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Reproductive Coercion by an Intimate Partner: Occurrence, Associations, and Interference with Sexual Health Decision Making

Jonel Thaller and Jill Theresa Messing

Reproductive coercion is a form of intimate partner violence (IPV) in which a variety of tactics can be used to force pregnancy on an intimate partner. This study investigated the occurrence of male-perpetrated reproductive coercion, its relationship to other forms of IPV, and interference with women's sexual health decision making. Two data sets were collected, by conducting client-practitioner screenings ($n = 2,108$) and anonymous surveys ($n = 84$), from women seeking reproductive health services in a southwestern state and analyzed separately. Prevalence and correlates of reproductive coercion varied according to data-collection method, indicating that behaviorally based screening tools and anonymous screening may increase disclosure rates. In the screening sample, reproductive coercion was associated with forced sex, threats of physical harm, and verbal abuse. In the survey sample, reproductive coercion was associated with being nonwhite, fear of asking one's partner to use a condom, and fear of refusing sex. Social workers should be aware that reproductive coercion is a form of coercive control that may be associated with increased fear and IPV and may interfere with sexual health decision making; however, disclosure of reproductive coercion or IPV is not necessary for intervention. The article concludes with a discussion of screening and intervention strategies.

KEY WORDS: *domestic violence; family planning; intimate partner violence; reproductive health; screenings*

Globally, approximately 30 percent of women over the age of 15 have experienced physical or sexual violence from an intimate partner (Devries et al., 2013). Likewise, in the United States, recent estimates indicate that approximately one in three women over the age of 18 have experienced physical or sexual violence or stalking from an intimate partner at some point in their lifetime (Black et al., 2011). IPV results in a multitude of negative physical and mental health consequences, with women reporting injury, chronic fatigue, headaches, gastrointestinal problems, and gynecological problems, as well as depression, suicide or suicidal ideation, shame, and posttraumatic stress disorder (Campbell, 2002; Golding, 1999). In part due to these negative health and mental health consequences, it is likely that social workers—particularly those in health care settings—will come into contact with women who are experiencing IPV. Though studies have found that women are more likely to seek assistance for IPV from friends and family members than formal service providers (Goodkind, Sullivan, & Bybee, 2004; Martin,

Houston, Mmari, & Decker, 2012), universal screening can be useful in identifying and intervening in IPV (Thackeray, Stelzner, Downs, & Miller, 2007; Trabold, 2007).

The association between IPV and unintended pregnancy has been well documented (see, for example, Coker, 2007; Gee, Nandita, Wan, Chavkin, & Long, 2009; Miller et al., 2011; Pallitto, Campbell, & O'Campo, 2005; Williams, Larsen, & McCloskey, 2008). However, little is known about the mechanisms underlying this association. Limited control of sexual health decision making appears to be a factor, and recent studies have investigated the prevalence and correlates of *reproductive coercion*, defined as when a male partner attempts to get his female partner pregnant when she does not want to be (see, for example, Miller et al., 2010; Moore, Frohwirth, & Miller, 2010). This exploratory study reports on data collected through two approaches: (1) a screening conducted by health care providers and (2) a survey conducted by researchers to (a) investigate the occurrence of male-perpetrated reproductive coercion

in public health clinics across a southwestern state, (b) analyze differences in reported reproductive coercion according to the manner in which questions were asked, (c) learn more about the relationship between reproductive coercion and other forms of IPV, and (d) identify ways in which reproductive coercion may interfere with women's sexual health decision making.

