A Novel Intimate Partner Violence Curriculum for Internal Medicine Residents: Development, Implementation, and Evaluation

Emily R. Insetta, MD*, Colleen Christmas, MD

*Corresponding author: emily.insetta@jhmi.edu

Abstract

Introduction: Intimate partner violence (IPV) is a prevalent problem with profound health consequences. Research suggests that internal medicine (IM) residents are unprepared to screen for and address IPV. We designed a curriculum to improve IM residents’ knowledge, attitudes, and practices in caring for IPV survivors. Methods: The curriculum was delivered to first-year IM residents from 2016 to 2017 at Johns Hopkins Bayview. Part 1 was 60 minutes long, with a video, evidence-based didactic teaching, and case-based discussion. Part 2 was 90 minutes long, with evidence-based didactic teaching, role-play of patient-provider conversations about IPV, and debriefing about strategies for discussing IPV. We evaluated knowledge, confidence, and self-reported behaviors pre- and postintervention using two-tailed paired t tests. Results: Thirty-two residents received IPV training. In comparing precurriculum (n = 29, 91% of total participants) and postcurriculum (n = 28, 88% of total participants) surveys, there was significant improvement in knowledge about IPV (p < .001). Postcurriculum, learners reported greater confidence in detecting IPV (p < .001), documenting IPV (p < .001), and referring to resources (p < .001). Participants reported increased comfort in managing difficult emotions about IPV in patients (p < .01) and themselves (p < .001) and increased comfort in discussing IPV with female (p < .001) and male (p < .001) patients. Postcurriculum, all respondents felt they were more skillful in discussing IPV and would be more likely to screen for IPV. Discussion: Our curriculum improved residents’ knowledge, confidence, comfort, and preparedness in screening for and discussing IPV.

Keywords
Intimate Partner Violence, IPV, Curriculum Development, Trauma-Informed Care, Women’s Health, Internal Medicine, Clinical/Procedural Skills Training, Test Design/Psychometrics

Educational Objectives

By the end of this activity, learners will be able to:

1. Define the prevalence of intimate partner violence (IPV).
2. Identify at least three red flags for IPV.
3. List at least one physical, mental, and behavioral health consequence of IPV.
4. Describe recommendations for documenting and reporting IPV.
5. Access local and national services for IPV victims.
6. Describe an evidence-based approach to screening for and discussing IPV with patients.
7. Express increased confidence and comfort in caring for IPV survivors.

Introduction

Intimate partner violence (IPV) is defined by the Centers for Disease Control and Prevention as physical violence, sexual violence, psychological abuse, or stalking against an intimate partner, which includes a current or former spouse, boyfriend, girlfriend, dating partner, or ongoing sexual partner.¹ IPV is a widespread problem: One in three women and one in four men will experience physical violence by an intimate partner in their lifetime.² Traumatic injuries can lead to activity limitations, disability, and death.³ IPV is associated with detrimental physical, mental, and behavioral health consequences lasting even decades after the trauma has occurred. IPV survivors are more likely to experience chronic health conditions including heart disease, hyperlipidemia, asthma, arthritis, and stroke. High-risk health behaviors are also more common among IPV survivors, resulting in more sexually transmitted infections and unplanned
Screening for IPV has been recommended by several medical societies, including the Institute of Medicine, the United States Preventive Services Task Force (USPSTF), the American Medical Association, and the American College of Obstetrics and Gynecology. The Affordable Care Act classifies IPV screening as a reimbursable primary prevention or early intervention service. A 2012 systematic review for the USPSTF described multiple validated IPV screening instruments with high diagnostic accuracy. For example, the four-item Hit, Insult, Threaten, Scream (HITS) tool has 86% sensitivity and 99% specificity for identifying IPV.

Despite the known prevalence and consequences of IPV and the evidence for effective screening tools, there are no guidelines for including IPV training in graduate medical education. The majority of internal medicine (IM) residents (62%) think it is the doctor’s responsibility to find and treat IPV, and 76% of IM residents think IPV should be included in medical training. However, 78% of IM residents have never heard of IPV screening tools, and 70% of IM residents state they never or rarely screen for IPV. Practicing physicians most often describe provider-related barriers to IPV screening rather than patient-related barriers, highlighting personal discomfort, lack of knowledge, and time constraints as interfering with their screening capabilities.

