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Clinical Rounds

Caring for Women Experiencing Reproductive Coercion

Karen Trister Grace, CNM, MSN

Reproductive coercion is behavior that interferes with a woman's decision making regarding reproductive health. It may consist of contraception sabotage and/or pressure to either carry a pregnancy to term or to have an abortion. Reproductive coercion may coexist with intimate partner violence and be associated with higher rates of unintended pregnancy. Midwives and other women's health care providers can play an integral role in identifying reproductive coercion and implementing harm-reduction strategies.
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Keywords: Contraception, domestic violence, intimate partner violence, pregnancy, pregnancy, unwanted, reproductive coercion, sexual violence

CASE REPORT

C.C. is an 18-year-old gravida 0 who presented to the women's health clinic with her male partner for a pregnancy test. She was known to the clinic staff due to frequent visits for pregnancy testing. On this day, the urine pregnancy test was negative. C.C. and her partner requested an appointment with the midwife to discuss the results.

C.C. and her partner returned to the clinic the following week. They reported that they had been trying to conceive for several months and were concerned that C.C. may be infertile. C.C. reported regular menses and sporadic use of condoms. The midwife informed C.C. and her partner that she would need to perform a physical examination and, as per clinic policy, C.C.'s partner would need to wait in the waiting room. He complied with this request.

When C.C.'s partner was out of the room, the midwife repeated her earlier questions about C.C.'s plans for conceiving. C.C. then reported that she was planning to start college soon and had been actively avoiding pregnancy. Her partner, however, had on several occasions removed the condom while they were having sex and frequently told her he wished her to become pregnant. She reported that in the past there had been episodes of him "losing his temper" with her, and she feared he had the potential to become violent.

The midwife reviewed options for contraception that were not easily detectable by a partner, such as the intrauterine device (IUD) and contraceptive implant. C.C. expressed interest in the copper IUD (Paragard). The midwife inserted the IUD at the visit, cutting the strings short enough that they were not visible outside the cervical os. The midwife asked C.C. if she felt safe to return home with her partner, and she replied that she did. C.C. declined to take any written materials, but the midwife reviewed safety resources for intimate partner violence (IPV) and encouraged her to return to the clinic at any point if she had further concerns. (Note: This case report is a composite of elements from different patients.)

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INTRODUCTION

Midwives and other women's health care providers have long recognized that women in abusive relationships can experience negative reproductive health outcomes. Abusive intimate partners may wield power and control over a woman's reproductive health choices, such as interfering with contraceptive methods or pressuring her regarding getting pregnant or the outcome of a pregnancy. In recent years, these behaviors have been labeled *reproductive control* and *reproductive coercion*, and have been studied and identified as a unique phenomenon that may occur with or without concomitant violence and that itself is a manifestation of abusive behavior.[1–3] Estimates of the prevalence of reproductive coercion in the United States range from 8%[4] to 16%.[5] The literature on reproductive coercion is still emerging, but existing studies reveal that reproductive coercion disproportionately affects non-Hispanic black and multiracial women,[2,5–7] single women, and women in a dating relationship.[5,7] Evidence points to younger women as more frequent victims of reproductive coercion.[7,8] Women with less education have higher rates of experiencing reproductive coercion[7]; however, a recent study of female college students found that 8% of participants reported experiencing pregnancy coercion or contraception sabotage.[9] Although the case in this article describes reproductive coercion by an intimate partner, coercion may also be perpetrated by family members of the woman or her intimate partner (in-laws).[10]

REPRODUCTIVE COERCION

Reproductive coercion or control is any behavior that interferes with a woman's autonomous decision making with regard to her reproductive health.[3] One element of reproductive coercion is contraception sabotage.[2] This could take the form of hiding or discarding contraceptive pills; removing a condom or damaging a condom prior to use; manually removing a vaginal ring, contraceptive patch, or IUD; or preventing a woman from accessing contraception, such as by refusing to provide transportation or funding or by using threats.

The second component of reproductive coercion is pregnancy pressure.[2] This could take the form of pressure to become pregnant, carry a pregnancy to term, or have an

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induced abortion. Pregnancy pressure may be combined with threats to leave the relationship or have a child with another partner if the woman does not comply.[2] Women may be threatened with using violence to abort a pregnancy if they do not seek an abortion from a health care provider, or they may be threatened if their preference is to have an abortion.[3] The extent to which coercion from a male partner impacts the decision to have an abortion is unclear, with some studies finding that partner influence was minimal.[11] Threats and intimidation regarding infidelity when a woman requests that a partner use contraception may be experienced as interference with contraception or as pregnancy pressure. In most cases, this pressure is perceived as coercion when it is in opposition to the woman's desires. In other cases, women may not name the pressure as coercion, but the behaviors described are clearly coercive to an outside observer.

