Intimate Partner Violence Detected during Abortion-Related Visits: A Systematic Review of Screenings and Interventions

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Abstract

Objective To perform a systematic review of screening tools and interventions focused on reducing adverse health outcomes associated with intimate partner violence (IPV) at abortion-related visits.

Study Design Studies were eligible if they included individuals seeking pregnancy options health care services in the United States, screening for or implementation of an intervention for IPV, and were published in English after the year 2000. The primary outcomes were to summarize screening tools, interventions studied, and if interventions led to individuals being connected to IPV-related resources. Secondary outcomes included patient responses to the IPV-related interventions and any other outcomes reported by the studies (PROSPERO #42021252199).

Results Among 4,205 abstracts identified, nine studies met inclusion criteria. The majority ($n = 6$) employed the ARCHES (Addressing Reproductive Coercion in Health Settings) tool for identification of IPV. Interventions included provider-facilitated discussions of IPV, a safety card with information about IPV and community-based resources, and referral pathways to directly connect patients with support services. For the primary outcome, IPV-related interventions were shown to better inform patients of available IPV-related resources as compared to no intervention at all. For the secondary outcomes, screening and intervening on IPV were associated with improvements in patient perception of provider empathy (i.e., caring about safety) and safer responses by patients to unhealthy relationships.

Conclusion Screening for and intervening on IPV at abortion-related visits are associated with positive outcomes for patient safety and the patient–provider relationship. However, data on effective tools for identifying and supporting these patients are extremely limited. This review emphasizes the unmet need for implementation and evaluation of IPV-specific interventions during abortion-related clinical encounters.

Keywords

- reproductive health
- abortion visits
- intimate partner violence
- screening
- intervention
- Dobbs decision

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Key Points

- The abortion visit offers a crucial setting to address IPV among a highly affected population.
- This study reviews others that analyzed interventions and associated outcomes for IPV at abortion-related visits.
- Appropriate interventions for IPV can improve patient-provider relationships and connect patients to essential resources.

Intimate partner violence (IPV) as defined by the World Health Organization is any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship.[1] In the United States, IPV is one of the most common causes of injury in women, and over 50% of all cisgender female murders are committed by partners or ex-partners.[2,3] The prevalence of IPV is even higher for those receiving abortion care. In pregnant people who seek abortion, between 24 and 39.5% had a history of abuse.[4] Since IPV often includes sexual violence and reproductive coercion (RC), there is a large overlap between individuals seeking an abortion and those who have experienced IPV.

Roe v Wade, a landmark 1973 U.S. Supreme court case which confirmed the constitutional right to abortion in the United States, was overturned by Dobbs v Jackson Women's Health Organization in June 2022 and eliminated that right.[5] This decision has created a ripple effect that has impacted many factors including primary health care access—which is an important point of contact for people who are experiencing IPV and also precipitated an unparalleled crisis in abortion rights and access.[6] Those that are able to access abortion services, therefore, may represent a highly needy population in need of comprehensive health services.

Currently the USPTF (United States Preventative Services Task Force) has a grade B recommendation to "screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services."[7] These screening protocols and subsequential interventions for IPV at abortion-related health care visits are important not only because of the high prevalence of patients experiencing IPV, but because the abortion visit provides a key environment for intervention. Only about one in three women seeks medical care after sexual assault,[8] so a health care visit related to abortion may be the first-time women with rape-related pregnancies access care after an assault. Furthermore, it is common for U.S. women to use family planning clinics—stand-alone clinics that provide sexual and reproductive health care, such as abortion care—as their primary, and sometimes only, point of health care.[9]

Thus, the purpose of the study is to evaluate strategies used for screening patients for IPV and then subsequently supporting patients that have screened positive for experiencing IPV in the setting of a visit pertaining to abortion. By examining current methods, we can better understand both patient and provider barriers that limit effective implementation of clinic-based interventions that promote universal education and assessment of IPV.