Several IPV curricula have been published in MedEdPORTAL in recent years, all of which target medical student learners. For example, a curriculum utilizing standardized patients to practice discussing IPV was published in 2015, a multidisciplinary approach to teaching about IPV health policy and advocacy was published in 2016, and a small-group model for teaching about IPV screening and counseling was published in 2017. IPV falls within the new umbrella term of trauma-informed care, which has recently been gaining recognition in the medical education literature. In the past 2 years, MedEdPORTAL has featured three trauma-informed care curricula, and yet again, these are all targeted toward medical student learners. Our work makes a unique contribution to the existing literature by designing and implementing an IPV curriculum for graduate medical education. IPV training is particularly important for IM residents, who must devote at least one-third of their time to outpatient care and represent a significant proportion of physicians who will enter the adult primary care workforce. With no preexisting IPV curriculum at our institution, we designed and implemented a novel IPV curriculum for first-year residents and evaluated its impact on knowledge, attitudes, and practices.

Methods

Curriculum Development

We used the six-step approach to curriculum development to develop and implement our curriculum. For our project, one of the facilitators (Emily Insetta) had prior clinical and research experience working with IPV victims in a women’s shelter. The other facilitator (Colleen Christmas) had expertise in medical education and curriculum development. Both investigators gained current knowledge in the field of IPV by visiting the local women’s shelter and performing a thorough review of the literature about the health consequences of IPV and existing IPV curricula. Our educational content was adapted from published IPV curricula for IM residents in the United States, general practitioners in the Netherlands, and general medicine residents and practitioners in Greece. Based on this existing work, we designed our curriculum using synchronous, iterative, multimodal teaching strategies.

The curriculum was delivered in two parts. Part 1 provided foundational information about IPV, and Part 2 focused on how to apply the information in clinical settings. For Part 1 of our curriculum, the objectives were for learners to be able to (1) describe the prevalence of IPV, (2) identify red flags for IPV, (3) list health consequences of IPV, (4) define recommendations for documenting and reporting IPV, and (5) access local services for IPV victims. Part 1 began with a presentation, either a recorded TED Talk from an IPV survivor or an in-person discussion with a social worker from the local House of Ruth women’s shelter; these are considered optional curricular components of the current publication, depending upon the availability of resources. The TED Talk was delivered by an upper-class, educated, Caucasian woman who shared her personal experience as an IPV victim in order to emphasize the psychological dynamics of violent relationships and also the prevalence of IPV among all sociodemographic classes. The social worker from the women’s shelter emphasized similar topics by discussing the top five myths about IPV based on her experience working with victims; after her 10-minute talk, there was time for a brief question-and-answer session with the residents about IPV and how to best care for IPV victims. The instructional method of starting with a video or in-person discussion about real-life IPV experience was used to capture the learners’ attention, help them understand the psychological complexity of IPV, and inspire empathy for IPV victims.
The remainder of Part 1 of the curriculum involved a PowerPoint presentation (Appendix A) describing evidence-based information about IPV demographics, health consequences, and reporting requirements. A case-based approach was also used to help learners apply the knowledge to patient care; the presentation centered around a hypothetical clinical case of an IPV victim seeking care in a primary care clinic. There were questions included throughout the presentation to stimulate interactive discussion.

The objectives for Part 2 of the curriculum were for learners to be able to (1) list evidence-based approaches to screening for and discussing IPV with patients and (2) express increased confidence and comfort in caring for IPV survivors. During Part 2 (Appendix B), we used a brief PowerPoint presentation to review Part 1’s content and highlight evidence-based communication strategies, including the HITS screening tool\(^\text{12,13}\) and recommendations from IPV survivors in qualitative studies.\(^\text{27,28}\) A handout of key slides from the two presentations (Appendix C) was distributed to students for quick reference during the subsequent role-play activity of Part 2, where learners spent the majority of their time. Role-play was chosen as an effective instructional method for teaching medical trainees about communication skills and providing opportunities for observation, rehearsal, discussion, and feedback.\(^\text{29}\) Small groups of three learners each received five role-play scenarios (Appendix D) during which they practiced screening for and discussing IPV. They rotated roles as the physician, patient, and patient’s partner or observer. Each role-play scenario lasted about 5 minutes. After each scenario, the learners joined together as a large group to debrief for approximately 7 minutes about how the scenario felt in each role, what the physician did well, and how the physician might improve his/her strategies to screen for and respond to IPV. The facilitator guide (Appendix E) also included additional questions depending upon the scenario, such as assessing the victim’s stage of change\(^\text{30,31}\) or discussing the cultural contexts of IPV.\(^\text{32}\)

