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"Are You Safe at Home?": Clinician's Assessments for Intimate Partner Violence at the Initial Obstetric Visit

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Abstract

Few studies have empirically examined patient–clinician conversations to assess how intimate partner violence (IPV) screening is performed. Our study sought to examine audio-recorded first obstetric encounters' IPV screening conversations to describe and categorize communication approaches and explore associations with patient disclosure. We analyzed 247 patient encounters with 47 providers. IPV screening occurred in 95% of visits: 57% used direct questions, 25% used indirect questions, 17% repeated IPV screening later in the visit, 11% framed questions with a reason for asking, and 10% described IPV types. Patients disclosed IPV in 71 (28.7%) visits. There were no associations between disclosure and any categories of IPV screening.

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Keywords

intimate partner violence; patient–clinician communication; assessment/screening; disclosure of violence; obstetrical care; pregnancy

Introduction

Intimate partner violence (IPV) is a global health crisis affecting one in three women during her lifetime (American College of Obstetricians and Gynecologists [ACOG], 2012; Chamberlain & Levenson, 2013; O'Doherty et al., 2015; Smith et al., 2018). Commonly referred to as "domestic violence," IPV is more specifically defined by the Centers for Disease Control and Prevention (CDC) as physical, sexual, and psychological acts of violence by a current or former partner (Smith et al., 2018). IPV affects individuals regardless of race, ethnicity, socioeconomic status, religion, sexual orientation, or gender identity and is associated with numerous adverse physical and mental health sequelae (D'Inverno et al., 2019; World Health Organization, 2013). Prevalence rates for IPV during pregnancy have varied with most ranging between 3% and 9% (Chu et al., 2010; Martin et al., 2001; Saltzman et al., 2003); studies in particularly vulnerable, low-income populations have reported prevalence rates up to 50% (Bailey & Daugherty, 2007). Potential negative maternal and neonatal health consequences associated with IPV include increased risk for preterm birth, low birthweight, perinatal and postpartum depression, and maternal mortality from homicide and suicide (Donovan et al., 2016; Hill et al., 2016; World Health Organization, 2013).

The healthcare sector has a fundamental responsibility to comprehensively address IPV through both primary and secondary prevention. In response, health organizations have promoted universal IPV screening for women of reproductive age during clinic visits (ACOG, 2012; US Preventative Services Task Force, 2018). The US Preventive Services Task Force recently released updated IPV screening recommendations, and universal screening is recommended as Category B evidence (US Preventative Services Task Force, 2018). ACOG recommends that all pregnant patients are asked about IPV during their first obstetric visit, at least once each trimester, and at the postpartum visit (ACOG, 2012). Prior studies noted that obstetricians are the clinical specialty more likely to report asking their patients about IPV during the first obstetric visit (Horan et al., 1998; Rodriguez et al., 1999). However, few empiric studies have examined how obstetric care providers raise the topic of IPV, what communication approaches they use, or what specific questions they ask. Additionally, no prior studies have examined whether different styles of how clinicians ask about IPV promotes greater patient disclosure of IPV. To understand this, we conducted an analysis of IPV patient-provider communication using audio-recorded first obstetric visits between pregnant patients and their obstetric care providers.

Methods

We audio-recorded initial obstetric visits between obstetric care providers and pregnant patients, transcribed them verbatim, identified the portions that contained IPV assessment communication, and qualitatively coded these sections of the transcripts. We then

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transformed these codes into variables to perform descriptive statistics to assess proportion of visits using specific IPV communication approaches and bivariate analyses to examine associations between IPV screening and patient IPV disclosure (Zickmund et al., 2013).

