



ADVANCING HEALTH EDUCATION & RESEARCH

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AVA Research Review

ADVANCING HEALTH EDUCATION & RESEARCH

Review Title: Reproductive and Sexual Coercion: Practice Implications for Health Care Providers

Reviewers: **Andrew T. Schramm**, B.A., Doctoral Student, Clinical-Community Psychology, University of South Carolina¹; **Suzanne Swan**, Ph.D., Associate Professor, Department of Psychology and Women's & Gender Studies Program, University of South Carolina; **Bonnie S. Fisher**, Ph.D., Professor & Fellow of the Graduate School, School of Criminal Justice, University of Cincinnati; **Corrine M. Williams**, Sc.D., Assistant Professor, Department of Health Behavior, University of Kentucky.

Article: American College of Obstetricians and Gynecologists (2013). Reproductive and sexual coercion: Committee Opinion No. 554. *Obstetrics &*

Gynecology, 121, 411-415.

Reviewers' Introduction:

Intimate partner violence (IPV) occurs at an alarming rate: an estimated 35.6% of women in the United States have experienced rape, physical violence, and/or stalking in their lifetime in the context of an intimate relationship (Black et al., 2011). The harmful impact of these experiences has been well documented, and includes an expansive range of physical and psychological consequences, including poor reproductive health outcomes for women (Campbell, 2002; Coker et al., 2002). Women with an unintended pregnancy, for example, are four times more likely to have experienced IPV than those with intended pregnancies (Gazmararian et al., 1995) and women who have experienced IPV also are more likely to be diagnosed with sexually transmitted infections (STIs; Coker, Williams, Follingstad, & Jordan, 2010).

Reproductive and sexual coercion, the topic of the article under review, have been identified as constructs that help explain the link between IPV and negative reproductive health outcomes for women. This article reflects the efforts of the American College of Obstetricians and Gynecologists' (ACOG) Committee on Health Care for Underserved Women to improve women's reproductive health by educating health care providers about reproductive and sexual coercion and how to mitigate their negative impact on women's wellbeing. With this objective, the authors begin by defining reproductive and sexual coercion and provide a brief overview of existing research on these constructs and their association with IPV. Subsequently, the majority of the article describes the Committee's recommendations on how health care providers (especially obstetrician-gynecologists) should implement screening for reproductive and sexual coercion into their practice, and how to most effectively respond (e.g., harm reduction strategies, patient education) when screening questions are endorsed.

Article Summary²:

Brief Overview:

Reproductive coercion is a set of behaviors meant to exert control over a partner by attempting to influence whether or not that partner becomes pregnant and/or the partner's use of contraceptives.³ Birth control sabotage, the first of two forms of reproductive coercion described here, includes behaviors such as removing a condom during sex without the partner's consent, poking holes in condoms, and blocking access to or destroying oral contraceptives. Pregnancy pressure includes threatening to hurt a partner who does not agree to become pregnant, and forcing a partner to carry a pregnancy to term against her wishes.⁴ Sexual coercion refers to behavior aimed at to coercing a person to have sex without using physical force. Examples of sexual coercion include repeatedly pressuring someone to have sex, threatening to end a relationship if a partner does not have sex, forcing a partner to have sex without a condom, or intentionally exposing a partner to a STI. Prior research suggests that these experiences are highly prevalent and associated with negative health outcomes.

Against this background, the Committee has made several recommendations for obstetrician-gynecologists to improve the health of women

who are experiencing, or have experienced reproductive or sexual coercion. The first recommendation is that health care providers learn about reproductive and sexual coercion and their effects on women's health. The second recommendation is that obstetrician-gynecologists screen women and adolescent girls for reproductive and sexual coercion "at periodic intervals such as annual examinations, new patient visits, and during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup)" (p. 412). Examples of screening questions include: "Has your partner ever forced you to do something sexually that you did not want to do or refused your request to use condoms?" and "Are you worried your partner will hurt you if you do not do what he wants with the pregnancy?" (p. 412).

Practitioners also should take steps to create a safe environment for assessment and disclosure. It is important, for example, to ensure that patients have an opportunity to speak with the practitioner privately (i.e., without the presence of friends or partners) at some point during each visit. Displaying educational posters about IPV and placing resources or information, such as the contact information for crisis centers, in several

locations (e.g., exam rooms, bathrooms) also can signal to patients who are experiencing violence that they are in a supportive, affirming environment and help them connect with additional sources of support.