**Implementation**

Our curriculum was implemented in the Johns Hopkins Bayview IM residency program, which is an urban, academic training site for 64 residents in Baltimore, Maryland. Before this curriculum, there was no existing IPV training for residents at our institution. The curriculum was taught during July and August of 2016 and 2017 to two classes of first-year IM residents as they rotated through preexisting, mandatory ambulatory blocks. Part 1 lasted 60 minutes, and Part 2 was 90 minutes. Each part was conducted in person in a classroom equipped with a computer that connected to a screen large enough for the group to view.

Both parts were taught by the study investigators, clinician educators in the Department of General Internal Medicine at Johns Hopkins Bayview. For each session, one or both facilitators were present to teach five to nine learners; the small size of the group allowed a comfortable setting for the learners to participate in interactive discussions and role-plays. To be qualified to teach the curriculum, experience in facilitating role-plays is highly useful. The materials provided here should enable even those teachers who lack content expertise to prepare and deliver the curriculum.

This study was conducted with approval from the Johns Hopkins Institutional Review Board (IRB00101773). Compensation for study participants, a $10 Amazon gift card for each survey completed, was funded by faculty gift. While participation in the curriculum was required, the residents were informed that participation in the curriculum evaluation was voluntary.

**Evaluation**

Data were collected via voluntary pre- and postcurriculum surveys immediately before Part 1 (Appendix F) and immediately after Part 2 of the curriculum (Appendix G). Survey questions were adapted from the Physician Readiness to Manage Intimate Partner Violence Survey, which was published in 2015 in MedEdPORTAL\(^\text{33}\) and has been described as a reliable measure of physician preparedness to manage IPV.\(^\text{34}\) Time was allotted for participants to complete the paper survey in person. Surveys were placed in an envelope without names to preserve anonymity; a research assistant entered data into an Excel spreadsheet devoid of any personal identifiers.

**Data Analysis**

Paired two-tailed \(t\) tests were used to compare pre- and postcurriculum survey responses. Statistical significance was defined as \(p < .05\). For the four knowledge questions, the mean percentage correct was compared between the pre- and postcurriculum surveys. For the attitudes and practices questions, respondents answered using a Likert scale, and the mean pre- and postcurriculum scores were compared. Responses to three questions that were only in the postcurriculum survey were described using frequency of responses.

**Results**

**Demographics**

Thirty-two first-year residents received IPV teaching. Thirty participants (16 male) completed the baseline survey; one survey
was excluded from the baseline data due to illegible responses ($n = 29, 91\%$ of total participants). Twenty-eight participants (14 male) completed the postintervention survey ($n = 28, 88\%$ of total participants). The mean age for both pre- and postcurriculum survey respondents was 27 years old.

Effectiveness of the Intervention
Data are summarized in the Table. For the knowledge questions, there was a statistically significant improvement in the mean percentage correct (65\% vs. 87\%, $p < .001$). Responses about attitudes showed the majority of first-year residents at baseline agreed or strongly agreed that IPV was relevant to clinical practice, that IPV had an important impact on physical and mental health, and that IPV screening was important; this appreciation for IPV as a health problem did not change ($p > .05$).

After the curriculum, residents were more likely to report they had received adequate training in IPV ($p < .001$). There were improvements in self-efficacy, including increased confidence in detecting IPV, documenting IPV, and referring to resources (all $p < .001$). Participants reported increased comfort with managing difficult emotions regarding IPV in patients ($p < .01$) and themselves ($p < .001$). They also reported increased comfort with discussing IPV with both female and male patients (both $p < .001$).

