarriage), forbid sterilization, or control access to other reproductive health services (1).

Approximately 20% of women seeking care in family planning clinics who had a history of abuse also experienced pregnancy coercion and 15% reported birth control sabotage (7). In addition to unintended pregnancy risk, there are also risks specific to partner notification of an STI, which should be taken into account especially when considering expedited partner treatment. Women experiencing physical or sexual IPV are more likely to be afraid to notify their partners of an STI. In a study with a culturally diverse sample of women seeking care at family planning clinics, clients exposed to IPV were more likely to have partners who responded to partner notification by saying that the STI was not from them or accusing her of cheating (8). Some women reported threats of harm or actual harm in response to notifying their partners of an STI (9). Expedited partner therapy is only recommended after a health care provider has assessed for and confirmed that there is no risk of IPV associated with partner notification. It is also not intended for child abuse, sexual assault, or any situation where there is a question of safety.

## **Consequences of Intimate Partner Violence**

Some women subjected to IPV present with acute injuries to the head, face, breasts, abdomen, genitalia, or reproductive system, whereas others have nonacute presentations of abuse such as reports of chronic headaches, sleep and appetite disturbances, palpitations, chronic pelvic pain, urinary frequency or urgency, irritable bowel syndrome, sexual dysfunction, abdominal symptoms, and recurrent vaginal infections. These nonacute symptoms often represent clinical manifestations of internalized stress (ie, somatization). This stress can lead to post-traumatic stress disorder, which is often associated with depression, anxiety disorders, substance abuse, and suicide. Research confirms the long-term physical and psychologic consequences of ongoing or past violence (10).

Approximately 324,000 pregnant women are abused each year in the United States (11). Although more research is needed, IPV has been associated with poor pregnancy weight gain, infection, anemia, tobacco use, stillbirth, pelvic fracture, placental abruption, fetal injury, preterm delivery, and low birth weight (11–14). In addition, the severity of violence may sometimes escalate during pregnancy or the postpartum period (15, 16). Homicide has been reported as a leading cause of maternal mortality, with the majority perpetrated by a current or former intimate partner (14). High rates of birth

control sabotage and pregnancy pressure and coercion in abusive relationships are correlated with unintended pregnancies (1, 7).

The societal and economic effects of IPV are profound. Approximately one quarter of a million hospital visits occur as a result of IPV annually (17). The cost of intimate partner rape, physical assault, and stalking totals more than \$8.3 billion each year for direct medical and mental health care services and lost productivity from paid work and household chores (17, 18). Additional medical costs are associated with ongoing treatment of alcoholism, attempted suicide, mental health symptoms, pregnancy, and pediatric-related problems associated with concomitant child abuse and witnessing abuse. Intangible costs include women's decreased quality of life, undiagnosed depression, and lowered self-esteem. Destruction of the family unit often results in loss of financial stability or lack of economic resources for independent living, leading to increased populations of homeless women and children (19). Efforts to control health care costs should focus on early detection and prevention of IPV (18).

## **Special Populations**

### **Adolescents**

Approximately one out of ten female high-school students in the United States reported experiencing physical violence from their dating partners in the previous year (20). Of those who reported ever having had sexual intercourse, one out of five girls experienced dating violence. These girls were also more likely to have experienced pregnancy and STIs, including HIV, and to report tobacco use and mental health problems, including suicide attempts (20). It is important for adolescents to be aware of behavior that aims to maintain power and control in a relationship such as monitoring cell phone usage, digital dating abuse (including posting nude pictures against her will, stalking her through social networks, and humiliating her through social networks), telling a partner what to wear, controlling whether the partner goes to school that day, as well as manipulating contraceptive use (1). Early recognition is critical in this population because adolescent violence can be associated with partner violence in adult life.