INTIMATE PARTNER CONTROL OF REPRODUCTIVE HEALTH

Reproductive coercion has been defined as a variety of tactics used to assert reproductive control over an intimate partner. This type of controlling behavior is similar to, but different from, intimate partner *sexual* violence, such as forced sex or forced condom nonuse, because the intention is pregnancy. [Miller et al. \(2010\)](#) have categorized acts of reproductive coercion into two types: pregnancy coercion and birth control sabotage. Whereas pregnancy coercion can include physical violence, threats of physical violence, or forced sex, more subtle forms of coercion may include threats to withhold resources or to have a baby with someone else. Birth control sabotage can include breaking a condom or flushing birth control pills down the toilet with or without a partner's knowledge, as well as neglecting to "pull out" when that was the agreed-on method of birth control ([Miller et al., 2010](#); [Moore et al., 2010](#)). Though little is known about motivations for reproductive control of an intimate partner, researchers have hypothesized that relationship insecurity, masculine gender ideologies around fertility, and sexual proprietariness play a role in its perpetration (see, for example, [Miller et al., 2007](#); [Moore et al., 2010](#); [Rosen, 2004](#)).

The prevalence of reported reproductive coercion ranges from 14 percent to 74 percent across community samples of women seeking reproductive health services, those receiving domestic violence services, and adolescent mothers (see, for example, [De Bocanegra, Rostovtseva, Khera, & Godhwani, 2010](#); [Miller et al., 2010](#); [Moore et al., 2010](#); [Raphael, 2005](#)). The highest prevalence thus far was found with a sample of mostly African American women ($n = 71$, ages 18 through 49 years) seeking services from reproductive health clinics and reporting physical or sexual violence from an intimate partner. Within this sample, 74 percent of women reported having experienced reproductive coercion ([Moore et al., 2010](#)). Reproductive coercion was also prevalent

in a sample of primarily African American (95 percent) teenage mothers using government assistance ($n = 474$); 51 percent reported experiencing at least one form of birth control sabotage in the past year ([Center for Impact Research, 2000](#); [Raphael, 2005](#)). However, prevalence statistics at the U.S. population level are much lower, with 4.8 percent of women reporting that they had experienced reproductive coercion at some point in their lifetime ([Black et al., 2011](#)). In a study of women receiving low-cost reproductive health services (Title X) within a Northern California county, reproductive coercion was significantly associated with being nonwhite ([Miller et al., 2010](#)). However, the prevalence of reproductive coercion according to race at the population level is unknown at this time.

Data regarding reproductive coercion has found that it only sometimes co-occurs with other types of IPV ([Miller et al., 2010](#); [Moore, et al., 2010](#); [Rosen, 2004](#)). Yet, when a study sample is reduced to only women who have experienced IPV, the prevalence of reported reproductive coercion is higher than in broader samples of women. Within the sample of adolescent mothers receiving government assistance ($n = 474$), researchers found that the severity of reported birth control sabotage increased as the severity of intimate partner physical violence increased ([Center for Impact Research, 2000](#); [Raphael, 2005](#)). In the study of women receiving reproductive health services in Northern California ($n = 1,278$), women who experienced physical or sexual violence from an intimate partner were more than twice as likely to report experiencing reproductive coercion as women who had not ([Miller et al., 2010](#)). Moreover, women who experienced physical or sexual violence in tandem with reproductive coercion were approximately twice as likely as women who had not experienced either to report unintended pregnancy ([Miller et al., 2010](#)). Finally, among a sample of women seeking services at domestic violence shelters ($n = 53$), intimate partner forced sex was significantly correlated with birth control sabotage ([De Bocanegra et al., 2010](#)).

Studies of reproductive coercion add to our understanding of women's ability to fully consent to sexual activity in the context of IPV. Women's compromised sexual health decision making or relationship-specific restrictions around their ability to make autonomous contraceptive choices may underlie the well-documented association between IPV and unintended pregnancy (see, for example, [Coker, 2007](#); [Gee et al.,](#)

2009; Miller et al., 2011; Pallitto et al., 2005; Williams et al., 2008). For example, low-income adolescent mothers ($n = 35$) who reported physical or sexual abuse in their relationships also reported that their partners were the primary decision makers around contraception and reproductive outcomes (Rosen, 2004). Likewise, reproductive health patients ($n = 1,463$) experiencing physical or sexual violence, or threats of physical violence, from an intimate partner reported not using birth control because their partners did not want them to (Gee et al., 2009). In another sample of women recruited through health care settings ($n = 225$), those who had experienced past-year reoccurring or severe physical, sexual, or emotional abuse were nearly twice as likely to report not using their preferred method of contraception (Williams et al., 2008). Finally, in a review of data from family planning clinics ($n = 2,000$), women who reported past-year physical or sexual violence were over six times as likely to change contraceptive methods or use emergency contraception than women who did not, and they were nearly 10 times more likely to be using no method of contraception at all (Fantasia, Sutherland, Fontenot, & Lee-St John, 2012).