Participants reported increased screening frequency for male patients ($p < .01$; Figure 1). The change in reported IPV screening frequency for female patients did not reach statistical significance ($p = .07$; Figure 2). All 28 participants agreed or strongly agreed that after Parts 1 and 2 of the curriculum, they would be more likely to screen for IPV and more skillful in discussing IPV (Figure 3). Twenty-five of 28 postsurvey participants agreed or strongly agreed that after the training they would be better equipped to refer to resources.

**Discussion**
IPV is a prevalent problem with detrimental health consequences. IPV screening and counseling are recognized as important preventive health services, but there is a paucity of literature describing IPV training for IM residents. At baseline, we found that residents appreciated the importance of IPV in the health assessment, which confirms the findings of prior research. We demonstrated the effectiveness of our curriculum in improving the knowledge, attitudes, and self-efficacy of first-year IM residents. Our curriculum was successfully implemented using widely available resources, including a web-based TED Talk, PowerPoint presentations, and role-plays. The brevity of our curriculum also makes it a feasible and generalizable intervention, while still producing outcomes comparable to those of other studies. The total curricular time was 2.5 hours for each learner. Notably, the aforementioned IPV curricula developed in Philadelphia, the Netherlands, and Greece required 4 hours, 1.5 days, and 9 hours of training, respectively.23-25

**Improvement in Knowledge and Attitudes**
Our data showed improvements in knowledge scores as well as increased confidence and comfort in screening for and

| Survey Category | Item                                                                 | Precurriculum Mean | Postcurriculum Mean | $p$   |
|-----------------|----------------------------------------------------------------------|-------------------|--------------------|-------|
| Knowledge       | Knowledge score (% correct)                                          | 65\%              | 87\%               | <.001* |
| Attitudes: importance\(^a\) | Identifying IPV is relevant to my clinical practice. | 5.4               | 5.6                | .19   |
|                 | IPV has an important impact on a patient's mental health.            | 5.9               | 5.9                | .35   |
|                 | IPV has an important impact on a patient's physical health.          | 5.9               | 5.9                | .92   |
|                 | Screening for IPV is an important part of every patient's health assessment. | 5.4               | 5.4                | .81   |
| Attitudes: confidence\(^b\) | I am confident in my ability to detect IPV indicators based on a patient's history and physical exam. | 3.1               | 4.4                | <.001* |
|                 | I know how to document IPV in a patient's chart.                     | 2.4               | 4.1                | <.001* |
|                 | I know how to make referrals to resources for patients with trauma. | 2.2               | 4.3                | <.001* |
|                 | I've received an adequate amount of training about IPV.              | 2.7               | 4.8                | <.001* |
| Attitudes: comfort\(^c\) | I am comfortable with managing difficult emotions that may arise in a patient when discussing IPV. | 3.6               | 4.4                | <.01*  |
|                 | I am comfortable with managing difficult emotions that may arise in myself when discussing IPV. | 3.9               | 4.6                | <.001* |
|                 | I am comfortable discussing IPV experiences with female patients.    | 3.7               | 4.8                | <.001* |
|                 | I am comfortable discussing IPV experiences with male patients.      | 3.7               | 4.5                | <.001* |
| Practices: screening frequency\(^d\) | How often do you ask female patients about the possibility of IPV? | 2.5               | 2.9                | .07   |
|                 | How often do you ask male patients about the possibility of IPV?     | 1.6               | 2.1                | <.01*  |

Abbreviation: IPV, intimate partner violence.

\(^a\)Statistically significant, $p < .05$.

\(^b\)Rated on a 6-point Likert scale (1 = strongly disagree, 2 = disagree, 3 = somewhat disagree, 4 = somewhat agree, 5 = agree, 6 = strongly agree).

\(^c\)Rated on a 5-point Likert scale (1 = never, 2 = rarely, 3 = sometimes, 4 = nearly always, 5 = always).
discussing IPV, similar to the results published by Papadakaki, Petridou, Kogevinas, and Lionis\textsuperscript{25} and Kripke, Steele, O’Brien, and Novack.\textsuperscript{23} Our results are limited to short-term, self-reported data only. It is reassuring that Papadakaki and colleagues\textsuperscript{25} demonstrated their effects up to 12 months after the intervention. Kripke and colleagues\textsuperscript{23} found that attitudes and knowledge improvements were sustained at 6 months but that skills were not. The best way to maintain the
long-term benefits of this curriculum is a potential area for future study.