Materials and Methods

Studies were eligible if they included individuals who were seeking abortion services and discussed IPV screening and/or IPV-related interventions. Results were restricted to those in the English language, published between 2000 and 2021. We chose to begin our screening in the year 2000 as we believe that laws have changed significantly, especially around mandated reporting.[10] Thus, we believe that initiatives after 2000 would likely prove to be more useful and timely to the current legal climate we live in related to reporting and intervening on IPV. Furthermore, given the heterogeneity in support services for IPV and different laws regarding abortion in different countries, we limited our search to studies published from the United States. A librarian (M.S.) collaboratively developed the search strategies with the other authors (T.S., A.P, I.R., and M.S.) and ran the searches in the following databases: MEDLINE (PubMed), clinicaltrials.gov, Embase (Elsevier), Cochrane Library (Wiley), Scopus (Elsevier), Web of Science (Clarivate), and ProQuest Dissertation & Theses Global (ProQuest). The search strategies of all databases were adapted from the MEDLINE search strategy. All databases were limited to 2000 to present and English language. Searching for eligible studies to include in the review involved the following approaches: controlled vocabulary (MeSH headings and thesauri of relevant databases) and the keywords of intimate partner violence, domestic abuse, surveys, questionnaires, pregnancy counseling, family planning, and abortion. We also attempted to discover additional studies by searching the reference lists of key studies and relevant systematic reviews. The review protocol was registered on May 17, 2021, in the PROSPERO database (CRD42021252199). The search was completed in June 2021. A combination of keywords and subject headings (when available) was used to locate relevant literature (►**Supplementary Material A**, available in the online version). The full study protocol was uploaded to PROSPERO (CRD no.: 42021252199).

Rayyan was used to identify and remove 3,159 duplicate records. The remaining 4,205 records were reviewed by multiple authors (T.S., S.N., I.R., and P.E.) based on title and abstracts. Relevant articles meeting inclusion criteria were selected for full textual analysis. Disagreements on included texts were resolved by consensus with other investigators (I.R. and A.P.).

Risk of bias was evaluated with use of the Newcastle–Ottawa scale for observational cohort analyses, while the Cochrane Collaboration was used for randomized controlled trials.[11] For qualitative data, the Critical Appraisals Skills Programme checklist was utilized.

The relevant outcomes for the included studies were the types of interventions used when IPV was detected during an abortion-related health care visits, reported effectiveness of IPV interventions, and barriers to implementation of IPV interventions. Due to the heterogeneity of the reported interventions and multiple types of reported outcomes, we decided,

a priori, to report our findings as a systematic review. This systematic review adheres to the PRISMA 2020 guidelines.[12]

A Note on Nomenclature

Throughout this manuscript, we use the term "woman," "women," or "female," in line with the included literature's use of the term. We acknowledge that people experiencing IPV who are seeking abortion-related services may not identify as women, and we stand in solidarity with those individuals.

Results

Of the 7,364 abstracts eligible for evaluation, 3,159 were removed due to duplication. Of the remaining abstracts, 4,153 were deemed ineligible and excluded. A total of 52 manuscripts were available for full-text analysis, of which 9 met inclusion criteria and were eligible for analysis (►Supplementary Appendix 1). Summary of studies analyzed below (►Table 1).[13–21] Assessment of Newcastle–Ottawa scale and Cochrane Collaboration assessment are presented in ►Tables 2 and 3.

Types of IPV Interventions

Collectively, the most effective interventions included provider education, the implementation of an institutional protocol, and additional on-site resources, such as a victim advocate or social worker. While interventions and outcome measures to assess effectiveness varied among studies (see next section), brief interventions (e.g., increasing general awareness of domestic violence with brochures and posters and providing aids to remind physicians how to identify victims) only improved practicing physicians' perceptions, knowledge, and skills in managing domestic violence, but did not increase referrals to domestic violence support resources.[21] Instead, studies that provided system-level support for survivors of IPV demonstrated significant improvement in knowledge, attitudes, and identification of survivors by clinicians with referral to resources.[21] Thus, training programs that contain interactive learning components combined with system-level support may be beneficial in increasing awareness and survivor identification.