METHOD

This study consisted of two distinct methods of data collection: a screening by health care providers and an anonymous survey conducted by researchers. First, we examined data from a screening instrument administered by health care professionals in 14 Title X reproductive health clinics across one southwestern state. The screening instrument was intended to screen for reproductive coercion, pregnancy avoidance, and experiences of IPV. To our knowledge, no previous research has reported the prevalence of reproductive coercion as disclosed to health care providers who are screening directly for this form of abuse. Following this screening period, more in-depth survey data were collected at three Title X reproductive health clinics in a rural county in the same southwestern state. Survey data were intended to supplement the screening data by providing more in-depth information about reproductive coercion and IPV among a smaller sample of women. The different forms of data collection also allow for comparisons in reported reproductive coercion across the screening instrument and survey. Data collection for this project was approved by the researchers' institutional review board.

Screening Data

Screenings were administered verbally by health care professionals who were trained by staff at the state-level Coalition Against Domestic Violence. Screening was conducted in English or Spanish, took less than five minutes, and was intended to begin a conversation between the patient and practitioner regarding reproductive coercion and IPV. The screening was implemented as part of the practitioner-client interaction, and clients did not receive an incentive for their time, though clinics participating in the screening received \$1 per patient screened. After screening, all patients were provided with information outlining indicators of reproductive coercion and options for discreetly avoiding pregnancy. Screening data were mailed to researchers over a period of 14 months and were entered into SPSS (2013) for data analysis.

Demographic and Relationship Information. The screening instrument included an area for the health care provider to fill in the patient's age, race or ethnicity, primary language, marital status, employment, number of children living with her, and whether the patient was currently pregnant. Participants were also asked the following yes-or-no questions: "Are you currently in a relationship or sexually active?" and "If yes, does your partner know that you are here today?"

Reproductive Coercion and Pregnancy Avoidance. Health care practitioners asked a single question about reproductive coercion: "Has a partner tried to get you pregnant when you did not want to be?" Practitioners also asked a single question about pregnancy avoidance: "Have you ever hidden birth control from a partner so he won't get you pregnant?" Participants could respond yes = 1 or no = 0 to either of these questions.

IPV and Abuse. The Hurt-Insult-Threaten-Scream (HITS) scale was used to assess for IPV (Sherin, Sinacore, Li, Zitter & Shakil, 1998). The HITS scale consists of four items that participants answer on a Likert scale (ranging from 1 = never to 5 = frequently); as such, scores range from 4 to 20. The four items are as follows: (1) "How often does your partner physically hurt you?"; (2) "How often does your partner insult you or talk down to you?"; (3) "How often does your partner threaten you with harm?"; and (4) "How often does your partner scream and curse at you?" When tested with women, the HITS scale has been found to have sensitivity from 30 percent to 100 percent, specificity from 86 percent to 99 percent, and a Cronbach's alpha ranging from

.76 to .80 (Rabin, Jennings, Campbell, & Bair-Merritt, 2009). In addition, the reliability and validity of the HITS scale has been tested in Spanish (Chen, Rovi, Vega, Jacobs, & Johnson, 2005). Because this screening instrument does not screen for intimate partner sexual violence, a yes-or-no question was added: "Is anyone making you have sex when you don't want to?" In addition, the following question was included to assess participant experiences of coercive control: "How often does your partner have the final say about what you do on a daily basis?" Response options for this item were consistent with the responses provided to the HITS screening. The scores for the HITS screening were calculated. In addition, dichotomous measures (yes = 1, no = 0) of intimate partner abuse (insult or talk down to you, scream or curse at you, or have a final say about what you do) and IPV (physically hurt you, threaten you with harm, or make you have sex) were created.