### **Immigrant Women**

Women from different backgrounds may have different perceptions about IPV and need culturally relevant care that is sensitive to language barriers, acculturation, accessibility issues, and racism. Immigrant women may be hesitant to report IPV because of fears of deportation. It is important to increase awareness that a U Nonimmigrant Visa allows immigrants who have been subjected to substantial physical or mental abuse caused by IPV or other crimes to legally remain in the United States if it is justified on humanitarian grounds, ensures family unity, or is otherwise in the public interest (21).

## Women With Disabilities

Women with physical and developmental disabilities usually are less able to care for themselves and are more reliant on their partners or caregivers for help. This sets up a dangerous dynamic where abusers may be in a position to physically abuse their victims by withholding medication, preventing use of assistive equipment such as canes or wheelchairs, and sabotaging other personal service needs such as help with bathing, bathroom functions, or eating. Also, many violence shelters do not accept women with disabilities or are not trained to respond adequately to the needs of women with disabilities.

## Older Women

An estimated 1–2 million U.S. citizens aged 65 years or older have been injured, exploited, or mistreated by someone caring for them (22). For the obstetrician–gynecologist, the importance of elder abuse relates to the increasing number of older women in the population (23). Older women seek care for pelvic floor relaxation, sexual dysfunction, breast and reproductive tract cancer, and other problems. Elder abuse can occur in the patient’s home, the home of the caregiver, or in a residential facility in which the patient is residing. There is no typical victim of elder abuse. Elder abuse occurs in all racial, social, educational, economic, and cultural settings. Victims of elder abuse know their perpetrator 90% of the time (24). Approximately two thirds of abusers are adult children or partners (24). Abuse can be physical, sexual, and psychologic and includes neglect (refusal or failure to fulfill caregiving obligations), abandonment, and financial exploitation (illegal or improper exploitation of funds or other assets through undue influence or misuse of power of attorney). For more information go to: [http://www.acog.org/About\\_ACOG/ACOG\\_Departments/Violence\\_Against\\_Women/Elder\\_Abuse\\_\\_An\\_Introduction\\_for\\_the\\_Clinician.aspx](http://www.acog.org/About_ACOG/ACOG_Departments/Violence_Against_Women/Elder_Abuse__An_Introduction_for_the_Clinician.aspx).

## Role of Health Care Providers

The medical community can play a vital role in identifying women who are experiencing IPV and halting the cycle of abuse through screening, offering ongoing support, and reviewing available prevention and referral options. Health care providers are often the first professionals to offer care to women who are abused. The U.S. Department of Health and Human Services has endorsed the Institute of Medicine’s recommendation that IPV screening and counseling be a core part of women’s health visits (25). Adequate training and education among health care providers will provide the skills and confidence they need to work with patients, colleagues, and health care systems to combat violence and abuse (26). Obstetrician–gynecologists are in the unique position to provide assistance for women who experience IPV because of the nature of the patient–physician relationship and the many opportunities for intervention that occur during the course of annual examinations, family planning, pregnancy, and

follow-up visits for ongoing care. Screening all patients at various times is also important because some women do not disclose abuse the first time they are asked. Health care providers should screen all women for IPV at periodic intervals, such as annual examinations and new patient visits. Signs of depression, substance abuse, mental health problems, requests for repeat pregnancy tests when the patient does not wish to be pregnant, new or recurrent STIs, asking to be tested for an STI, or expressing fear when negotiating condom use with a partner should prompt an assessment for IPV. Screening for IPV during obstetric care should occur at the first prenatal visit, at least once per trimester, and at the postpartum checkup. Studies have shown that patient self-administered or computerized screenings are as effective as clinician interviewing in terms of disclosure, comfort, and time spent screening (27, 28). Screening for IPV should be done privately. Health care providers should avoid questions that use stigmatizing terms such as “abuse,” “rape,” “battered,” or “violence” (see sample questions in [Box 1](#)) and use culturally relevant language instead. They should use a strategy that does not convey judgment and one with which they are comfortable. Written protocols will facilitate the routine assessment process:

- 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 that staff receives training about IPV and that training is regularly offered.

Even if abuse is not acknowledged, simply discussing IPV in a caring manner and having educational materials readily accessible may be of tremendous help. Providing all patients with educational materials is a useful strategy that normalizes the conversation, making it acceptable for them to take the information without disclosure.