We conducted this study between 2005 and 2008 at an urban, academic medical center in Pittsburgh, PA that provided both obstetric and gynecologic care to a diverse patient population, the majority of whom relied on medical assistance. Obstetric health care providers were eligible for study participation if they were a clinician who conducted first obstetric visits at the study site. Patient eligibility criteria included: (a) 18 years of age or older, (b) presented to the clinic to see a participating provider for their first obstetric visit, (c) spoke and understood English, and (d) were not accompanied by other adult guests such as partners, family or friends, or children above the age of 2 into the exam room while the interview and physical exam were being conducted. Both obstetrics care providers and patients were recruited to participate in a "patient–provider communication study" and informed that all topics of conversation during the visits would be analyzed with a focus on behavioral health topics; thus, neither provider nor participant was aware of a specific focus on IPV. During the time of the study, obstetrics providers used printed prenatal forms to guide and document their history-taking. The form had prompts for IPV screening. We determined the sample size for our study to ensure that the subject population would be large enough to contain a proportion of women who have experienced lifetime IPV like proportions seen in other clinical populations. Choosing a sample size of 246 participants provided us with a two-sided 95% confidence interval range of 0.05 from the observed proportion for an expected prevalence of 20%. We targeted 250 patient participants for enrollment.

We placed digital audio-recorders in exam rooms when the patients entered the room prior to the obstetric care provider's arrival to obtain an audio-recording of the entire interaction between provider and patient. All audio-recordings were transcribed verbatim. At the end of the visit, patients completed a brief demographic questionnaire that included questions regarding whether they felt study participation and being recorded changed their behavior during the visit.

Two coders independently reviewed all transcribed visits to identify whether obstetric care providers asked about IPV in any manner. Visits in which no IPV screening or discussion occurred were coded as "no IPV screening." Visits in which IPV was assessed were coded for type of screening. The codebook for IPV screening communication was developed in an iterative, constant comparison fashion by two coders with final codebook applied to all transcripts.

We coded obstetric care provider questions about the patient's relationship with her partner (e.g., "How are things with your partner?") or generally inquired about safety (e.g., "Do you feel safe at home?") but that did not directly indicate a focus on IPV as "implicit IPV screening." Assessments that directly asked about IPV ("explicit IPV screening") used words such as "violence," "abuse/d," "hurt," "control/led," "afraid," or "threaten/ed." We also noted circumstances when the obstetric care provider asked about IPV more than once at different times during the encounter with these questions separated by dialogue/discussion

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on other topics. We coded this as “repeat IPV screening.” When obstetric providers added descriptions of different types of IPV (e.g., “Any domestic violence—physical, sexual, emotional?”), we coded this as “detailed IPV screening.” Prior studies and a recently reaffirmed ACOG Committee Opinion on IPV recommended that health care providers give a “framing statement” or “reason for asking” to reduce stigma and normalize the screening by explaining why the patient is being asked about IPV (ACOG, 2012; Chang, 2014; Chang et al., 2005). We thus created a code called “reason for IPV screening” for any communication that offers this framing or explanation for the IPV questioning. We also noted a few instances when obstetric providers would ask about IPV in a manner that already assumed that the answer would be negative. For these, we created the code “leading question” (e.g., “No history of domestic violence?”).

IPV disclosure was coded as “positive IPV disclosure” if the patient endorsed previous or current IPV in response to a screening. If the patient disclosed IPV with no prompting by a provider, we coded this “self-disclosure of IPV.”

These codes were applied independently to all visit transcripts by two coders. We calculated inter-coder agreement using Cohen’s kappa coefficient for common codes such as implicit IPV screening, explicit IPV screening, no IPV screening, and repeat IPV screening (Burla et al., 2008; Viera & Garrett, 2005). We used Atlas.ti qualitative analysis software Version 7 (Berlin, Germany) to store and organize the coded transcripts.

To explore associations between IPV screening categories, we converted the screening codes to dichotomous variables to perform descriptive and bivariate statistics. Descriptive and bivariate statistics using chi-square tests were analyzed (Type 1 error rate = 5%).

This study was approved by the University of Pittsburgh Institutional Review Board (IRB0602015), and both patient and provider participant groups provided written informed consent.