Survey Data

Following collection of the screening data, women from 14 to 45 years of age receiving services at three Title X reproductive health clinics in a rural county in the same southwestern state were recruited to complete a confidential computer survey while waiting for their appointments in the clinic's waiting room. All clinics participating in this portion of the research had implemented screening and referral procedures described earlier. With cooperation from staff, research assistants approached potential participants waiting for their appointments and invited them to complete data collection through an audio computer-assisted survey on a laptop in a private area within the clinical setting. Within this private setting, participants read or listened to via headphones survey instructions/questions and entered responses directly into the computer. Participants earned a \$10 gift card and typically completed the survey in 10 to 15 minutes.

Demographic and Relationship Characteristics.

Participants were asked about their age, racial or ethnic background, and whether they were born in the United States. Age was reported in years and used as a linear variable. Participants were asked to report their race or ethnicity in mutually exclusive categories: American Indian or Alaska Native, Asian, black or African American, Hispanic or Latina, Native Hawaiian or other Pacific Islander, white, or multiracial. Because of the disproportionately small

number of participants identifying as American Indian, black or African American, Asian, Hawaiian or Pacific Islander, or multiracial, race and ethnicity were dichotomized into white = 0 and nonwhite = 1. Participants were also asked whether they were born in the United States (yes = 1, no = 0). Participants were asked about their relationship status and could choose among the following five options: (1) single, (2) dating more than one person, (3) dating one person or in a serious relationship, (4) married, or (5) married with more sex partners than husband.

IPV. Physical and sexual IPV was measured with three questions examining physical violence, forced sex, and sexual coercion, respectively: (1) "Have you ever been hit, pushed, slapped, choked, or otherwise physically hurt by someone you were dating, going out with, or married to?"; (2) "Has someone you were dating, going out with, or married to used force or threats to make you have sex (vaginal, oral, or anal sex) when you didn't want to?"; and (3) "Has someone you were dating, going out with, or married to made you have sex (vaginal, oral, or anal sex) when you didn't want to but didn't use force or threats?" Response options were yes = 1 or no = 0.

Reproductive Coercion. Reproductive coercion (both pregnancy coercion and birth control sabotage) was measured with the following questions: "Has someone you were dating, going out with, or married to: (a) tried to force or pressure you to become pregnant?; (b) told you not to use any birth control (like the pill, shot, ring, etc.)?; (c) said he would leave you if you didn't get pregnant?; (d) told you he would have a baby with someone else if you didn't get pregnant?; (e) taken off the condom while you were having sex so you would get pregnant?; (f) put holes in the condom so you would get pregnant?; (g) broken the condom on purpose so you would get pregnant?; (h) taken your birth control (like pills) away from you or kept you from going to the clinic to get birth control?; (i) made you have sex without a condom so you would get pregnant?; and (j) hurt you physically because you did not agree to get pregnant?" Response options for all questions were yes = 1 or no = 0.

Compromised Sexual Health Decision Making.

Interference in participants' sexual health decision making was assessed with the following three questions: (1) "In the past three months, have you been afraid to ask your partner to use a condom?"; (2) "In the past three months, have you been afraid to discuss birth control (like the pills or the shot) with your sex

partner?"; and (3) "In the past three months, have you been afraid to refuse sex with a sex partner?" Response options were yes = 1 or no = 0.

Help-Extending Behavior. Participants were asked about the likelihood that they would provide support to a friend or family member who was experiencing reproductive coercion in the form of (a) listening to or comforting her, (b) helping her find information about birth control or counseling, or (c) encouraging her to talk about it. They were asked if they were not likely at all, somewhat likely, very likely, or extremely likely to offer these supports.