### **Box 1. Sample Intimate Partner Violence Screening Questions** ←

While providing privacy, screen for intimate partner violence during new patient visits, annual examinations, initial prenatal visits, each trimester of pregnancy, and the postpartum checkup.

#### **Framing Statement**

"We've started talking to all of our patients about safe and healthy relationships because it can have such a large impact on your health."<sup>\*</sup>

#### **Confidentiality**

"Before we get started, I want you to know that everything here is confidential, meaning that I won't talk to anyone else about what is said unless you tell me that...(insert the laws in your state about what is necessary to disclose)."<sup>\*</sup>

#### **Sample Questions**

"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)<sup>†</sup>

"Has your partner ever hit, choked, or physically hurt you?"

("Hurt" includes being hit, slapped, kicked, bitten, pushed, or shoved.)<sup>‡</sup>

*For women of reproductive age:*

"Has your partner ever forced you to do something sexually that you did not want to do, or refused your request to use condoms?"<sup>\*</sup>

"Does your partner support your decision about when or if you want to become pregnant?"<sup>\*</sup>

"Has your partner ever tampered with your birth control or tried to get you pregnant when you didn't want to be?"<sup>\*</sup>

*For women with disabilities:*

"Has your partner prevented you from using a wheelchair, cane, respirator, or other assistive device?"<sup>‡</sup>

"Has your partner refused to help you with an important personal need such as taking your medicine, getting to the bathroom, getting out of bed, bathing, getting dressed, or getting food or drink or threatened not to help you with these personal needs?"<sup>‡</sup>

<sup>\*</sup>Family Violence Prevention Fund. Reproductive health and partner violence guidelines: an integrated response to intimate partner violence and reproductive coercion. San Francisco (CA): FVPF; 2010. Available at: [http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro\\_Guide.pdf](http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro_Guide.pdf). Retrieved October 12, 2011. Modified and reprinted with permission.

<sup>†</sup>Family Violence Prevention Fund. National consensus guidelines on identifying and responding to domestic violence victimization in health care settings. San Francisco (CA): FVPF; 2004. Available at: <http://www.futureswithoutviolence.org/userfiles/file/Consensus.pdf>. Retrieved October 12, 2011. Modified and reprinted with permission.

<sup>‡</sup>Center for Research on Women with Disabilities. Development of the abuse assessment screen-disability (AAS-D). In: Violence against women with physical disabilities: final report submitted to the Centers for Disease Control and Prevention. Houston (TX): Baylor College of Medicine; 2002. p. II-1–II-16. Available at <http://www.bcm.edu/crowd/index.cfm?pmid=2137>. Retrieved October 18, 2011. Modified and reprinted with permission.

Futures Without Violence and the American College of Obstetricians and Gynecologists have developed patient education cards about IPV and reproductive coercion for adults and teens that are available in English and Spanish. For more information visit <http://fvpfstore.stores.yahoo.net/safetycards1.html>.

If the clinician ascertains that a patient is involved in a violent relationship, he or she should acknowledge the trauma and assess the immediate safety of the patient and her children while assisting the patient in the development of a safety plan. Risk factors for intimate

partner homicide include having experienced previous acts of violence, estrangement from partner, threats to life, threats with a weapon, previous nonfatal strangulation, and partner access to a gun (29). Patients should be offered information that includes community resources (mental health services, crisis hotlines, rape relief centers, shelters, legal aid, and police contact information) and appropriate referrals. Clinicians should not try to force patients to accept assistance or secretly place information in her purse or carrying case because the perpetrator may find the material and increase aggression. To assist

clinicians in responding to IPV, a local domestic violence agency is often the best resource. It is important to note that when abuse is identified, it is very useful to offer a private phone for the patient to use to call a domestic violence agency. Controlling partners often monitor cell phone call logs and Internet usage. Offering a private phone to call the National Domestic Violence hotline is a simple but important part of supporting a victim of violence. The National Domestic Violence hotline is a multilingual resource that can connect a patient to local domestic violence programs, help with safety planning, and provide support. A protocol with all the information needed to perform an IPV assessment should be kept on site. Futures Without Violence also provides educational materials, IPV assessment and safety assessment tools (including scripts for clinical assessment of IPV and reproductive coercion), and free technical assistance specifically for health care providers and settings. For more information, visit [www.futureswithoutviolence.org/section/our\\_work/health](http://www.futureswithoutviolence.org/section/our_work/health).