Reproductive coercion may not always be defined as such by the women who experience it. Multiple factors, such as age differentials, power dynamics, concurrent violence in the relationship, and romantic feelings may prevent a woman from naming the behaviors detailed above as coercion.[12] Potential benefits of IPV screening by health care providers include assisting women in naming the behaviors they experience as coercive and enabling them to seek help in regaining autonomy and control over their reproductive health.[1] Women may respond to coercive behaviors in a variety of ways. They may capitulate to the pressure, seek contraception that is not detectable by a partner, or end the relationship.[12] More research is needed to elucidate the underlying motivation from the male perspective, as well as to clearly describe the phenomenon from the female perspective.

INTERSECTION BETWEEN INTIMATE PARTNER VIOLENCE, UNINTENDED PREGNANCY, AND REPRODUCTIVE COERCION

There are many unanswered questions in this evolving area of knowledge, but patterns are emerging regarding the intersection of reproductive coercion with IPV and unintended pregnancy. It is known that women who experience IPV are at greater risk of unintended pregnancy.[2,13] The additive effect of experiencing both IPV and reproductive coercion almost doubles the odds of having an unintended pregnancy, as compared to women who only experience IPV or reproductive coercion.[2] There is clear correlation between reproductive coercion and IPV; recent findings indicate one-third of women who report experiencing reproductive coercion also experienced IPV from the same partner.[5] It is possible that the correlation between IPV and reproductive coercion may help explain some of the relationship between IPV and unintended pregnancy. There is conflicting evidence on whether experiencing reproductive coercion without violence impacts unintended pregnancy to a significant extent.[2,7]

The argument can be made that reproductive coercion is itself a form of IPV, but there may be value from a research perspective in viewing these phenomena as distinct. As research into reproductive coercion grows and begins to explain its complexities, it will be useful to define it as separate from IPV in order to more clearly define its antecedents and outcomes. However, from an advocacy and health care provider perspective, viewing reproductive coercion as closely linked to IPV will ensure that advocates and providers are alert for signs of both when presented with one, and will be mindful of the risk for IPV when counseling about contraceptive or abortion options.

A complex array of sociological, psychological, and epidemiologic factors are at play in the phenomenon of reproductive coercion. The influence of cultural norms, gender roles and expectations, and interpretations of masculinity impact how men and women experience and understand decisions and pressure regarding reproductive health.[14]

The nature and direction of the associations between reproductive coercion, IPV, and unintended pregnancy are still largely unknown. What is known is the potential for health care providers to intervene and to make a significant impact in the lives of women experiencing reproductive coercion. Because causal relationships are still unclear in the study of reproductive coercion, midwives and other women's health care providers should remain aware that clinical presentations may vary and be harbingers of different phenomena. A woman who reports incidents of reproductive coercion may also be a victim of IPV; a woman who is unable to follow a contraceptive regimen may be experiencing reproductive coercion and/or IPV; and a woman who reports IPV may also be experiencing reproductive coercion and may present with an unintended or unwanted pregnancy. Additionally, a woman experiencing IPV may have limited ability to control any aspect of her health; and her reproductive choices may be impacted as a direct result of that abuse, even without specific instances of reproductive coercion.

IMPLICATIONS FOR PRACTICE

A host of interventions, at the clinical practice level and at the clinic environment level, may be effective in working with women who have experienced reproductive coercion. Clinicians are accustomed to routine screening for IPV and are encouraged to add specific questions that screen all women for reproductive coercion (see Table 1 for suggested screening questions to integrate into reproductive health visits, and resources from Futures Without Violence[15] for additional scripts to use in practice). The American College of Obstetricians and Gynecologists recommends that screening for reproductive coercion occur at the same intervals as screening for IPV: during establishment of care, annual examination visits, the first prenatal visit, each trimester of pregnancy, and the postpartum visit.[16] As with screening for IPV, a positive response to these questions should be followed with an exploration of what the behavior means to the woman, her understanding of it, and what she would like the next steps to be. Midwives and other women's health care providers should be vigilant when women, especially adolescents, exhibit inconsistent use of contraceptives or frequently request emergency contraception or pregnancy testing,[12,17] because these may be indicative of a woman experiencing reproductive coercion.