Analysis

All data were analyzed in SPSS. Sample characteristics are described using univariate analyses. Given the exploratory nature of this research, bivariate analyses (chi square and *t* test) were used to examine relationships between reproductive coercion and pregnancy avoidance and (a) demographic characteristics, (b) IPV, (c) compromised sexual health decision making, and (d) help-extending behavior. Results are reported separately for screening and survey data.

RESULTS

Screening Data

Demographic and Relationship Information. Participants screened by health care professionals ($n = 2,108$) were primarily Latina (45.2 percent) and white (42.0 percent). Ages ranged from 12 to 56 years ($M = 23.94$, $SD = 7.84$). Over one-quarter of the sample (26.7 percent) reported that their primary language was Spanish, and 2.8 percent reported being bilingual (Spanish and English). A small number of women ($n = 6$) reported that their primary language was a language other than Spanish or English. The majority of women reported that they were single (73.7 percent; this includes women in current intimate relationships), followed by married (20.3 percent) and separated, divorced, or widowed (6.0 percent). The majority of women (55.1 percent) reported being unemployed. Most women (55.3 percent) did not have children living with them; for those who did, the median number of children was two. A small proportion of women reported that they were pregnant (2.8 percent) or unsure if they were pregnant (1.9 percent). Finally, 82.1 percent of women reported that their partner knew that they were at the clinic on the day of their visit.

Reproductive Coercion and Pregnancy Avoidance.

Sixty-five women screened by health care professionals, or 3.3 percent of the 1,978 who responded to the question, reported reproductive coercion. A smaller number of women—38 participants, or 1.9 percent of the 1,987 women who responded to the question—reported that they had hidden birth control from their partner to avoid pregnancy. The majority of women who reported reproductive coercion did not report engaging in pregnancy avoidance ($n = 53$), though reproductive coercion and pregnancy avoidance are significantly associated with one another [$\chi^2(1, N = 1,975) = 97.41$, $p < .001$]. Women who were nonwhite were significantly [$\chi^2(2, N = 1,911) = 13.30$, $p < .001$] more likely to report that they had hidden birth control from their partner to avoid pregnancy but not more likely to report reproductive coercion. There were no additional relationships found between demographic characteristics and women's reports of reproductive coercion or pregnancy avoidance.

IPV and Abuse. Within this sample, 2.7 percent of women reported experiencing physical or sexual IPV. HITS scores ranged from 4 to 20 ($M = 4.39$, $SD = 1.16$), though most women (82.2 percent) reported that their partner never engaged in any of the four abusive or violent acts on the HITS screening instrument. Women who reported reproductive coercion [$t(1707) = -3.62$, $p < .01$] were significantly more likely to have a higher mean score on the HITS assessment than women who did not report reproductive coercion. There were no significant differences in HITS scores for women who reported pregnancy avoidance and those who did not. Women who experienced reproductive coercion were significantly more likely to report forced sex [$\chi^2(1, N = 1,978) = 10.23$, $p < .001$], threats of physical harm [$\chi^2(1, N = 1,970) = 9.06$, $p < .01$], and verbal abuse [$\chi^2(1, N = 1,965) = 10.99$, $p < .001$], though reproductive coercion was not significantly related to physical violence.

Survey Data

Demographic and Relationship Characteristics. Survey respondents who answered that they had never had sex (vaginal, oral, or anal) and those who had only had female partners were excluded from the analysis of survey data. The age of study participants after these exclusions ($n = 84$) ranged from 14 to 45 years ($M = 22.35$, $SD = 7.11$). Of the women in the final sample ($n = 84$), a majority identified as white

(76.2 percent, $n = 64$), followed by Hispanic or Latina (17.9 percent, $n = 15$), American Indian (2.4 percent, $n = 2$), black or African American (1.2 percent, $n = 1$), Native Hawaiian or other Pacific Islander (1.2 percent, $n = 1$), and multiracial (1.2 percent, $n = 1$). In regard to relationship status, 48.8 percent ($n = 41$) reported dating one person or being in a serious relationship, 39.3 percent ($n = 33$) reported being single, 8.3 percent ($n = 7$) being married, 2.4 percent ($n = 2$) dating more than one person, and 1.2 percent ($n = 1$) married with more sex partners than husband.