Results

We approached 476 pregnant patients and 253 (53.1%) agreed to enroll in our study. The most common reasons for refusal included that (a) the patient indicated she was not interested in research or (b) the patient had a guest accompanying her who she wished to remain in the room for the entire visit. Among the 253 who enrolled, one patient was not pregnant and in five of the visits the audio-recorder was not turned on, stopped recording prematurely, or the sound quality was poor preventing confidence in hearing all details of the conversation. Our final sample size was 247. Participant characteristics are shown in Table 1. Most participants were young (mean age=25) and single (77%). The majority (83.9%) of patients reported an annual income less than $20,000; 45.7% reported less than $5,000 annually. Our sample population was approximately half Black/African American and half White/Caucasian. Most participants had given birth prior to this pregnancy. Most participants (90%) reported that having their visit recorded did not affect their honesty; 92% reported the recording did not make them feel uncomfortable; 93% reported that having their

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visit recorded did not change their actions in the visit; and 93% reported that the recording of their visit did not change the way they talked during the visit.

Fifty-two provider participants enrolled in the study; 47 participated in the 247 recorded visits with complete recordings. Table 2 describes characteristics of these providers. They included nurse midwives, nurse practitioners, physician assistants, and obstetrics and gynecology resident physicians from all four years of training. Each provider performed between 1 and 11 recorded first obstetric visits.

The average kappa score was 80% based on "explicit IPV screening," "implicit IPV screening," "repeated IPV screening," and "no IPV screening" codes.

Table 3 shows examples of each IPV screening category. IPV screening occurred in 238 (96.4%) visits and was repeated at least twice at different times in the encounter in 40 (16.2%) visits. There were 9 (3.6%) visits where no screening took place. Among the 205 visits in which IPV screening occurred only once, 143 (69.8%) involved only explicit IPV screening, 19 (9.3%) only implicit, and 35 (17.1%) a combination of implicit and explicit questioning. When IPV screening occurred more than once during an encounter, obstetric providers mostly (29/41, 70.7%) used explicit screening questions repeatedly; in 17/41 (41.5%) they used a combination of explicit and implicit approaches. In only one visit did the provider use an implicit screening approach in both during the initial and repeated inquiries.

In 31 encounters (12.5%), the provider verbalized a reason for why they were asking about IPV ("reason for IPV screening"). Detailed screening occurred in 26 visits (10.5%). Leading questions were noted in 44 visits (17.8%).

Among 230 total IPV screening questions, 228 (99.1%) were closed-ended, primarily yes/no questions. Only two were open-ended, and both were coded as implicit IPV screening (Table 3). One of these two open-ended questions referenced evidence of a sustained injury:

> OBP: "And, ah, I couldn't help but notice you have a little bruise on your eye, what happened?"
>
> P: "Yeah, well, I was, actually, the father of the baby is pretty aggressive. I'm staying in a domestic violence shelter right now."

Although fewer of our recorded visits were conducted by nurse practitioners (26) or physician assistants (10), 100% of these visits contained IPV screening. Most visits (169) were conducted by resident obstetrics and gynecology physicians; 95.9% (162/169) of these visits contained IPV screening. Nurse midwives conducted 39 of the recorded visits with 38/39 (97.4%) of these visits containing IPV screening. Differences in screening rates by provider type were not statistically significant ($p = .058$). IPV screening was not significantly associated with patient age, parity, race, marital status, educational attainment, or reported annual household income level.

Before addressing IPV, most providers asked questions related to mental health. In 31% of visits where providers used explicit screening methods, providers assessed a patient's

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mental health history immediately prior to IPV screening (implicit screening, 10%; detailed screening, 19%; self-disclosure, 25%). After screening for IPV, providers most commonly discussed medication (explicit screening, 54.5% followed by medication inquiry; implicit screening, 19%; detailed screening 31%; self-disclosure, 37.5%).

Patients disclosed any history of IPV in 71 (28.7%) visits. Of those 71 visits, 49 (69%) occurred in response to explicit screening questions, 3 (4.2%) in response to implicit screening questions, and 18 (25.4%) in visits where both implicit and explicit types of screening were used. In 8 (3.0%) visits, the patient self-disclosed IPV prior to any IPV screening questions posed by the care provider. Among all IPV disclosures including self-disclosures, most (56, 78.9%) related to IPV that occurred in the past and not experienced in the current pregnancy. Five women described current IPV; another six described both past and current experiences of IPV. Four disclosures did not indicate whether the IPV was past or current (nor did the clinician clarify). Among just the eighth who self-disclosed IPV, six self-disclosed past IPV, one self-disclosed past and current IPV, and one did not clarify timing of her IPV experience.