The third recommendation concerns how to intervene when an individual endorses reproductive or sexual coercion. Health care providers should be ready to provide referral information for domestic violence services. An important aspect of a provider's response to a patient who has endorsed reproductive or sexual coercion is a re-assessment of the best form of contraception for the patient in light of the reported coercion. For example, if a female patient has been forced to have sex without a condom, or her partner has restricted access to oral contraceptives, discrete forms of contraception with which an abusive partner cannot as readily interfere represent a viable harm-reduction approach. These alternatives include intrauterine devices (IUDs), depot medroxyprogesterone acetate injections (Depo-Provera), and etonogestrel implants (Implanon). It is important that health care providers be intentional about taking a supportive, collaborative stance throughout conversations in

which they explore contraceptive options so that they do not inadvertently send the message that their partner's abusive behavior is the patient's fault or responsibility. The final recommendation is to "include reproductive and sexual coercion and IPV as a part of the differential diagnosis when patients are seen for pregnancy or STI testing, emergency contraception, or with unintended pregnancies" (p. 414).

Resources to aid in screening, intervention, and prevention of reproductive and sexual coercion are available. One notable example is safety cards that have been developed by ACOG and the nonprofit organization Futures Without Violence. These wallet-sized safety cards are available in English and Spanish and include screening questions IPV and reproductive and sexual coercion, harm reduction and safety planning information, and information about other relevant organizations and resources.⁵

Reviewers' Comment:

The article under review, published by one of the foremost authorities on women's reproductive health, has sent a clear message: Reproductive and sexual coercion should be a part of

health care providers' conceptualization of IPV and the factors that influence the wellbeing of women. This expanded conceptualization is especially important for providers specializing in women's reproductive health because of the numerous opportunities they have to provide treatment that is responsive to the specific needs and challenges that arise as a result of experiencing sexual and/or reproductive coercion. In the commentary that follows, we aim to consider how the recommendations made in the article under review relate to the existing body of research on reproductive and sexual coercion and to describe how future research can address current limitations that characterize the literature.

Given the nascent nature of the construct of reproductive coercion, which was only recently labeled and defined as a construct (Miller et al., 2010), it is not surprising that research on its prevalence, correlates, and impact is markedly sparse. Albeit limited, the existing literature does provide preliminary support for the recommendations made in this document. Partner interference with health care has been identified as a significant problem for women who are in abusive relationships

(McCloskey et al., 2007), who also are much less likely to report using their preferred method of contraception (Williams, Larsen, & McCloskey, 2008).

One of the most salient recommendations made is that health care providers, especially obstetrician-gynecologists, should regularly screen women and adolescent girls specifically for reproductive and sexual coercion and that screening for IPV in general terms is insufficient. The results of a recent study on IPV, reproductive coercion, and unintended pregnancy amongst women seeking reproductive health care at a family clinic (Miller et al., 2014) provide support for this recommendation. This study found that women who experienced reproductive coercion were more likely to report an unintended pregnancy regardless of whether or not they had experienced IPV (e.g., physical abuse).

Despite the empirical support for the ACOG recommendations, this area of research is very new and has limitations. Issues with how constructs are measured are present throughout the literature on IPV (Saltzman, Fanslow, McMahon, & Shelley, 1999; Thompson,

Basile, Hertz, & Sitterle, 2006), and this is certainly apparent in research on reproductive and sexual coercion. For example, the psychometric properties of the items that have been used to assess reproductive coercion have not been rigorously examined. Future research that addresses these, and other, methodological limitations will enhance the ability of organizations such as ACOG to create policy recommendations that lead to practices that most effectively meet the needs of persons who have experienced reproductive and/or sexual coercion.

Another limitation of existing research on reproductive coercion is its exclusive focus on the limited demographic of heterosexual women with male partners. This focus is understandable given that the impetus for the development of the construct was among women's reproductive health experts who sought to explain the link between IPV and unintended pregnancy. However, limiting the application of this theoretical framework and developing body of knowledge to this specific demographic represents a missed opportunity to improve the health of others. Lesbians and bisexual women, for example, should not be excluded from an analysis of such phenomena

that influence women's health. Another example is gay or bisexual men (and/or men who have sex with men [MSM]), who continue to be the most severely affected by HIV in the United States (Centers for Disease Control and Prevention, 2014); research on this demographic would undoubtedly benefit from the analysis of sabotage of condom use. Thus, we also raise the issue of expanding the outcomes of reproductive coercion from including only "reproduction" (i.e., a woman's pregnancy status) to including other aspects of sexual health such as STIs.

Given the dearth of research on the topic of reproductive coercion, it seems that more questions than answers exist at this point. This ACOG Committee Opinion represents a promising step in the right direction. For more information about reproductive and sexual coercion, and about utilizing resources such as the safety cards, we direct readers to the guide for health care settings produced by ACOG and Futures Without Violence (Chamberlain & Levenson, 2010).

Foot Notes:

¹ This author may be reached by e-mail at schramm.andrew@gmail.com or on Twitter @andrewtschramm.

² This section is written from the perspective of the authors of the ACOG article under review, including aspects of this article that are potentially limited. We reserve the analysis of such limitations for the “Reviewers’ Comments” section.

³ Birth control sabotage is also sometimes referred to in the literature as “contraceptive sabotage”.

⁴ Pregnancy pressure is also sometimes referred to in the literature as “pregnancy coercion”.

⁵ To obtain safety cards, send a request to underserved@acog.org.

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