It was likely that training for IPV interventions improved outcomes because they enhanced patient self-efficacy while avoiding stigmatizing language during the encounter. In a qualitative evaluation of a multisite randomized controlled trial, Miller et al found that providers' use of scripts that were provided during IPV-related training avoided assumptions about violence experiences and factored heavily into the IPV screening intervention's acceptability by patients.[19] This finding is consistent with past research documenting that women in abusive relationships prefer clinical providers to be neutral and not make assumptions about past or current IPV experiences.[22,23]

Effectiveness of Conducted Interventions

Evaluation of effectiveness of IPV-related interventions differed between studies. From a patient perspective, qualitative evaluation of patient experiences in a multicenter randomized trial aimed at informing patients of IPV available resources and demonstrating how RC and partner violence can affect sexual and reproductive health demonstrated multiple patient-centered improvements in care.[19] Not only did it increase patient knowledge about violence-related services, including recognition of the clinic as a safe resource, but it also reduced patient isolation from their support system or external resources.[19] The importance of IPV interventions was also seen across studies as intervention exposure was associated with many patients leaving a relationship because it felt unhealthy or unsafe[17] and with many patients reporting significantly less RC at 1 year follow-up.[18]

In another multi-site, pre-post study, patients who reported receipt of either element of the ARCHES (Addressing Reproductive Coercion in Health Settings) intervention were significantly more likely to feel that their provider cared about their safety and felt that the provider would know what to do if the patient were in an unhealthy relationship.[14] Among patients who lacked knowledge of violence-support resources at baseline, acquisition of knowledge about violence-related resources by follow-up was significantly higher among patients who received the intervention.[14]

Current Barriers to Universal IPV Interventions

Across several studies, providers noted similar barriers for IPV interventions in their clinics: insufficient time, lack of training, inadequate resources, personal discomfort, and uncertainty about how to handle patients' disclosures of IPV/RC.

Insufficient Time

Both licensed and unlicensed providers stated that they do not have enough time to effectively address all aspects of patients' needs.[13] Many interventions addressed this barrier by having patients complete a screening questionnaire while waiting to see a provider or having other members of clinical staff conduct the initial portion of the screening. This created a clinic workflow that did not significantly alter the patient–provider encounter.[15,21]

Lack of Training and Inadequate Resources

Providers expressed frustration that they do not always have immediate access to social work services within and outside of the organization. In a 2010 cross-sectional survey of family planning center staff screening for IPV, one licensed professional remarked, "We need to know there is immediate access to a social worker in case of an [emotional] crisis [that might result from a disclosure]."[13] Other providers have also noted that IPV training is not accessible for clinics or clinical staff.[14] However, the collective studies have noted that several new IPV training modules are available, such as the ARCHES program and a widely available resource from Futures Without Violence. Not only do these programs provide attainable training, but also have connections for resources for clinics without adequate staffing like social work.