There was no significant association between overall IPV disclosure and any category of IPV screening. We did not observe any associations between patient disclosure and type of provider (i.e., physician, nurse, etc.). Patients who disclosed IPV were significantly more likely to self-describe their marital status as single ($p < .0001$). There was no association with IPV disclosure by patient age, self-described race, level of educational attainment, or reported annual household income. Gravidity, but not parity, was noted to be significantly associated with IPV disclosure; with each additional pregnancy experienced by the patient, there was a 24% higher odds of IPV disclosure.

Discussion and Conclusion

Our study provides an assessment of how obstetric providers screen their pregnant patients for IPV during first obstetric visits. Overall, we noted higher (>95%) than average screening rates. A prior study conducted in this same clinical setting also noted high IPV screening rates (Scholle et al., 2003). Qualitative work among the clinicians and staff in this clinical setting described confidence and comfort dealing with IPV, high leadership commitment to IPV as a priority women's health issue, having good IPV resources and supports, working in as a team in responding to IPV, and specific training in IPV (Chang et al., 2009). This factors likely contributed to the high IPV screening rates we noted in this study. Other studies have also noted that environmental or medical record prompts also increased IPV screening rates (McCaw et al., 2001; Ulbrich & Stockdale, 2002).

Despite high IPV screening rates, it is important to note that disclosure rates among this patient population was still below known lifetime prevalence of IPV in this population. When IPV disclosure did occur, it was almost always in the context of a provider probing about a patient's experiences. This is consistent with other studies noting that women's IPV disclosure is generally in response to health providers' assessment or discussion of the topic and rarely a spontaneous self-disclosure (Caralis & Musialowski, 1997; Gerbert et al., 1996; McCauley et al., 1998; Othman et al., 2014; Petersen et al., 2004; Rodriguez et al., 1996).

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Several well-documented patient-level barriers, including fear of retribution from a partner or feelings of stigma and judgment from healthcare professionals, contribute to patients' decisions to not disclose, even when asked (Caralis & Musialowski, 1997; Gerbert et al., 1996; McCauley et al., 1998; Othman et al., 2014; Petersen et al., 2004; Rodriguez et al., 1996).

Although other studies suggested that direct and specific questions regarding IPV would be more likely to elicit disclosure (Spangaro et al., 2016), we did not find this in our study. While our results show some variation in the ways obstetric care providers ask about IPV during the first obstetric visit, most addressed the topic with words such as "violence" and "abuse." However, only a few obstetric care providers further explained what types of behaviors constitute IPV. This is important as patients may not perceive themselves as "abused" or may minimize the severity of the violent behavior against them (Chang et al., 2012). In addition, women who primarily experience harm from psychological or emotional IPV may not recognize this treatment as IPV and thus may "screen negative." It is possible that because of the ambiguity with terms such as "abuse," particularly in the case of emotional IPV, we did not observe a difference in disclosure between explicit and implicit screening methods. Female IPV survivors have described that when clinicians provide a reason for asking about IPV to frame the topic prior to addressing, it reduces feelings of stigma and reassures women that the obstetric care provider is asking out of concern for the patient's safety (Chang et al., 2005). Despite these recommendations, our findings demonstrate that these normalizing statements were uncommon. This may be because providers often screened for IPV after assessing mental health history and symptoms. As such, clinicians may perceive that this contextual sequence itself provides some framing as the discussion had already shifted to addressing psychiatric, emotional, and behavioral issues.

Among limitations to this study was that all encounters were from one single clinical site, in an academic center that has high IPV screening rates, potentially limiting broader generalizability. In addition, we only audio-recorded first obstetric visit discussions between the obstetric care clinicians and the patient and did not have data on patient conversations with registered nurses, medical assistants, or social workers nor any conversations that occurred in subsequent prenatal visits. Additionally, we chose to exclude patients who desired or insisted on having partners, friends, or family members above age two years in the room during the encounter and patient-provider conversation. There is the possibility that patients with controlling or abusive partners may have been more reticent to excuse the partner from the visit and thus may have been less likely to participate. Our quantitative analyses was also exploratory and given that some IPV categories were infrequently observed, we may not have had enough power to determine associations with IPV disclosure.

