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Reproductive coercion and partner violence: implications for clinical assessment of unintended pregnancy

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Abstract

Unintended pregnancy is common, disproportionately affects younger women and is associated with intimate partner violence. Forced sex, fear of negotiating condom and contraceptive use, inconsistent condom use and partner interference with access to healthcare all contribute to this association between unintended pregnancy and intimate partner violence. A growing body of literature on male partner influences on contraception and pregnancy decision-making has identified a range of male partner pregnancy-controlling behaviors which we have termed reproductive coercion, defined as male partners' attempts to promote pregnancy in their female partners through verbal pressure and threats to become pregnant (pregnancy coercion), direct interference with contraception (birth-control sabotage), and threats and coercion related to pregnancy continuation or termination (control of pregnancy outcomes). This article examines recent studies on male partner reproductive coercion, underscores the link between unintended pregnancy and intimate partner violence and highlights future directions for research as well as implications for clinical practice.

Keywords

barrier contraception; condom nonuse; domestic violence; family planning services; gender-based violence; intimate partner violence; unwanted pregnancy

Reproductive coercion defined

Unintended pregnancy (defined broadly as pregnancy that was not planned, was unexpected or mistimed, or not wanted by a woman) is common and disproportionately affects younger women [1]. Physical and sexual violence victimization by an intimate partner is associated with poor reproductive health, including unplanned pregnancies, poor pregnancy outcomes and sexually transmitted infections [2–10]. Unintended pregnancies are two- to three-times

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more likely to be associated with intimate partner violence (IPV) than planned pregnancies [6,7,11–15]. Forced sex, fear of negotiating condom and contraceptive use, inconsistent condom use and partner interference with access to healthcare all contribute to this association between unintended pregnancy and IPV [16–21].

In addition to these mechanisms, a growing body of literature on male partner influences on contraception and pregnancy decision-making has identified a range of male partner pregnancy-controlling behaviors which we have termed reproductive coercion. Male partner reproductive coercion (to be distinguished from the range of state control of women's reproductive health across the globe, including forced sterilization) is defined as male partners' attempts to promote pregnancy in their female partners through verbal pressure and threats to become pregnant (pregnancy coercion), direct interference with contraception (birth-control sabotage), and threats and coercion related to pregnancy continuation or termination (control of pregnancy outcomes). Abusive male partners have been found to actively promote pregnancy via behaviors spanning verbal pressure to become pregnant, condom manipulation, threats or actual violence in response to condom requests and direct acts of birth-control sabotage (e.g., removing a vaginal ring, throwing out birth-control pills and blocking women from seeking access to contraception). In addition, once their female partner is pregnant, abusive male partners may enact behaviors to control the outcomes of the pregnancy including violent acts to attempt to induce miscarriage and coercion to either continue or terminate the pregnancy. While women may also attempt to become pregnant or control the outcome of a pregnancy without their partner's knowledge, the focus here is on how male partner abusive behaviors may be connected to unintended pregnancy (i.e., pregnancy that is mistimed, unplanned or unwanted from the woman's perspective). This article reviews recent studies on male partner reproductive coercion, examining further evidence of the link between unintended pregnancy and IPV and highlighting future directions for research as well as implications for clinical practice.

Literature review of male partner reproductive coercion

The following studies focus specifically on male partner attempts to promote pregnancy and control pregnancy outcomes, and were found by reviewing the literature broadly for evidence of the association between IPV and unintended pregnancy. A study of teen mothers receiving public assistance, for example, reported that almost half of the young women had experienced verbal pressure from their male partners not to use birth control (e.g., "You would have my baby if you loved me") as well as 14% reporting their partners' interference with her use of contraception (e.g., "My boyfriend won't let me use family planning") [101].

Another in-depth qualitative study among 53 ethnically diverse young women, sexually active females aged 15–20 years with known histories of partner violence, found that a quarter of participants had experienced explicit attempts by their male partners to promote pregnancy, including verbal pressure, birth-control sabotage and forced sex without condoms. The male partners of those reporting such coercion to get pregnant were on average 4 years older than their female partners, and these relationships were longer term (lasting more than a year) relative to young women who did not report reproductive coercion [22]. A related quantitative study among young women (aged 14–20 years) attending teen health centers produced similar findings; over two-fifths of the sample (45%) had experienced IPV (further indicating the need for providers to address this issue) and those experiencing IPV were more likely to report being afraid to ask their male partner to use a condom, negative consequences of making such a request, and being coerced into not using a condom compared with girls not reporting IPV (adjusted odds ratios: 2.9–5.3) [19].