Reproductive Coercion. Within the total sample, 15.5 percent ($n = 13$) of participants reported ever experiencing one of more forms of reproductive coercion, and 8.3 percent ($n = 7$) reported experiencing one or more forms of reproductive coercion in the last three months. Nearly half of women ($n = 6$) who had experienced reproductive coercion in their lifetime only experienced one form (that is, their partner forced or pressured them to become pregnant, told them not to use birth control, told them they would have a baby with someone else, took their birth control, made them have sex without a condom, or removed a condom during sex), but five women reported experiencing two forms of reproductive coercion, one woman reported three forms, and another reported five forms. Pregnancy coercion and birth control sabotage were significantly related [$\chi^2(1, N = 84) = 28.816, p < .01$]. Of the total women in the study sample ($n = 84$), 11.9 percent ($n = 10$) experienced at least one form of pregnancy coercion, and 7.1 percent ($n = 6$) experienced at least one form of birth control sabotage, with some women experiencing one form of both pregnancy coercion and birth control sabotage. In regard to participant demographic characteristics, age, education, or place of birth were not significantly related to ever having experienced some form of reproductive coercion. However, being nonwhite was significantly related to ever having experienced reproductive coercion from an intimate partner [$\chi^2(1, N = 84) = 7.649, p < .006$].

IPV. Participants in this sample experienced levels of IPV comparable to results of the nationwide population-level survey (Black et al., 2011): 34.5 percent ($n = 29$) of the sample reported ever experiencing physical violence or forced sex from by an intimate partner in her lifetime, and 9.5 percent ($n = 8$) of the total sample reported experiencing physical violence or forced sex from an intimate partner in the past three months. More specifically, 31 percent ($n = 26$) reported ever experiencing physical

violence from an intimate partner, 11.9 percent ($n = 10$) reported ever experiencing forced sex from an intimate partner, 8.3 percent ($n = 7$) reported experiencing physical violence from an intimate partner in the past three months, and 2.4 percent ($n = 2$) reported forced sex by an intimate partner in the past three months. In addition, 19 percent ($n = 16$) reported ever having experienced sexual coercion from an intimate partner, and 2.4 percent ($n = 2$) reported experiencing sexual coercion in the past three months. In this sample, lifetime or past three months' experience of physical violence, forced sex, or sexual coercion from an intimate partner was not significantly related to reproductive coercion, race or ethnicity, age, education, or place of birth.

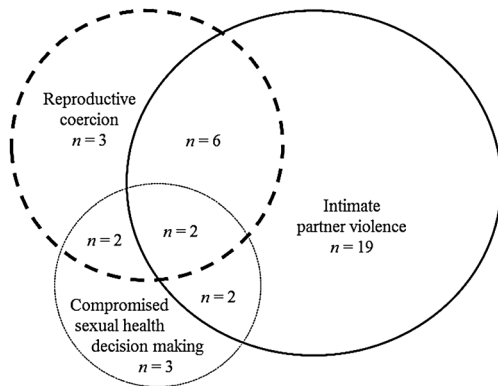
Compromised Sexual Health Decision Making. In total ($n = 77$), 10.4 percent ($n = 8$) of participants reported ever having been afraid to ask a partner to use a condom, and 5.2 percent ($n = 4$) reported ever having been afraid to refuse sex with a partner. Ever having experienced reproductive coercion was significantly related to being afraid of asking a partner to use a condom [$\chi^2(1, N = 77) = 8.04, p < .005$] and being afraid to refuse sex with a partner [$\chi^2(1, N = 77) = 11.32, p < .001$]. However, physical violence, forced sex, and sexual coercion were not significantly related to these fears, nor were race or ethnicity, age, education, or place of birth. Though neither compromised sexual health decision making nor reproductive coercion were significantly related to IPV, Figure 1 represents the frequencies at which these multiple phenomena co-occurred. For example, of the total cases of reported IPV ($n = 29$), six also reported reproductive coercion, two reported compromised sexual health decision making, and two experienced both reproductive coercion and compromised sexual health decision making in conjunction with IPV.