Improvement in Self-Reported Screening Frequency
Our hope is that changes in knowledge and attitudes will translate into practices. It is encouraging that all 28 respondents in our postintervention survey stated that after the training, they would be more likely to screen for IPV and more skillful in discussing IPV (Figure 3). There was a statistically significant increase in self-reported screening frequency for male patients, suggesting that our curriculum taught awareness of the high prevalence of IPV across socioeconomic classes, cultures, and genders. Although there was a trend toward increased screening for female patients, the change was not statistically significant. This finding may have multiple explanations: Screening frequency was higher for female patients at baseline, the Likert scale may not have captured subtle changes, the 2-month time frame may have been too short, the sample size may have been too small, and/or the curriculum may have been insufficient to impact screening for female patients.

Because the survey was administered immediately after Part 2 of the curriculum, we suspect the reported increase in screening frequency for male patients reflected the participants’ response to Part 1 of the curriculum, which had been administered 1-2 months prior. We do not know what longer-term follow-up after Part 2 of the curriculum would have revealed. Although we relied on short-term self-reporting, there were promising results from the 2006 study that trained general practitioners in the Netherlands and tracked the impact of a curriculum on IPV screening by chart review 6 months postintervention. That study found higher rates of screening and detection of IPV among practitioners who participated in the intervention compared to those who did not.24

Improvement in Referrals to Resources
In addition to teaching screening and counseling techniques, we emphasized the importance of referrals to IPV resources; 25 of 28 participants reported being better equipped to refer to resources after the curriculum (Figure 3). Research shows that connecting patients with specialized IPV services leads to improved outcomes. The 2012 systematic review by Nelson, Bougatsos, and Blazina showed that a variety of IPV counseling and mentorship programs are effective in reducing depressive symptoms, decreasing subsequent violent incidents, and improving birth outcomes for IPV victims.8 Similarly, a 2017 meta-analysis and systematic review demonstrated the effectiveness of short-term interventions for IPV survivors in reducing posttraumatic stress disorder, depression, distress, substance abuse, and subsequent violence while increasing self-esteem, life functioning, emotional well-being, and safety.35 Ultimately, as described by Miller, McCaw, Humphreys, and Mitchell, an integrated systems approach is necessary to provide the best possible care for IPV survivors, of which training health care professionals is recognized as one important component.36

Lessons Learned
Through repeated delivery, self-reflection by the investigators, and informal feedback from participants, the curriculum has been improved throughout implementation. For Part 1, the TED Talk video was long, and some of the key points were lost by the end when questions were presented and discussed. We decided to
mitigate this by (1) omitting less relevant parts of the video, (2) showing the video in short segments, (3) posing questions prior to each segment to focus learners’ attention, and (4) pausing to discuss the questions after each segment, rather than waiting until the end. During Part 1, we also found that learners were asking for additional information about documenting IPV. Thus, a slide was added with an explicit example of IPV documentation. Finally, Part 1 initially had long periods of didactic lecturing; to promote learner engagement, we integrated multiple-choice questions throughout the presentation.

For the role-play activities during Part 2 of the curriculum, the debriefing questions initially only asked learners to express how they felt in their roles and how the physician could improve. This yielded limited discussion. To stimulate richer conversation about the complex issues surrounding IPV, we added questions about assessing victims’ stages of change,30,31 eliciting learners’ real-life experiences, and exploring the cultural contexts of IPV32 to the facilitator guide.

Limitations and Future Directions
Our work shows that a brief curriculum about IPV can have a significant impact on the knowledge, self-efficacy, and self-reported behaviors of first-year IM residents. We demonstrated self-reported benefits with only 2.5 hours of teaching time during the first year of residency. These findings may translate into greater efficacy in screening, detection, counseling, and referrals to resources.

