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AVA Research Review

ADVANCING HEALTH EDUCATION & RESEARCH

Review Title: Reproductive Coercion and Co-occurring Intimate Partner Violence in Obstetrics and Gynecology Patients

Reviewers: Joanne Sampson, Master's Student, Department of Human Development and Family Studies, University of Delaware, and Ruth Fleury-Steiner, PhD, Associate Professor, Department of Human Development and Family Studies, University of Delaware

Article: Clark, L. E., Allen, R. H., Goyal, V., Raker, C., & Gottlieb, A. (2014). Reproductive coercion and co-occurring intimate partner violence in obstetrics and gynecology patients. Am J Obstetrics & Gynecology, 210(1), 42.e1-8.

Article Summary:
Brief Overview:

In 2010, a large-scale survey by the Centers for Disease Control and Prevention found 9% of a sample of 9000 women experienced reproductive coercion (Black et al., 2011). Reproductive coercion (RC) is defined as "male behavior to control contraception and pregnancy outcomes of female partners" (p. 42.e1). These behaviors include birth control sabotage (interfering with/ destroying contraceptive pills, deliberately breaking condoms), and pregnancy coercion (physical or psychological pressure to become pregnant) (p. 42.e1). Miller et al.'s (2010) groundbreaking study of 1300 women attending a family planning clinic showed 19% and 15% had been subject to pregnancy coercion and birth control sabotage, respectively. Also, women who had experienced either of these had a higher probability of an unintended pregnancy.

In addition to the negative impact on women's

reproductive agency and health, studies show an association between RC and intimate partner violence (IPV). IPV includes physical, psychological, or sexual abuse, isolation, stalking, financial control, intimidation, and threats by a current or past intimate partner. The Miller et al. (2010) study found almost 75% of the women who experienced RC had also experienced IPV. A study by Gee et al. (2009) of 1500 women visiting Planned Parenthood clinics revealed an increased incidence of RC when there was a lifetime history of IPV. However, these studies failed to identify if the IPV and RC occurred within the same intimate relationships. Previous research has focused on high-risk settings like domestic violence shelters and community family planning clinics. To expand the current literature base, the authors set out to identify the incidence of RC in a large, urban, university-based obstetrics and gynecology clinic, using a modified, cross-sectional, anonymous survey.

Aims of the article:

This study speaks to gaps in the research by identifying the prevalence of RC co-occurring with IPV within the same intimate relationship, using a representative sample of women (ages 18 to 44) in a large, urban obstetrics and gynecology clinic. In addition, the authors gathered data on the helping role of the healthcare professional from the perspective of women experiencing RC.

Relevant Findings:

Of the 641 women who completed the survey the average age was 26 and the sample was ethnically diverse (42% Latina, 16% black, 27% white, and 15% another or mixed race). Relationship status included 28% of the women identifying as single or dating, and 70% as married or committed. More than half of the women (58%) were pregnant and most (94%) had been within their lifetime. A significant proportion of the women (46%) had attained some form of higher education. Medicaid was the most common form of medical insurance (74% of women).

One hundred and three (16%) of the women sampled had lifetime experiences of birth control sabotage, pregnancy coercion, or both. Univariate analysis found RC was associated with being single or in a dating relationship; being black, multiracial, or "other"; free hospital care, no health insurance, or not knowing their healthcare coverage; and not being pregnant. After controlling for relationship and pregnancy condition, form of insurance, and race and ethnicity, multiple logistic regression analysis revealed being single or dating doubled women's exposure to RC, and relationship uncertainty increased their risk nearly six fold.

The number of women who experienced RC and IPV within the same relationship was 32% (approximately 50% reported birth control sabotage and 34% pregnancy coercion co-occurring with IPV). Univariate analysis of this group identified the following risk factors: being single, dating, or in an unidentified relationship, and being white, Latina, or of more than one race.

Lastly, the 103 women subjected to RC were asked questions with regard to what healthcare providers could do to help. Twenty percent reported getting information about "hidden" forms of birth control (Depo shot or IUD), 14% said being asked if they had felt pressured into pregnancy, and 3% said being asked if their partner had interfered with birth control would have been helpful.

Author's Conclusions:

The authors' study confirms that RC is widespread for

women ages 18 to 44 and that there is a connection between RC and having a history of IPV. This supports the previous research, which focused on high-risk populations of women who experience RC. In addition, it expands the academic knowledge of prevalence—including rates of RC concomitant with IPV—by using a more representative sample. These findings can inform the clinical policies and practices of health care providers for screening and intervening in cases of RC and IPV, highlighting the importance of asking the right questions and providing options, such as "hidden" forms of contraception.

Limitations of the article/ findings:

The authors used a very limited definition for IPV in their screening instrument, and only women who answered in the positive to RC were assessed. Answering "yes" to any one of the 14 questions on RC redirected participants to answer three additional questions on IPV. These questions exclusively focused on threats of physical harm, physical harm, or sexual abuse. Such a limited scope of questions on IPV ignores the many ways women experience physical and sexual violence within intimate relationships, allowing some participants to slip through the cracks. Whilst the authors mention—as a limitation—a lack of questions relating specifically to emotional IPV, they fail to address the exclusion of questions on other forms of IPV, such as economic abuse, stalking, and other forms of power and control. This narrow definition of IPV contributes to underreporting of IPV experiences. The authors also acknowledge that women experiencing co-occurring RC within the same abusive relationship may have been missed because the total population of women in the study (641) did not answer questions on IPV (compared to the 103 who did).

The authors recognize that association does not imply causality either between RC and IPV, or between RC and being a single, uncommitted or dating woman. However, the study fails to mention this is also true for women of color, and for women with lower incomes, who are at increased risk for IPV and RC. One possible explanation is that these women are tentative about committing themselves to an abusive partner.

Reviewer's Comments:

The implication of this research is that obstetric and gynecological clinics need to assess for RC as well as IPV; a significant proportion (68%) of the women who experienced RC did not flag positively for IPV. In addition, clinics need to improve IPV screening to include all forms of abuse, rather than just physical and sexual. Further studies need to assess for verbal, emotional, and psychological abuse by intimate partners to fully inform how IPV and RC intersect. This research highlights the importance of assessing for current and past coexisting IPV and RC within the same relationship to paint a clearer picture of prevalence.

In addition, future research and practice needs to explore the complex interactions between race, RC, and IPV in more depth. While univariate analyses suggested that RC was more likely to be committed against Black, multiracial, and "other" women, RC in the context of IPV was more likely to be committed against White, Latina, or multiracial women. Understanding the dynamics at play here could help to ensure that healthcare providers and community services are better able to provide appropriate and culturally competent services.

There is an urgent need for policies requiring training for health care and domestic violence professionals. Future training could be incorporated into continuing education

credits and include how to screen for IPV and RC, how to have a conversation about alternative forms of contraception (including long-acting reversible contraception like IUDs and implants), and how to provide community based IPV resources for patients. This study is among the first to assess for coexistent IPV and RC within the same relationship. It makes an important contribution to the extremely limited research on RC in general, and highlights the previously unknown prevalence of this issue, which has considerable implications for the reproductive health of women.

References:

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