Table 1 Studies Included

Author (year)	Study design	Population	Exposure	Primary outcome	Secondary outcomes	Results
Colarossi (2010)	Cross-sectional survey	Family planning center staff who screened for intimate partner violence.	A brief, anonymous, self-administered survey at the end of routine, monthly administrative staff meetings. After the same administrative meetings, staff participated in 30-minute focus group discussions about the intimate partner violence policy and procedures.	Attitudes toward performing intimate partner violence screening.	Perceptions of the helpfulness of using a written screening form and conducting secondary verbal screening with patients.	Providers expressed positive attitudes about screening for intimate partner violence and considered it an important part of comprehensive health care. Negative attitudes were mostly related to provider perceptions that clients were not responsive enough to advice or referrals that providers offered after a disclosure of partner violence.
Decker (2017)	Multi-site, quasi-experimental, single group pretest–posttest study	English-speaking women, ages 18–35, patients at two family planning health centers in the Baltimore area from January to April 2014	A brief ARCHES (Addressing Reproductive Coercion in Health Settings) intervention. The intervention is delivered through: (1) a provider-facilitated discussion on IPV/RC and (2) the provision of a palm-sized safety card with information on IPV/RC, its health impact, and support resources.	Intervention fidelity, reported by participant self-report of intervention receipt.	Intervention acceptability and perception by participants.	65% reported receiving the intervention. Women who reported receipt of either element of the intervention were significantly more likely to feel that her provider cared about her safety (91.9 vs. 73.9%; RR: 1.22, 95% CI: 1.01–1.47), and feel that provider would know what to do if she were in an unhealthy relationship (90.7 vs. 67.4%; RR: 1.35, 95% CI: 1.09–1.66). Among women who lacked knowledge of violence-support resources at baseline, acquisition of knowledge about violence-related resources by follow-up was significantly higher among women who received the intervention (33.3 vs. 8.0%, RR:: 4.29, 95% CI 1.05–17.55).
Hill (2019)	Multi-site, single-blind randomized controlled trial	Female, 16–29 years old, English-speaking patients at four family planning clinics in Western Pennsylvania	Patients were assigned to either TIPS (Trauma-Informed Personalized Scripts)-Basic, which included tailored provider scripts, or TIPS-Plus, which included tailored provider scripts and psychoeducational messages for patients.	A summary score that captured any discussion of intimate partner violence (IPV) or reproductive coercion (RC)	Implementation rates of the TIPS program compared to the previous ARCHES program.	The mean summary score for any discussions about harmful partner behavior was 2.37 in TIPS-Plus and 2.39 in TIPS-Basic ($p = 0.635$). For IPV discussion, implementation increased from 48.1 to 78.8% ($p < 0.0001$). For RC discussion, implementation increased from 9.8 to 63.4% ($p < 0.0001$).
Hill (2021)	Prospective cohort study	Female, 18–29 years, English speaking, and scheduled for a clinic visit with a provider enrolled in the study. Patients who consented to the parent study (Zachor et al) were asked to participate in an audio-recorded visit with their provider.	Not applicable	A description of the content, style, and approach with IPV assessments in the recorded encounters.	Not applicable	Ninety encounters (91.8%) contained discussions related to IPV, healthy relationships, or other controlling partner behaviors. In 83 encounters (84.7% of total visits), providers asked patients ''yes/no'' IPV screening questions. Despite an emphasis on universal education, in 14 of 83 encounters (16.9%) providers asked isolated screening questions with no efforts to normalize the conversation or provide resources. In seven encounters, patients disclosed IPV—six were in response to provider assessment.

Table 1 (*Continued*)

Author (year)	Study design	Population	Exposure	Primary outcome	Secondary outcomes	Results
Miller (2011)	Multi-site, single-blind randomized controlled trial	All English- and Spanish-speaking females ages 16 to 29 years seeking care in four participating urban family planning clinics in North Carolina were eligible.	An enhanced IPV screening versus standard of care, which involves responding to two violence screening questions on an intake form	Two domains of reproductive coercion were assessed: recent (past 3 months) pregnancy coercion and recent (past 3 months) birth control sabotage.	Awareness and recent use of IPV services were also measured along with relationship changes from baseline to follow-up survey at 12–24 weeks post-intervention.	Among those who reported at baseline having experienced IPV in the past 3 months, the intervention demonstrated a 71% reduction in the odds of pregnancy coercion compared to participants in the control clinics (0.29, 95% CI: 0.09–0.91). Awareness of IPV-related services and reports of utilization of those services increased in both intervention and control groups. Across the total sample, more women in the intervention than the control arm reported having stopped going out with someone in the past 3 months because the relationship was unhealthy, or they felt unsafe ($p = 0.013$).
Miller (2016)	Multi-site, single-blind, cluster randomized controlled trial	All English- and Spanish-speaking female clients ages 16 to 29 years seeking care at participating family planning clinics in Western Pennsylvania were eligible.	Clinicians and staff with a half-day ARCHES training versus continued usual care.	Rates of disclosure of reproductive coercion and physical and sexual IPV victimization.	Rates of incident and unintended pregnancy; use of harm reduction behaviors; knowledge of IPV-related resources; use of IPV resources and services	There were no differences between groups for RC, IPV, or unintended pregnancy outcomes. Intervention participants were more likely to know about the national domestic violence hotline (93 vs. 87%, $p < 0.001$), more likely to have called the hotline (1.4 vs. 0.8%, $p = 0.003$), and more likely to have shared the number with someone else (9.5 vs. 4.8%, $p = 0.002$).
Miller (2017)	Structured case interviews	Women who reported a history of partner violence in the final computerized survey of the Miller (2016) randomized trial and providers and staff at participating clinics of the Miller (2011) trial.	Audio-recorded interviews of providers, staff, and patients at participating clinics.	Administrator and provider interpretation of intervention.	Participant interpretation of intervention.	All administrators found the intervention straightforward to implement and had greater contact with local victim service agencies after the intervention. Providers reported increased confidence talking with their patients about partner violence, and many noted an increase in disclosures about partner violence once they implemented the intervention. Patient interviews revealed that the intervention helped increase their knowledge about violence-related services (including their recognition of the clinic as a safe resource) and reduced isolation.