Reporting of the abuse of children is mandatory; however, reporting IPV, particularly mandatory reporting, is controversial. Although the intent of mandatory reporting is to identify and protect individuals before the next act of violence, the individual's safety, in fact, may be jeopardized (30). Most states do not mandate reporting of IPV or only mandate reporting in certain circumstances (31). To ensure compliance with state laws and federal regulations, it is important to contact the local law enforcement or domestic violence agency to become familiar with the laws in a specific jurisdiction. A summary of state laws can be found at: [www.futureswithoutviolence.org/userfiles/file/HealthCare/MandReport2007FINALMMS.pdf](http://www.futureswithoutviolence.org/userfiles/file/HealthCare/MandReport2007FINALMMS.pdf). All fifty states and the District of Columbia have laws in effect authorizing the provision of adult protective services in cases of elder abuse or the abuse of individuals with disabilities, although the laws vary significantly between states. Physicians generally are mandated to report abuse in these instances. A current listing of state laws on elder abuse can be found at: [www.ncea.aoa.gov/NCEARoot/Main\\_Site/Find\\_Help/State\\_Resources.aspx](http://www.ncea.aoa.gov/NCEARoot/Main_Site/Find_Help/State_Resources.aspx).

Documentation of the clinical interaction provides important evidence for any future legal proceedings. Accurate reflection of the patient's condition, including any pertinent photographs or body maps, should be included with direct and specific quotations. The health care provider should review with the patient in advance what form of future communication is best because medical bills and follow-up phone calls may prompt retaliation from the abuser. Despite encountering violence, a patient may deny her circumstances based on fear of retaliation from her partner, fear of involvement with law enforcement and the justice system, embarrassment, or shame. Even if women do not reveal violence to their physicians, hearing validating messages and knowing that options and resources may be available could help prompt them to seek help on their own in the future.

## Conclusion

Based on the prevalence and health burden of IPV among women, education about IPV; screening at periodic intervals, including during obstetric visits; and ongoing clinical care can improve the lives of women who experience IPV. Preventing the lifelong consequences associated with IPV can have a positive effect on the reproductive, perinatal, and overall health of all women.

## Intimate Partner Violence National Resources

### Hotlines

- National Domestic Violence Hotline  
1-800-799-SAFE (7233)
- Rape Abuse & Incest National Network (RAINN) Hotline  
1-800-656-HOPE (4673)

### Web Sites

- Futures Without Violence (previously known as Family Violence Prevention Fund)  
[www.futureswithoutviolence.org](http://www.futureswithoutviolence.org)
- National Coalition Against Domestic Violence  
[www.ncadv.org](http://www.ncadv.org)
- National Network to End Domestic Violence  
[www.nnedv.org](http://www.nnedv.org)
- National Resource Center on Domestic Violence  
[www.nrcdv.org](http://www.nrcdv.org)
- Office on Violence Against Women  
(U.S. Department of Justice)  
[www.usdoj.gov/ovw](http://www.usdoj.gov/ovw)