This data was also collected more than a decade ago in a period prior to health system changes such as the implementation of electronic medical records. Although some aspects of clinician–patient communication and interactions have like changed during this time and more recent data would be preferable, this is one of the few studies that empirically recorded and analyzed clinical communication related to IPV among pregnant patients and

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their obstetric care providers. Prior studies focusing on IPV screening have focused on whether IPV screening occurred and IPV disclosure rates rather than how clinicians are asking and talking about IPV (Chisholm et al., 2017; Nelson et al., 2012). Our findings provide a unique historical description of clinician IPV communication behavior to which we can now compare more recent observations and practices. Since the data collection for this study, several IPV screening tools have been developed and reviewed, mostly in nonpregnant populations (Chisholm et al., 2017; Nelson et al., 2012). If health systems have adopted such screening tools, a replication of our study now could demonstrate more comprehensive and standardized IPV communication. Conversely, the implementation of computerized IPV assessments could potentially reduce the frequency and quality of clinician IPV communication if clinicians defer this task to technology. Regardless, a prior qualitative study comparing in-person and computerized screening noted continued patient expectations for and perceived benefit of clinicians discussing IPV during the in-person visit (Chang et al., 2012). Thus, how clinicians talk and ask about IPV will continue to be important. Additionally, while we would hope that clinicians of all types would quickly adopt new evidence-based clinical guidelines and approaches, studies have noted that new clinical guideline implementation is often challenging and slow (Gupta et al., 2017; Zaher et al., 2014). We thus suspect that many of these same IPV communication behaviors we observed are still occurring.

Despite these limitations, our findings contribute to current literature in corroborating obstetrics clinicians self-reported rates of asking patients about IPV in the first obstetric visits, demonstrating no difference in patient IPV disclosure when using explicit or implicit questioning, and illustrating that few of these conversations are introduced to patients using framing or introductory statements that explain the reasons for asking.

Knowing how providers talk to their patients about IPV, we can identify key points for intervention, particularly given that the way in which providers communicate about IPV has been described as incredibly important to survivors (Chang et al., 2003, 2005). For example, our findings demonstrate that many providers used ambiguous approaches to discuss IPV (e.g., “Do you feel safe at home?”) which could be misinterpreted by patients who may be thinking of smoke detectors and neighborhood qualities. Additionally, several providers used leading questions when asking about IPV which likely discourages disclosure. Very few providers introduced the topic of IPV with a framing statement or reason for asking that would normalize the conversation and communicate understanding of IPV. More research is needed to identify and develop clinic and provider characteristics that increase patient comfort and safety that may allow patients to be more receptive to conversations about IPV and may increase opportunities to connect women to relevant services and supports. Additionally, new studies assessing current practices are needed to note if and how communication has changed and how IPV communication affects IPV survivors’ experiences and outcomes.

Additionally, more research is needed to identify whether IPV screening communication is associated with outcomes besides IPV disclosure. Cluss and colleagues proposed a Psychosocial Readiness Model to describe the process of change and safety-seeking behaviors among women experiencing IPV. This model described three key internal

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factors: awareness, self-efficacy/power, and perceived support. External factors—including interactions with healthcare providers—influence the process of safety-seeking by impacting on these internal factors (Cluss et al., 2006). In this regard, potential outcomes for provider IPV screening or counseling communication could be awareness/understanding of IPV (and whether what one is experiencing constitutes IPV), obtaining information and strategies to promote safety, and realizing that one is not alone and has support (Chang et al., 2003).

Indeed, recent work have suggested that targeting IPV disclosure as the primary outcome for IPV discussions in clinical settings may be missing opportunities for important intervention. Numerous studies documenting IPV survivors' experiences with fear and stigma and difficulty disclosing IPV—even when IPV screening is performed and performed well (Caralis & Musialowski, 1997; Chang et al., 2005; McCauley et al., 1998; Othman et al., 2014). Women who have experienced IPV advised that all clinical setting should make IPV resources available to everyone; they stated that they could benefit from receiving information and resources even if they do not disclose (Chang et al., 2005). In two cluster-randomized trials examining this approach in family planning clinics, Miller et al. (2011) found women who received care from clinics in the intervention arm were significantly more likely to report ending a relationship they perceived to be unhealthy at follow-up.