Our study is limited by a small sample size at a single institution and a short time interval; future directions may be to apply the curriculum to a broader sample size and to repeat surveys at a later time interval. To promote sustained behavior change, there could be additional teaching sessions to remind learners about IPV at later points in their training. For example, bringing learners to the local women’s shelter as a mandatory part of the curriculum could inspire empathy for IPV victims and thereby translate into more frequently addressing IPV in clinical practice; opportunities at our local shelter were offered on a volunteer basis only, which involved just a few of the study participants. Additionally, a future direction could be to provide feedback to providers with reports of how often they are completing IPV screening items in the health record in order to reinforce sustained behavior change. Another significant limitation to our data was that behaviors were self-reported. Future directions could include assessing behaviors beyond self-reporting, such as by chart review for documentation of IPV discussions, active reporting of IPV cases by physicians, or collecting data from the clinic social worker and/or local IPV shelters about trends in the number of referrals made and completed.

Our IPV curriculum extends prior interventions for medical students to target IM residents, who will comprise an important component of the future physician workforce. Successfully training resident physicians is one important step in promoting the best possible comprehensive care for IPV survivors.

Appendices
A. IPV Part 1 - Introduction.pptx
B. IPV Part 2 - Application.pptx
C. IPV Learner Guide.docx
D. IPV Role-Play Scenarios.docx
E. IPV Role-Play Facilitator Guide.docx
F. IPV Preintervention Survey.docx
G. IPV Postintervention Survey.docx

All appendices are peer reviewed as integral parts of the Original Publication.

Emily R. Insetta, MD: Assistant Professor of Medicine, Division of Hospital Medicine, Johns Hopkins University School of Medicine
Colleen Christmas, MD: Associate Professor of Medicine, Division of General Internal Medicine, Johns Hopkins University School of Medicine; Associate Professor of Medicine, Division of Geriatric Medicine and Gerontology, Johns Hopkins University School of Medicine

Disclosures
None to report.

Funding/Support
None to report.

Prior Presentations:
Insetta ER, Christmas C. Teaching about intimate partner violence: assessment of a curriculum for internal medicine residents. Poster presented at: Society of General Internal Medicine Annual Meeting; April 20, 2017; Washington, DC.

Ethical Approval
The Johns Hopkins Institutional Review Board approved this study.

References
1. Breiding MJ, Basile KC, Smith SG, Black MC, Mahendra RR. Intimate Partner Violence Surveillance: Uniform Definitions and
11. Family Violence Prevention and Services Program. The Affordable Care Act & women’s health. U.S. Department of Health and Human Services website. Updated December 2013. Accessed October 10, 2018. https://www.acf.hhs.gov/sites/default/files/fy13/aca_fvpsa_20131211.pdf

12. Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A. HITS: a short domestic violence screening tool for use in a family practice setting. *Fam Med.* 1998;30(7):508-512.

13. Chen P-H, Rovi S, Vega M, Jacobs A, Johnson MS. Screening for domestic violence in a predominantly Hispanic clinical setting. *Fam Pract.* 2005;22(6):617-623. https://doi.org/10.1093/fampra/cmi075

14. Pagels P, Kindratt TB, Reyna G, Lam K, Silver M, Gimpel NE. Establishing the need for family medicine training in intimate partner violence screening. *J Community Health.* 2015;40(3):508-514. https://doi.org/10.1007/s10900-014-9964-1

15. Sprague S, Madden K, Simunovic N, et al. Barriers to screening for intimate partner violence. *Womens Health.* 2012;52(6):587-605. https://doi.org/10.1080/03630242.2012.690840

16. Jung D, Kavanagh M, Joyce B, Lucia V, Afonso N. Novice health care students learn intimate partner violence communication skills through standardized patient encounters. *MedEdPORTAL.* 2015;11:9977. https://doi.org/10.15766/mep_2374-8265.9977

17. Clithero A, Albright D, Bissell E, et al. Addressing interpersonal violence as a health policy question using interprofessional community educators. *MedEdPORTAL.* 2016;12:10516. https://doi.org/10.15766/mep_2374-8265.10516

18. Schrier MW, Rougas SC, Schrier EW, Elisseou S, Warrie S. Intimate partner violence screening and counseling: an introductory session for health care professionals. *MedEdPORTAL.* 2017;13:10622. https://doi.org/10.15766/mep_2374-8265.10622

19. Elisseou S, Puranam S, Nandi M. A novel, trauma-informed physical examination curriculum for first-year medical students. *MedEdPORTAL.* 2019;15:10799. https://doi.org/10.15766/mep_2374-8265.10799