## References

1. Family Violence Prevention Fund. Reproductive health and partner violence guidelines: an integrated response to intimate partner violence and reproductive coercion. San Francisco (CA): FVPF; 2010. Available at: [http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro\\_Guide.pdf](http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Repro_Guide.pdf). Retrieved October 12, 2011. ↩
2. Black MC, Basile KC, Breidig MJ, Smith SG, Walters ML, Merrick MT, et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2011. Available at: [http://www.cdc.gov/ViolencePrevention/pdf/NISVS\\_Report2010-a.pdf](http://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf). Retrieved December 16, 2011. ↩
3. Tjaden P, Thoennes N. Extent, nature, and consequences of intimate partner violence: findings from the National Violence Against Women Survey. Washington, DC: Department of Justice; 2000. Available at: <https://www.ncjrs.gov/pdffiles1/nij/181867.pdf>. Retrieved August 17, 2011. ↩
4. Bureau of Justice Statistics. Homicide trends in the United States. Washington, DC: Department of Justice; 2010. Available at: <http://bjs.ojp.usdoj.gov/content/pub/pdf/htius.pdf>. Retrieved August 12, 2011. ↩
5. American Medical Association. Diagnostic and treatment guidelines on domestic violence. Chicago (IL): AMA; 1992. ↩