This has led to suggestions in the IPV research and victims' advocacy community to shift from traditional screening to universal education. For example, Futures Without Violence, an advocacy organization working to end violence against women and children globally, has developed and endorsed one strategy of universal IPV education called the Confidentiality, Universal Education and Empowerment, and Support (CUES) approach (Futures Without Violence). This approach focuses on CUES. Providing universal IPV education thus offers patients who are not ready to disclose IPV to a provider the same opportunity to receive resources and information as those who disclose. Furthermore, information about healthy relationships and IPV provides increased awareness and education for all patients, including those who have never experienced IPV—in this circumstance, this universal education serves as primary prevention. This change in practice would likely require communication styles and approaches different to the ones observed. However, understanding the IPV communication obstetric providers currently use with their pregnant patients provides a starting point for developing and tailor training in using these new recommended approaches to helping women experiencing IPV.

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Cynthia L. Holland has been performing public health and clinical research for over 20 years contributing to increasing research understanding of substance use disorders,

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intimate partner violence, patient-provider communication, and sport-related concussions. She currently coordinates numerous projects in the UPMC Freddie Fu Sports Medicine Concussion Program. Prior to this, she worked with Dr. Chang at Magee-Womens Hospital working on multiple projects related to patient–clinician communication in obstetrics, prenatal substance use, and intimate partner violence.

Lynn Hawker has contributed decades of service as a victims' advocate and counselor for individuals healing from intimate partner violence and trauma. She is retired from her role as Director of Clinical Services at the Women's Center and Shelter of Greater Pittsburgh. She had also provided service in Community Mental Health. She continues to consult on various research projects regarding intimate partner violence including understanding and addressing violence perpetration.

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Table 1.

Patient Participant Characteristics ($N = 247$).

Characteristic	*M*/number	Range/percent
Age	25 years	18–42 years
Marital status		
Single	183	74.0%
Married	40	16.0%
Separated	5	2.0%
Widowed	4	1.6%
Divorced	1	0.4%
Living with same sex partner	4	1.6%
Did not answer	10	4.0%
Self-described race		
White/Caucasian	115	46.6%
Black/African-American	115	46.6%
Hispanic/Latinx	3	1.2%
Asian	1	0.4%
Other	9	3.6%
Did not answer	5	2.0%
Highest level of education completed		
Grade school	10	4.0%
High school or GED	113	45.7.%
Some college	80	32.4%
Finished college	27	10.9%
Graduate school	9	3.6%
Did not answer	8	3.2%
Self-reported yearly household income		
Less than $5,000	102	41.3%
$5,000–$9,999	32	13.0%
$10,000–$14,999	25	10.2%
$15,000–$19,999	28	11.3%
Over $20,000	36	14.6%
Did not answer	24	9.7%
Gravidity	3	1–13
Parity	1	0–6
Type of provider seen in recorded visit		
Nurse midwife	39	15.8%
Nurse practitioner	26	10.5%
Physician assistant	10	4.0%
Resident obstetrics/gynecology physician	172	69.6%

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Table 2.

Obstetric Provider Participant Characteristics ($N = 47$).

Characteristic	*M*/number	Range/percent
Age	31 years	22–54 years
Gender		
Female	43	91%
Male	4	9%
Clinician type		
Nurse midwife	6	13%
Nurse practitioner	3	6%
Physician assistant	1	2%
Resident obstetrics/gynecology physician	36	77%
Faculty obstetrics/gynecology physician	1	2%
Self-described race		
White/Caucasian	42	89%
Black/African-American	3	6%
Hispanic/Latinx	1	2%
Did not answer	1	2%
Number of recorded visits	5	1–11

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Table 3.

Examples of IPV Screening Categories.

