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Male Perpetration of Intimate Partner Violence and Involvement in Abortions and Abortion-Related Conflict

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Men aged 18 to 35 years (n=1318) completed assessments of perpetration of intimate partner violence (IPV), abortion involvement, and conflict regarding decisions to seek abortion. IPV was associated with greater involvement by men in pregnancies ending in abortion and greater conflict regarding decisions to seek abortion. IPV should be considered within family planning and abortion services; policies requiring women to notify or obtain consent of partners before seeking an abortion should be reconsidered; they may facilitate endangerment and coercion regarding such decisions. (*Am J Public Health.* 2010;100:1415–1417. doi:10.2105/AJPH.2009.173393)

Intimate partner violence (IPV) is a major public health issue that affects the lives and health of approximately 20% to 25% of adolescent and adult US women,[1,2] with women of reproductive age at greatest risk.[3,4] Major reproductive health concerns associated with experiences of IPV include unintended[5] and rapid repeat pregnancies.[6–8] Given that unintended and unwanted pregnancies are the primary reason for seeking abortion,[7,9] abused women are thought to be more likely to experience abortion than are their nonabused counterparts.[10–12] Recent qualitative research suggests there is a broad role played by abusive male partners in controlling women's reproductive health,[13–15] including attempts to control abortion-related decisions.[13,15] However, quantitative data on this issue have primarily been collected from women attending abortion services, which therefore precludes comparisons to women with no abortion history.[10–12] Given the increasing recognition of the role of male partners in controlling a woman's reproductive health and decision-making, coupled with the continuing public debate concerning both women's access to abortion and the role of family members in decisions regarding abortion (e.g., spousal consent),[16] it is critical to understand to what extent abuse from male partners may relate to both women's seeking abortion and coercion regarding abortion-related decisions. We examined the association of young adult men's reports of perpetration of IPV and their participation in pregnancies ending in abortion as well as conflict surrounding abortion-related decisions.

METHODS

English-, Spanish-, or Portuguese-speaking men between the ages of 18 and 35 years were recruited from 3 large community health centers located in lower-income, urban, Boston-area neighborhoods. The participants completed a computer-based anonymous survey and received a $20 gift card and a list of local resources upon completion. The participation rate of men approached for inclusion was 65%; our sample was limited to participating men who reported ever having had sex (n=1318).

Lifetime history of perpetration of physical and sexual IPV was assessed by use of modified versions of the Conflict Tactics Scale 2[17] and the Sexual Experiences Survey.[18] Abortion involvement was assessed by a single item, "How many pregnancies that you have been involved in have resulted in abortion?"; responses were coded to reflect involvement in no abortions, 1 or 2 abortions, or 3 or more abortions. Conflict over abortion was assessed via a single item on the basis of our previous qualitative study: "Sometimes couples fight over what to do about a pregnancy. Have you and your girlfriends/sex partners/wife ever fought about a pregnancy?" Positive responses included "Yes, we fought because I wanted her to have the baby and she wanted an abortion" and "Yes, we fought because I wanted an abortion and she wanted to have the baby." Prevalence estimates were

TABLE 1—Sample Demographics and Prevalence of Intimate Partner Violence (IPV) and History of Abortion: Boston, 2007

		Perpetration of IPV		Involved in at Least 1 Abortion	
	Sample Demographic, %[a]	%[b]	*P*	%[b]	*P*
Age, y			.002		<.001
18–21	31.1	25.8		19.7	
22–25	21.3	38.4		37.3	
26–30	21.0	29.5		41.8	
31–35	26.6	35.2		38.7	
Race/ethnicity			.136		<.001
White	8.1	34.6		33.6	
Black	48.5	34.0		39.7	
Hispanic	31.5	30.7		27.1	
Other[c]	11.9	24.8		22.9	
Total		31.9		33.2	

Note. IPV = intimate partner violence. *P* values were determined with the χ^2 test.
[a]Column %.
[b]Row %.
[c]Asian/Pacific Islander/Native American.

calculated for lifetime history of IPV perpetration, abortion involvement, and abortion conflict; differences in abortion outcomes on the basis of the perpetration of IPV were assessed by χ^2 analyses. Log-binomial regression models estimating adjusted risk ratios (ARRs) and 95% confidence intervals (CIs) for the associations of IPV perpetration and abortion outcomes were constructed with adjustment for age, race/ethnicity, and recruitment site.

RESULTS

Approximately 1 in 3 participants reported having perpetrated physical or sexual violence against a female partner (31.9%; Table 1) or having been involved in a pregnancy that ended in abortion (33.2%; Table 2). Experiences of abortion involvement were more common among men reporting IPV perpetration (48.9% versus 25.9%; ARR=1.79; 95% CI=1.54, 2.06). The risk of being involved in 3 or more abortions was also greater for abusive men (8.8% versus 3.1%; ARR=3.39; 95% CI=2.06, 5.56). Similarly, partner conflict regarding abortion was more likely among abusive men (19.8% versus 7.0%; ARR=2.80; 95% CI=2.06, 3.82), with the perpetration of IPV associated with men's attempts to both promote and restrict the seeking of abortion services by female partners (ARRs=2.41–2.60).