6. Baram DA, Basson R. Sexuality, sexual dysfunction, and sexual assault. In: Berek JS, editor. *Berek & Novak's gynecology*. 14th ed. Philadelphia (PA): Lippincott Williams & Wilkins; 2007. p. 313–49. [↔](#)
7. Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, et al. Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception* 2010; 81:316–22. [\[PubMed\]](#) [\[Full Text\]](#) [↔](#)
8. Decker MR, Miller E, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, et al. Intimate partner violence and partner notification of sexually transmitted infections among adolescent and young adult family planning clinic patients. *Int J STD AIDS* 2011;22:345–7. [\[PubMed\]](#) [↔](#)
9. Bauer HM, Gibson P, Hernandez M, Kent C, Klausner J, Bolan G. Intimate partner violence and high-risk sexual behaviors among female patients with sexually transmitted diseases. *Sex Transm Dis* 2002;29:411–6. [\[PubMed\]](#) [↔](#)
10. Commonwealth Fund. Addressing domestic violence and its consequences: policy report of the Commonwealth Fund Commission on Women's Health. New York (NY): CF; 1998. [↔](#)
11. Brown HL. Trauma in pregnancy. *Obstet Gynecol* 2009; 114:147–60. [\[PubMed\]](#) [\[Obstetrics & Gynecology\]](#) [↔](#)
12. McFarlane J, Wust WH. Documentation of abuse to pregnant women: a medical chart audit in public health clinics. *J Womens Health* 1996;5:137–42. [↔](#)
13. Parker B, McFarlane J, Soeken K. Abuse during pregnancy: effects on maternal complications and birth weight in adult and teenage women. *Obstet Gynecol* 1994;84:323–8. [\[PubMed\]](#) [\[Obstetrics & Gynecology\]](#) [↔](#)
14. El Kady DE, Gilbert WM, Xing G, Smith LH. Maternal and neonatal outcomes of assaults during pregnancy. *Obstet Gynecol* 2005;105:357–63. [\[PubMed\]](#) [\[Obstetrics & Gynecology\]](#) [↔](#)
15. Brownridge DA, Taillieu TL, Tyler KA, Tiwari A, Chan KL, Santos SC. Pregnancy and intimate partner violence: risk factors, severity, and health effects. *Violence Against Women* 2011;17(7):858–81. [\[PubMed\]](#) [↔](#)
16. Cheng D, Horon IL. Intimate-partner homicide among pregnant and postpartum women. *Obstet Gynecol* 2010; 115:1181–6. [\[PubMed\]](#) [\[Obstetrics & Gynecology\]](#) [↔](#)
17. National Center for Injury Prevention and Control. Costs of intimate partner violence against women in the United States. Atlanta (GA): Centers for Disease Control and Prevention; 2003. Available at: <http://www.cdc.gov/violenceprevention/pdf/IPVBook-a.pdf>. Retrieved August 12, 2011. [↔](#)
18. Family Violence Prevention Fund. The health care costs of domestic and sexual violence. San Francisco (CA): FVPF; 2010. Available at: [http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Health\\_Care\\_Costs\\_of\\_Domestic\\_and\\_Sexual\\_Violence.pdf](http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Health_Care_Costs_of_Domestic_and_Sexual_Violence.pdf). Retrieved August 12, 2011. [↔](#)
19. Health care for homeless women. Committee Opinion No. 454. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2010;115:396–9. [\[PubMed\]](#) [\[Obstetrics & Gynecology\]](#) [↔](#)
20. Silverman JG, Raj A, Clements K. Dating violence and associated sexual risk and pregnancy among adolescent girls in the United States. *Pediatrics* 2004;114:e220–5. [\[PubMed\]](#) [\[Full Text\]](#) [↔](#)
21. Immigrant Legal Resource Center. Department of Labor U visa process and protocols: question – answer. San Francisco (CA): ILRC; 2011. Available at: [http://www.ilrc.org/files/documents/dol\\_u-visa\\_certification\\_protocols.pdf](http://www.ilrc.org/files/documents/dol_u-visa_certification_protocols.pdf). Retrieved August 12, 2011. [↔](#)
22. National Center on Elder Abuse. Elder abuse prevalence and incidence. Washington, DC: NCEA; 2005. Available at: [http://www.ncea.aoa.gov/ncearoot/Main\\_Site/pdf/publication/FinalStatistics050331.pdf](http://www.ncea.aoa.gov/ncearoot/Main_Site/pdf/publication/FinalStatistics050331.pdf). Retrieved October 11, 2011. [↔](#)
23. Cooper C, Selwood A, Livingston G. The prevalence of elder abuse and neglect: a systematic review. *Age Ageing* 2008;37:151–60. [\[PubMed\]](#) [\[Full Text\]](#) [↔](#)
24. National Center on Elder Abuse. The national elder abuse incidence study: final report. Washington, DC: NCEA; 1998. Available at: [http://aoa.gov/AoA\\_Programs/Elder\\_Rights/Elder\\_Abuse/docs/ABuseReport\\_Full.pdf](http://aoa.gov/AoA_Programs/Elder_Rights/Elder_Abuse/docs/ABuseReport_Full.pdf). Retrieved October 11, 2011. [↔](#)
25. Institute of Medicine. Recommendations. In: *Clinical preventive services for women: closing the gaps*. Washington, DC: National Academies Press; 2011. p. 71–141. [↔](#)
26. Ambuel B, Trent K, Lenahan P, Cronholm P, Downing D, Jelley M, et al. Competencies needed by health professionals for addressing exposure to violence and abuse in patient care. Eden Prairie (MN): Academy on Violence and Abuse; 2011. Available at: <http://www.nsvrc.org/sites/default/files/CoreCompetenciesRevApril2011.pdf>. Retrieved January 10, 2012. [↔](#)
27. Chen PH, Rovi S, Washington J, Jacobs A, Vega M, Pan KY, et al. Randomized comparison of 3 methods to screen for domestic violence in family practice. *Ann Fam Med* 2007; 5:430–5. [\[PubMed\]](#) [\[Full Text\]](#) [↔](#)
28. Ahmad F, Hogg-Johnson S, Stewart DE, Skinner HA, Glazier RH, Levinson W. Computer-assisted screening for intimate partner violence and control: a randomized trial. *Ann Intern Med* 2009;151:93–102. [\[PubMed\]](#) [\[Full Text\]](#) [↔](#)
29. Campbell JC, Glass N, Sharps P, Laughon K, Bloom T. Intimate partner homicide: review and implications of research and policy. *Trauma Violence Abuse* 2007;8:246–69. [\[PubMed\]](#) [↔](#)
30. Hyman A, Schillinger D, Lo B. Laws mandating reporting of domestic violence. Do they promote patient well-being? *JAMA* 1995;273:1781–7. [\[PubMed\]](#) [↔](#)
31. Futures Without Violence. State codes on intimate partner violence victimization reporting requirements for health care providers. Available at: <http://www.futureswithoutviolence.org/userfiles/file/HealthCare/MandReport2007FINALMMS.pdf>. Retrieved October 7, 2011. [↔](#)

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