Factors at the level of the practice environment can provide a supportive space for women to reveal reproductive coercion to the clinician. As with screening for IPV, questions should only be asked in a private space that is out of hearing

Table 1. Sample Reproductive Coercion Screening Questions

During pregnancy testing or at a preconception care visit
Some women tell us their partners are pressuring them to get pregnant. Have you ever experienced something like that?
During a contraceptive counseling or postpartum visit
Before I review all of your birth control options, I want to understand if your partner is supportive of your using birth control. Has your partner ever tampered with your birth control or tried to get you pregnant when you didn't want to be?[15]
Additional questions
Has your partner ever forced you to do something sexually that you did not want to do or refused your request to use condoms?[16]
Has your partner ever tried to get you pregnant when you did not want to be pregnant?[16]
Are you worried your partner will hurt you if you do not do what he wants with the pregnancy?[16]
Does your partner support your decision about when or if you want to become pregnant?[16]

range of other patients and staff. Screening should not be performed with a partner or other friend or family member, including children aged 3 years or older, in the room.[15,18] Partners should always be asked to wait in the waiting room for at least part of the clinic visit. This may be accomplished by creating a practice policy that patients must be alone for the examination component of the visit[15] or by sending the patient to another area of the clinic, such as a phlebotomy area or to the bathroom. If young children are present without another supervising adult, screening should be deferred until a time when the woman presents without them. Language issues are paramount in screening for reproductive coercion and IPV. Medical interpreters should be utilized when needed, and care should be taken to never use a partner, family member, or friend for translation of reproductive coercion or IPV screening questions.[19]

The dissemination of a wallet-sized information card on healthy relationships and coercive tactics in relationships has been shown to have a significant impact on reproductive coercion, as well as the ability of women receiving the intervention to end unhealthy relationships. The intervention was found to reduce the odds of pregnancy coercion by 71% and to significantly increase the odds of ending a relationship due to perceptions that it was unhealthy.[15,20]

For women who screen positive or report experiencing reproductive coercion, midwives and other women's health care providers may consider offering nondetectable methods of contraception, such as IUDs, implants, and injectables. The American College of Obstetricians and Gynecologists suggests that providers consider trimming IUD strings to a level that is undetectable by the partner and cannot be reached by the partner in an attempt to remove the IUD.[16] Women who experience reproductive coercion have higher rates of unintended pregnancy,[2] so clinicians providing abortion services should be prepared to screen for reproductive coercion and offer immediate postabortion access to nondetectable methods of contraception. A woman who desires abortion but is afraid of her partner finding out may be a candidate for medical abortion, which can more easily be disguised as a spontaneous miscarriage. However, some women may prefer a surgical abortion, which can be completed outside the home in a defined period of time. Likewise, clinicians who provide intrapartum and postpartum care should screen for reproductive coercion and consider offering immediate postpartum IUD insertion or injectable contraception prior to hospital discharge. Victims of reproductive coercion may also benefit from facilitated access to emergency contraception. Given the intersection of reproductive coercion with IPV,[2] clinicians should be prepared to offer referrals to local IPV resources, such as local advocacy programs. Supportive, validating messages in counseling are of the utmost importance.

CONCLUSION

This case report describes a woman experiencing reproductive coercion. She presented multiple times for pregnancy testing, which is common, and presented with her partner each time. The midwife in this case followed recommendations for screening for reproductive coercion with the partner out of the room, and had clinic protocols in place that allowed her to easily request his exit, without incident or arousing concern. The woman was interested in a reliable form of contraception that her partner could not easily detect, and the midwife followed recommendations from the American College of Obstetricians and Gynecologists in trimming the strings to the level of the cervical os to further prevent detection. The midwife also followed recommendations by assessing safety and offering IPV resources, although in this case the woman declined. This case reflects suggested management of reproductive coercion in the clinical setting and highlights the essential role that midwives and other women's health care providers can play in helping women avoid consequences such as unintended pregnancy.

Screening and prevention of IPV and its sequelae have long been a priority for health care providers,[21] and this commitment has been further emphasized with mandates by the Patient Protection and Affordable Care Act of 2010.[22] Midwives and other women's health care providers can easily incorporate screening for reproductive coercion into their routine IPV screening to expand the potential impact they can have on women's health and safety. There is no doubt that clinicians can offer positive support and effective safety measures to women experiencing reproductive coercion. However, many aspects of this phenomenon remain unclear and require further research. How men understand the phenomenon of reproductive coercion and how gender norms and identities contribute to this phenomenon need further exploration. When women do not identify the behavior that they experience as coercive, how and should reproductive coercion be addressed? Additionally, the causal relationships between reproductive coercion, IPV, and unintended pregnancy require further exploration.

AUTHOR

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CONFLICT OF INTEREST

The author has no conflicts of interest to disclose.

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