Help-Extending Behavior. Having experienced reproductive coercion [$\chi^2(1, N = 80) = 4.26, p < .039$], physical violence [$\chi^2(1, N = 80) = 4.10, p < .043$], or sexual coercion [$\chi^2(1, N = 80) = 5.23, p < .022$] by an intimate partner was significantly associated with encouraging other women to speak to someone they trust if experiencing reproductive coercion.

DISCUSSION

The American College of Obstetricians and Gynecologists recommended in 2013 that practitioners working in health care settings should be aware of

Figure 1: Co-occurrence of Intimate Partner Violence, Reproductive Coercion, and Compromised Sexual Health Decision Making in the Survey Sample



Note: Total 29 cases of intimate partner violence, 13 cases of reproductive coercion, and nine cases of compromised sexual health decision making.

indicators that female clients are being coerced into pregnancy and offer them information about discreet forms of contraception, such as intrauterine devices, contraceptive injections, or implants. Given their professional training, social workers, particularly those in health care settings, have a unique opportunity to intervene with women experiencing reproductive coercion. This study investigated the occurrence of reproductive coercion and its associations with other forms of IPV, as well as compromised sexual health decision making, in a sample of women receiving services at Title X clinics. Although women in both the screening and survey sample were recruited at similar locations, their reported prevalence of reproductive coercion differed noticeably (3.3 percent and 15.5 percent, respectively). This discrepancy might be attributed, at least partially, to the manner in which data were collected for each sample. Verbal screening by health care practitioners was used to gather data from the first sample, whereas an anonymous survey taken on a laptop computer situated in a private area of the clinic was used to gather data for the second sample. In addition, the survey sample was asked multiple questions about behaviorally specific acts of reproductive coercion, whereas the screening sample was asked a single question about reproductive coercion. Some participants may not feel comfortable self-reporting sensitive information (Tourangeau & Yan, 2007), and this may be exacerbated by having a practitioner ask for information directly, as opposed to reporting this

information through a computer-mediated platform. Perhaps screening that appears more private or asks behaviorally specific questions about reproductive coercion would increase disclosure rates.

Women experiencing IPV are more likely to disclose to a social worker than any other practitioner (Trabold, 2007); as such, social workers should be trained to screen for IPV, as well as reproductive coercion, in health care settings. However, social work students and practitioners have reported a lack of knowledge about IPV (Bent-Goodley, 2007; Danis & Lockhart, 2003). The National Association of Social Workers has recommended that social workers be prepared to respond to clients who disclose IPV (Thackeray et al., 2007), and this should include reproductive coercion. However, disclosure of IPV or reproductive coercion is not necessary for intervention. The act of screening alone raises awareness and demonstrates to women that the practitioner is educated and open to disclosure (perhaps at a later date). Furthermore, the act of screening provides practitioners with an opportunity to educate clients about local and national resources, as well as the availability of birth control options one can use without one's partner knowing whether or not the client has disclosed reproductive coercion (Chamberlain & Levenson, 2012). Because the results of the survey sample indicate women's willingness to encourage friends and family members to disclose reproductive coercion, it is important for social workers to consider the potential role of IPV survivors in public education. Social workers may have a unique opportunity to recruit survivors to educate and create awareness about reproductive coercion as a form of abuse.