These findings among adolescents are paralleled in studies involving adult women. A recent qualitative study among a diverse sample of adult women (aged 19–57 years) residing in domestic violence shelters revealed a high prevalence of birth control sabotage, forced sex and partner interference with access to healthcare. Of note, among the younger cohort (aged 19–32 years), 77% reported experiencing birth-control sabotage at the hands of their abusive partner. Among those females reporting birth-control sabotage, 80% had also experienced forced sex (compared with 48% with no history of birth-control sabotage), underscoring the association of birth-control sabotage with sexual violence. This study also identified multiple strategies that women utilize to resist male partner attempts to control their reproduction, including hiding birth control and seeking clinical care for intrauterine contraceptive placement [23].

Similar findings emerged from another qualitative study among 71 adult females (aged 18–49 years) with histories of IPV recruited from reproductive health clinics (family planning and abortion clinics) as well as a domestic violence shelter; 74% reported male partners' attempts to get them pregnant (i.e., pregnancy-promoting behaviors) as well as abusive behaviors related to controlling the outcomes of a pregnancy (either termination or continuation, following the male partner's wishes). Of note, these examples of the male partner's control of their female partner's reproductive autonomy (described in detail in this article) occurred in both physically violent as well as nonviolent relationships [24].

A quantitative study of adult men attending urban community health centers supports these findings of associations between IPV and pregnancy-controlling behaviors; men who reported IPV perpetration against a female partner were significantly more likely to have attempted to coerce a pregnant partner to either terminate or continue a pregnancy, and to have been involved in multiple pregnancies ending in abortions (i.e., unwanted pregnancies) [25].

A survey conducted among 1463 adult female patients seeking gynecologic care found that partner unwillingness to use contraception, partner desires that she become pregnant and partner interference with contraception were all positively associated with IPV [26]. Specifically, compared with women without histories of IPV, women with histories of IPV were 2.3-times more likely to report that their partner didn't want to use contraception or wanted her to get pregnant, and almost three-times more likely to report that their partner made it difficult to use birth control.

Our research team also conducted a quantitative study in 2009 among over 1200 young adult sexually active female users of free-standing reproductive health clinics (aged 16–29 years), seeking care for a variety of reasons including complete physicals, pregnancy testing and contraceptive counseling. Via a survey collected on a laptop computer using audio computer-assisted self-interviewing software, one-quarter reported ever experiencing reproductive coercion, which included both experiences of birth control sabotage (active interference with contraceptive methods) as well as pregnancy coercion (threats to promote a pregnancy) [27]. Over one-third of women with histories of IPV also reported reproductive coercion. Reproductive coercion increased the risk for unintended pregnancy twofold in the presence of IPV, suggesting that reproductive coercion may partially explain the link between IPV and unintended pregnancy.

These studies all highlight the phenomenon of male partner reproductive coercion that has not been well characterized in previous reproductive health or violence literature. Future research should be conducted that is population based to more definitively assess the prevalence of forms of reproductive coercion and associations with IPV. Similarly, beyond cross-sectional studies, prospective work to examine how reproductive coercion, IPV and

unintended pregnancy are inter-related, including specifying the relevant chronologies and patterns, is needed to inform the design of targeted interventions to reduce both the risk for unintended pregnancy as well as IPV victimization.

Implications for clinical assessment of unintended pregnancy

Given this body of evidence, male partner reproductive coercion may be one explanation for contraceptive nonadherence, a key behavior associated with unintended pregnancy. Where providers may have traditionally assumed that certain individual-level factors explain contraceptive nonadherence (such as lack of knowledge, carelessness or ambivalence about becoming pregnant), the addition of this lens of reproductive coercion as a potential explanation for contraceptive nonadherence offers an opportunity for providers to ask about the possibility of pregnancy-promoting behaviors by their patient's partner, and to assess a patient's safety. Specifically, providers should first assess for a woman's pregnancy intentions, followed by specific assessment for reproductive coercion and IPV. In addition to routine assessments, inconsistent or no contraceptive use, frequent requests for emergency contraception and frequent visits for pregnancy and sexually transmitted infection testing may all be clinical red flags for underlying reproductive coercion and IPV. Providers should know their local violence victimization resources (including on-site social workers if available) and how to access supports for women who are currently experiencing abusive and unsafe situations.

Women experiencing reproductive coercion may not necessarily recognize such coercive behaviors as unhealthy or abusive, especially if there is no history of physical or sexual violence in the relationship. Thus, reproductive health providers are in a unique position to increase awareness among their female patients about the impact of unhealthy relationships on their health, including pregnancy risk associated with reproductive coercion. In the clinical setting, offering verbal information as well as educational materials about reproductive coercion may facilitate women's recognition of IPV as well as provide an opportunity to introduce harm-reduction behaviors. Those harm reduction behaviors may include intrauterine device placement (a contraceptive method that is less likely to be sabotaged), longer-acting injectable contraceptives and access to emergency contraception. Providers also have an opportunity to speak directly with their patients about how to negotiate condom use in a safe way.