(*Continued*)

Table 1 (*Continued*)

Author (year)	Study design	Population	Exposure	Primary outcome	Secondary outcomes	Results
Saftlas (2014)	Multi-site, single-blind randomized controlled trial	Women who had experienced IPV by a current partner within the past year, aged 18 years or older, English-speaking, and was neither currently pregnant nor incarcerated.	Motivational interviewing by counselors to guide women in identifying feasible individual goals and small steps that they could safely take to increase their self-efficacy and feelings of control versus meeting with staff member who provided written materials and referrals to community-based resources.	Self- administered questionnaires regarding self-efficacy before randomization and 6 months later.	Depressive symptoms and stage of readiness to change	Within both groups, all outcomes improved significantly from baseline to follow-up. At follow-up, there were no significant differences between groups in mean depressive symptoms or self-efficacy; however, the decrease in depressive symptoms and the increase in self-efficacy were greatest among participants exposed to motivational interviewing. For stage-of-readiness-to-change, motivational interview subjects were less likely to be in precontemplation and more likely to be in the action or maintenance stage at follow-up.
Zachor (2018)	Multi-site, single-blind, stratified randomized controlled trial	Patients at four family-planning clinics in western Pennsylvania that had participated as control sites in the Addressing Reproductive Coercion in Health Settings (ARCHES) study, a randomized trial on IPV assessment and brief counseling.	IPV/RC communication skills building workshop using a simulated patient or a standard knowledge-based IPV/RC training (ARCHES intervention)	Provider discussion about IPV/RC	Receipt of a safety card with IPV/RC resources, and if the patient disclosed any history of IPV/RC during the visit	More patients in the clinics that received training reported receiving a safety card (72–84%) as compared to historical controls (9%, $p < 0.001$ for both). Patients in posttraining groups also reported more discussions about healthy versus unhealthy relationships than their respective pretraining historical control groups ($p < 0.001$ for both). Training of either type, but more so with standard knowledge-based training, significantly improved provider communication about IPV and RC.

Abbreviations: CI, confidence interval; IPV, intimate partner violence; RC, reproductive coercion; RR, relative risk.

Table 2 Critical Appraisal Skills Programme Qualitative Skills Checklist

Author (year)	Statement of aims	Appropriate methodology	Appropriate research design	Recruitment strategy	Data collection/ analysis	Clear statement of findings
Colarossi (2010)	*	*	*	*	*	*
Decker (2017)	*	*	*	*	*	*
Miller (2017)	*	*	*	*	*	*

Note: Asterisks represent presence of the theme listed in the column

Table 3 Cochrane collaborative's assessment of bias for randomized controlled trials

Author (year)	Randomization	Fidelity to assignment	Adherence to intervention	Missing outcomes	Measurement bias	Selected results reported	Overall
Hill (2019)	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk
Hill (2021)	Low risk	Unclear risk	Low risk	Low risk	Unclear risk	Low risk	Low risk
Miller (2011)	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk
Miller (2016)	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk
Saftlas (2014)	Low risk	Unclear risk	Low risk	Low risk	Unclear risk	Low risk	Low risk
Zachor (2018)	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk	Low risk