20. Pletcher BA, O’Connor M, Swift-Taylor ME, DallaPiazza M. Adverse childhood experiences: a case-based workshop introducing medical students to trauma-informed care. *MedEdPORTAL.* 2019;15:10803. https://doi.org/10.15766/mep_2374-8265.10803

21. Siegel M, Chen Gonzalez E, Wijesekera O, et al. On-the-go-training: downloadable modules to train medical students to care for adult female sexual assault survivors. *MedEdPORTAL.* 2017;13:10656. https://doi.org/10.15766/mep_2374-8265.10656

22. Kern DE, Thomas PA, Hughes MT, eds. *Curriculum Development for Medical Education: A Six-Step Approach.* 2nd ed. Johns Hopkins University Press; 2009.

23. Kripke EN, Steele G, O’Brien MK, Novack DH. Domestic violence training program for residents. *J Gen Intern Med.* 1998;13(12):839-841. https://doi.org/10.1046/j.1525-1497.1998.00248.x

24. Lo Fo Wong S, Wester F, Mol SSL, Lagro-Janssen TLM. Increased awareness of intimate partner abuse after training: a randomised controlled trial. *Br J Gen Pract.* 2006;56(525):249-257.

25. Papadakali M, Petridou E, Kogevinas M, Lioni C. Measuring the effectiveness of an intensive IPV training program offered to Greek general practitioners and residents of general practice. *BMC Med Educ.* 2013;13:46. https://doi.org/10.1186/1472-6920-13-46

26. Steiner LM. Why domestic violence victims don’t leave [video]. TED website. Published November 2012. Accessed October 5, 2018. https://www.ted.com/talks/leslie_morgan_steiner_why_domestic_violence_victims_don_t_leave?language=en
27. Chang JC, Decker MR, Moracco KE, Martin SL, Peterson R, Frasier PY. Asking about intimate partner violence: advice from female survivors to health care providers. Patient Educ Couns. 2005;59(2):141-147. https://doi.org/10.1016/j.pec.2004.10.008

28. Chang JC, Cluss PA, Ranieri L, et al. Health care interventions for intimate partner violence: what women want. Womens Health Issues. 2005;15(1):21-30. https://doi.org/10.1016/j.whi.2004.08.007

29. Nestel D, Tierney T. Role-play for medical students learning about communication: guidelines for maximising benefits. BMC Med Educ. 2007;7:3. https://doi.org/10.1186/1472-6920-7-3

30. Prochaska JO, Velicer WF. The transtheoretical model of health behavior change. Am J Health Promot. 1997;12(1):38-48. https://doi.org/10.4278/0890-1171-12.1.38

31. Chang JC, Dado D, Ashton S, et al. Understanding behavior change for women experiencing intimate partner violence: mapping the ups and downs using the stages of change. Patient Educ Couns. 2006;62(3):330-339. https://doi.org/10.1016/j.pec.2006.06.009

32. Gennari M, Giuliani C, Accordini M. Muslim immigrant men’s and women’s attitudes towards intimate partner violence. Eur J Psychol. 2017;13(4):688-707. https://doi.org/10.5964/ejop.v13i4.1411

33. Bays A, Ingram K. Critical Synthesis Package: Physician Readiness to Manage Intimate Partner Violence (PREMIS). MedEdPORTAL. 2015;11:10095. https://doi.org/10.15766/mep_2374-8265.10095

34. Short LM, Alpert E, Harris JM Jr, Surprenant ZJ. A tool for measuring physician readiness to manage intimate partner violence. Am J Prev Med. 2006;30(2):173-180.e19. https://doi.org/10.1016/j.amepre.2005.10.009

35. Arroyo K, Lundahl B, Butters R, Vanderloo M, Wood DS. Short-term interventions for survivors of intimate partner violence: a systematic review and meta-analysis. Trauma Violence Abuse. 2017;18(2):155-171. https://doi.org/10.1177/1524838015602736

36. Miller E, McCaw B, Humphreys BL, Mitchell C. Integrating intimate partner violence assessment and intervention into healthcare in the United States: a systems approach. J Womens Health (Larchmt). 2015;24(1):92-99. https://doi.org/10.1089/jwh.2014.4870

Received: April 5, 2019
Accepted: November 7, 2019
Published: May 27, 2020