Explicit	OBP: "Any history of sexual abuse or domestic violence?"	OBP: "Any history of um ah sexual abuse, domestic violence, times when you haven't felt safe in a relationship previously or currently?"	OBP: "Anyone harm you physically or sexually? Verbal abuse?"
Implicit	OBP: "Safe at home?"	OBP: "You guys [patient and her partner] are getting along okay?"	OBP: "How is your relationship with [partner's name]?"
Repeated	OBP: "Are you safe at home?" P: "Yeah." [discussion of recent incarceration, where she is living, identify of father of the baby, other pregnancies and their problems/outcomes, nutrition concerns, folic acid supplementation, other medical conditions] OBP: "Psychiatric problems—depression, anxiety?" P: "Nope." OBP: "Bipolar disorder? Other medical problems that I haven't asked you about?" P: "Just my right knee surgery. That is all I've had." OBP: "That is fine. Have you ever been a victim of sexual abuse or been forced to have sex against your will?" P: "No." OBP: "Have you been a victim of domestic violence?" P: "Yes." OBP: "Ok. Tell me about that." P: "With my son's father. The one year old."	OBP: "Are you safe right now at home?" P: "Yeah." OBP: "Who do you live with?" P: "My boyfriend and my children." [3 s pause] "I have a question." Q: Sure. [discussion of breastfeeding when on methadone, medications, allergies, past medical history, past surgical history, delivery experience with her last pregnancy, current medications, details regarding methadone dosage and clinic where patient receives it] OBP: "Any sexual abuse or domestic violence at home?" P: "No [drawn out for two seconds]. I had a little domestic violence um but that stopped. I had him arrested. It was minimal. He pushed me, but it still happened, so-"	OBP: "Do you feel safe where you're living?" P: "Yeah." M: "Do you feel safe in your pregnancy? Or in your relationship?" P: "Yeah." OBP: "This is, these are questions we'll askya every time you come in and —" P: "Okay." OPB: "The reason that we do that is because we know that abusive relationships often, the abuse of- abuse often starts during a pregnancy, or gets a lot worse." P: "Okay." OBP: "And so it's something we'd like you to keep an eye out for and also something we'll ask ya." P: "Oh." OBP: "Yeah, as long as no one's here with you." P: "Okay." OBP: "We'll ask you probably at every visit." P: "Okay." [discussion about unplanned pregnancy and how patient feels about it currently, patient's job and concerns she has about the job, OBP screening for depression/anxiety] OBP: "No [history of mental illness]? Things that previously can be very small, like minor depression can get a lot lot worse in pregnancy so that's why we always ask." P: "Okay." OBP: "And then, we also always ask about a history of sexual abuse, just because a lot of times, that, the uh concerns and the fears you have can really come up again during pregnancy." P: "Okay." OBP: "Have you ever been sexually abused?" P: "Nope." OBP: "How about physically abused? P: "Nope."
Reason for asking	OBP: "We ask all women in pregnancy whether they are having sexual abuse that can affect your experience [ah] and we also try to ask you every visit whether you are safe or if you are experiencing hitting, kicking, threatening, or abusing you?"	OBP: "The next couple of questions I ask because it is really common for women—about 20% of women will actually answer yes. Have you ever been sexually abused or physically abused by a partner, anyone in your life?"	OBP: "The next couple of questions are also always uncomfortable to have to ask or always uncomfortable to have to answer but I think it's important so we can really take care of all of you." P: "Okay." Q: "Any history of being in a relationship where you felt unsafe a boyfriend or a friend even hitting you or hurting you?"
Detailed	OBP: "Anyone that is threatening you physically, mentally, sexually, work, home? Anything like that?"	OBP: "And do you have any history of being abused at all? Sexual, physical, emotional?"	OBP: "Have you ever been forced to have sex against your will or been a victim of sexual abuse in any way?" P: "Uh uh." [no]

			OBP: “Okay. How about violence in the home? You ever been hit, slapped, kicked, punched?”
Leading	OBP: “No history of violence of being threatened or being abused?”	OBP: “Okay and he [partner] treats you well?” P: “Uh huh” OBP: “He’s never threatened to harm you or hurt you in any way?”	OBP: “You are safe at home. No one is hurting you?”

Note.OBP=obstetric care provider; P=patient.

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