Adequately Addressing IPV Disclosures

Many providers additionally felt that their responses to violence disclosure would be inadequate to "fix" the problem.[13] However, this may be the case because health care providers are often accustomed to administering specified and immediate treatment, thus they may find the inability to remedy partner violence particularly frustrating. Partner violence often occurs over a longer term than health problems, and those experiencing it may have less control over it than they do over health issues.[13] However, adequate training, such as the ARCHES intervention, which occurred in several of the study's intervention groups, may help tackle this barrier.[14,18,19,21] This program and others, such as TIPS (Trauma-Informed Personalized Scripts) in the Hill et al study, directly focus on the complicated nature of experiencing partner violence and the variety of ways to support those impacted.[14,15]

These studies did not explicitly cite state-level policies as a barrier of screening. However, since many of their publications, the Dobbs decision has made it much more difficult to access abortion care as there are now 14 total or near-total abortion ban states.[24] Thus, the influx of patient population to abortion clinic is ever changing across the country, making it even more difficult to implement universal measures at any clinic site.

Discussion

In this systematic review on IPV-related interventions, studies suggest that appropriate interventions screening for IPV can be effective in improving the patient–provider relationship and also connecting patients with integral IPV-related resources in family planning health care settings. Almost all studies cited that there is a high prevalence of lifetime IPV and RC in their patient population, which emphasizes the value of universal trauma-informed interventions that link patients with care.[14] Furthermore, studies have demonstrated that nearly half of patients who screened positive for abuse in the past year had already sought or planned to seek help, indicating that providing resources and targeted information in a clinical environment directly addresses a patient's social needs.[25]

From the data, we recommend the following for IPV screening at abortion-related visits:

- We recommend training all family planning service providers on screening for and following up on disclosures of IPV.
  - Training should include universal education (i.e., regarding healthy relationships) and also a review of the latest research findings about the potential effects of partner violence on a variety of reproductive health outcomes and should make providers aware that survivors may need time and ongoing, consistent support, information, and resources before they can take steps to address the problem.[13]
  - It should include clarification of job responsibilities and of how and when to make a referral, rather than addressing clients' needs through health care counseling alone. Follow-up protocols and risk reduction services may be necessary for clinical settings.[21]
- Practices should emphasize on provision of screening and IPV-related information and support for all patients to respect patient autonomy and sensitivities regarding IPV disclosure.[14]
- The focus of health care-based interventions for IPV on reducing reports of IPV prevalence may be less useful than a focus on increasing access to resources and supports for all women at risk for experiencing IPV.[18,20]

The strengths of this study are that we focused our literature review toward studies that included

implementation of a protocol or intervention rather than those that studied the association or prevalence of IPV among patient populations. The widespread prevalence of IPV, especially among populations seeking abortions, has already been well documented. However, there are few studies that address how to intervene on this issue in the health care setting. This review has been able to consolidate studies that have already been completed to better learn from their successes and shortcomings to make recommendations moving forward for abortion-based clinical settings.

Our study also has a few limitations. As previously discussed, there are few studies that examine interventions for IPV in the setting of abortion-related health care. Although all the studies selected in this review were screened to incorporate abortion-related visits, many of the studies were set in family planning clinics where visits can be for non-abortion-related purposes as well. Additionally, specific interventions at clinics may not demonstrate similar results at other locations or could be difficult to implement considering a clinic's time and resources that are available.[19]

This study analyzes and summarizes the current approaches in various clinics across the United States to address IPV in abortion-related visits. It demonstrates the importance of screening and implementing interventions for IPV as well as offers suggestions clinics can take in abortion-related visits as they dedicate efforts to address IPV for their own patient populations.

Note

Several studies have analyzed and demonstrated that there is a large prevalence of IPV in those seeking abortion, few have analyzed what to do about it. This study is a literature review of studies that analyze interventions for IPV at abortion-related visits and associated outcomes. It provides recommendations from previously successful interventions and offers suggestions moving forward. In the limelight of the recent Dobbs decision, this study provides insight into the importance abortion-related health care can play.

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Conflict of Interest

None declared.

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