TABLE 2—Associations of Perpetration of Intimate Partner Violence (IPV) With Abortion and Abortion-Related Conflict: Boston

		Perpetration of IPV		
	Sample Percentage, %	Yes, %	No, %	ARR (95% CI)
Abortion involvement				
None (Ref)	66.8	51.1	74.1	1.00
Any	33.2	48.9	25.9	1.79 (1.54, 2.06)
1–2	28.3	40.1	22.7	1.79 (1.52, 2.11)
≥3	4.9	8.8	3.1	3.39 (2.06, 5.56)
Disagreement about abortion				
None (Ref)	89.9	80.2	93.0	1.00
Any	11.1	19.8	7.0	2.80 (2.06, 3.82)
Male partner sought to prevent seeking abortion[a]	8.0	14.0	5.1	2.60 (1.76, 3.87)
Male partner sought to compel to seek abortion[a]	4.1	7.3	2.6	2.41 (1.38, 4.20)

Note. ARR = adjusted risk ratio; CI = confidence interval; IPV = intimate partner violence. ARRs were adjusted for age, race/ethnicity, and recruitment site.
[a]Responses not mutually exclusive.

DISCUSSION

Our findings clearly indicate that abusive men are more likely than their nonabusive peers to report being involved in pregnancies ending in abortion, with this effect amplified for the association of IPV and involvement in 3 or more abortions. Although these cross-sectional analyses did not allow us to reach definitive conclusions regarding causal relationships, the findings from previous research suggest that these results likely reflected abusive men's greater involvement in unintended pregnancy[8,9] stemming from a range of behaviors that include forced or coerced sex, condom refusal, and control over contraception.[13,19] Female partners of abusive men may also seek abortions more frequently on the basis of their fear of a shared child limiting their ability to leave the perpetrator or a fear of the abuse and neglect of such a child from this same man.[20,21] These data describe the significant threat to women's reproductive control related to violence from male partners, a threat that should be considered in the design of all services and policies related to family planning and abortion. An important example of such consideration are policies supporting screening clients regarding their ability to control contraception and ensuring women's access to methods of contraception that are beyond the control of male partners (e.g., injectable contraception).

Importantly, men who perpetrated IPV were also more likely to report conflicts with pregnant female partners regarding decisions related to seeking abortion. This finding is consistent with studies demonstrating that women who experience IPV are less likely to discuss abortion decisions with a partner, often because of fear.[22,23] Thus, clinical services requiring that women have the opportunity to meet privately with providers (i.e., without partners)

should be mandated to ensure safety and autonomy regarding women's decisions. These data in no way indicate that women's access to abortion services should be impeded, rather that reductions in abusive men's coercive control over women's reproductive choices may well reduce many women's need for such services. Policies aimed at requiring women to notify partners or to obtain partner consent before undergoing an abortion should be reconsidered because of the likelihood of both endangering women and placing them at risk for coercion regarding this critical decision. Efforts to prevent the violent and coercive behavior of men and boys should be incorporated within any comprehensive program to reduce unintended pregnancy and the subsequent need for abortion services. ■

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Author Contributions

J.G. Silverman originated and conceptualized the parent and current study, oversaw all data analyses, and led the development of the article. M.R. Decker participated in study conceptualization, project management, and analyses and contributed to interpretation and drafting of the article. H.L. McCauley participated in conceptualization of the article, interpretation of findings, and drafting of the article. J. Gupta participated in data collection, project management, and interpretation of findings. E. Miller participated in developing clinical implications of the study and in drafting the article. A. Raj co-led the conceptualization of the parent study and critically reviewed the article. A.B. Goldberg co-led the conceptualization of the current study and co-led the development of the clinical implications.

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All methods were approved by the Human Subjects Committee at the Harvard School of Public Health.

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Underlying Causes of the Emerging Nonmetropolitan Mortality Penalty

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The nonmetropolitan mortality penalty results in an estimated 40 201 excessive US deaths per year, deaths that would not occur if nonmetropolitan and metropolitan residents died at the same rate. We explored the underlying causes of the nonmetropolitan mortality penalty by examining variation in cause of death. Declines in heart disease and cancer death rates in metropolitan areas drive the nonmetropolitan mortality penalty. Future work should explore why the top causes of death are higher in nonmetropolitan areas than they are in metropolitan areas. (*Am J Public Health.* 2010;100:1417–1419. doi:10.2105/AJPH.2009.174185)