Finally, in addition to assessing for pregnancy-promoting behaviors and educating clients about reproductive coercion, providers also have an obligation to assess women's safety once a pregnancy is diagnosed. A straightforward question such as "How might the person who got you pregnant react if he were to know about your positive pregnancy test?" may reveal not only conflict around how to resolve the pregnancy, but may also inform how the provider will counsel about options available to their female patient. In an abusive relationship, a positive pregnancy test could lead to escalation of violence in order to terminate the pregnancy, forced continuation of the pregnancy or threats to kill her if she doesn't comply with his wishes regarding the pregnancy. Thus, options counseling with women regarding their desires related to a recently diagnosed pregnancy should also include a frank discussion (in private) with the woman about whether she has experienced reproductive coercion and how her partner might react were he to learn of her pregnancy diagnosis. As disclosures are likely to increase, providers should ensure that they know who the violence prevention advocates are who are available to support them within their clinical setting (such as social workers and victim advocates) and in their community (domestic violence agencies, shelters, rape crisis centers and child protective services).

Conclusion

In conclusion, while additional research is needed on this phenomenon of reproductive coercion, the evidence to date suggests that such experiences of male partner attempts to promote pregnancy may be common and may have important implications for the ability of a woman to prevent a pregnancy that she does not want. Provider training on IPV and reproductive coercion combined with additional educational materials to review with clients seeking care are needed to increase awareness of reproductive coercion among young women, ensure her safety in the context of an abusive relationship and reduce the risk for unintended pregnancy. Providers should also nurture close collaborations with on-site social workers and community-based violence prevention advocates to be able to confidently connect women to violence victimization-related resources.

Expert commentary

The associations between IPV and poor reproductive health outcomes have been well established in the women's health and violence literature. More recent studies have also identified that unintended pregnancy is more likely to occur in the context of abusive relationships than when the pregnancy is planned. Unintended pregnancy is linked to multiple adverse health outcomes in pregnancy, poor care-seeking among pregnant women, and poor infant and child health. Elucidation of the etiologies of unintended pregnancy and concrete programmatic and policy initiatives are needed urgently to improve maternal and child health. Abuse in relationships can include forced sex, violent intercourse, angry responses to requests for condom use, as well as fear and safety concerns which constrain a woman's ability to negotiate contraceptive and condom use with an abusive male partner. This new concept of male partner reproductive coercion described in this article represents another mechanism to consider in understanding connections between IPV and unintended pregnancy. Reproductive coercion emerges as a phenomenon that is both associated with and distinct from IPV. Thus, providers of women's health should receive training to assess for both reproductive coercion and IPV. With this new information about how male partners may actively try to promote a pregnancy that the female partner does not want and may attempt to control the outcomes of a pregnancy, pregnancy test counseling and options counseling for a pregnancy diagnosis should include assessments for reproductive coercion and IPV. This concept of reproductive coercion shifts the frame from a focus on individual factors (such as a woman's ambivalence about pregnancy) to the contribution of relationship factors that have a clear impact on a woman's ability to prevent an unwanted pregnancy. State-and national-level policies pertinent to women's health should include provider training on reproductive coercion and IPV, incorporate education about such coercion and partner violence into pregnancy prevention education, and ensure that women have access to violence-related support services when seeking health services.

Five-year view

As this concept of reproductive coercion continues to be examined in larger population-based studies as well as longitudinal research, it is likely that more prevention and intervention efforts will begin to include this concept in curriculum and patient education materials. In the meantime, clinical trials that are underway will have identified brief interventions in the clinical setting which can improve identification of reproductive coercion and offer strategies to reduce women's risk for unintended pregnancy and increase their safety. Maternal and child health and reproductive health programs across the country will also be revising their clinical guidelines and policies to more explicitly integrate intimate partner violence and reproductive coercion assessments and interventions into each public health program.

Key issues

- Unintended pregnancies are two- to three-times more likely to be associated with intimate partner violence than planned pregnancies.
- A growing body of literature on male partner influences on contraception and pregnancy decision-making has identified a range of male partner pregnancy-controlling behaviors termed reproductive coercion.
- Male partner reproductive coercion refers to male partners' attempts to promote pregnancy in their female partners through verbal pressure and threats to become pregnant (pregnancy coercion), direct interference with contraception (birth-control sabotage), and threats and coercion related to pregnancy continuation or termination (control of pregnancy outcomes).
- Reproductive coercion may be one mechanism that helps to explain the known association between intimate partner violence and unintended pregnancy.
- Pregnancy prevention efforts should include education about reproductive coercion and strategies to reduce women's risk for pregnancy via injectable and intrauterine contraceptives that are less vulnerable to male partner influence.
- Women's healthcare providers should be trained to assess for reproductive coercion and partner violence and be prepared to connect patients with violence-related support services in their communities.

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