Both the screening and survey samples included a relatively large portion of women who identified as Hispanic or Latina—45.2 percent and 17.9 percent, respectively. Because this ethnic group is the fastest growing in the United States, continuing research with this population is necessary to gain a comprehensive understanding of reproductive coercion and its effective intervention. Cultural characteristics and sociostructural inequality contribute to women's unique experiences of IPV and the scope of negative outcomes resulting from it (Bubriski-McKenzie & Jasinski, 2013), and race or ethnicity has been associated with reported reproductive coercion in previous research with a primarily nonwhite sample (Miller et al., 2010). In this study, being nonwhite was significantly related to

reproductive coercion in the survey sample and was associated with pregnancy avoidance or using birth control without the partner knowing in the screening sample. Given that the current public health intervention for reproductive coercion is to provide women with accessibility to discreet forms of contraception, it is important to understand the nuanced differences in women's engagement in pregnancy avoidance by race or ethnicity and how cultural characteristics, as well as historical links to social inequality and state-sanctioned reproductive control, may affect these behaviors. Future research regarding this intervention might also take into account some women's aversion to hormonal and temporarily irreversible forms of birth control.

Practitioners should be aware that reproductive coercion only sometimes occurs within the context of other forms of IPV, and for this reason it is important to screen for reproductive coercion in addition to screening for other forms of IPV. Reproductive coercion has been associated with physical and sexual violence in previous studies ([Miller et al., 2010](#); [Moore et al., 2010](#)). However, results from this study were mixed: Reproductive coercion was significantly related to other forms of IPV in the screening sample but not the survey sample. Still, women in the survey sample were asked about fear of their partners, and having experienced reproductive coercion was significantly associated with fear of asking a partner to use a condom or refusing sex with a partner. Given conflicting evidence, little is known about the relationship of reproductive coercion with other forms of IPV, and it is unknown whether reproductive coercion might be a precursor to escalating physical and sexual violence.

Study Limitations

The results of this study should be interpreted within the context of its limitations. The research was limited to one geographical location and is not generalizable to the rest of the country. The screening instrument was administered to a larger number of women than the anonymous survey, but this instrument was brief due to the limited time health care professionals spend with clients. More in-depth information was gathered through the anonymous survey; however, the sample was smaller and the geographical location more limited.

Methods of data collection (that is, face-to-face with a practitioner versus anonymously through a computer) must also be considered, as it may have

affected participants' willingness to disclose sensitive relationship information. Participants in the screening sample may have been reluctant to answer all questions honestly for fear of confrontation or mandatory reporting. In addition, health care professionals were trained to administer the screening, yet there may have been wide variation in both the manner in which the screening was administered and the demeanor of the helping professional. Women who completed the anonymous survey were assured that their health care provider would not see their answers; however, given that the survey was administered in the clinic setting, they may have also been reluctant to report instances of abuse. In addition, though participants in the survey sample were able to complete the survey in a private setting within the clinic, many had arrived with parents or boyfriends.

Finally, due to limitations in the data, some variables were reduced to dichotomous categories, which hinders our ability to learn more about the nuances of reproductive coercion. For example, race or ethnicity was dichotomized when analyzing data from both the screening and the survey instrument due to samples including primarily white and Hispanic or Latina women. In addition, reproductive coercion was dichotomized in both samples according to whether or not participants had experienced any form of reproductive coercion, which did not allow for differentiation between pregnancy coercion and birth control sabotage.

CONCLUSION

A limited amount of research has explored the motivations attached to the perpetration of reproductive coercion (see, for example, [Miller et al., 2007](#); [Moore et al., 2010](#); [Rosen, 2004](#)). Given this general lack of knowledge, the current solution for the problem of reproductive coercion has been to educate women on how to obtain forms of birth control they can hide from their partners ([Chamberlain & Levenson, 2012](#); [Miller et al., 2011](#)). Although social workers have a unique opportunity to intervene in this way, this intervention ultimately does little to treat the root cause of the issue. Although hidden birth control will help women who are experiencing reproductive coercion avoid unintended pregnancy, it will not stop the perpetrators from continuing to abuse them or many others in succession or prevent women from contracting HIV or sexually transmitted infections when engaging in unprotected sex. Thus, research is needed to learn more about perpetrators' motivations for

engaging in reproductive coercion so that social workers and other practitioners can understand more about the context within which it occurs. This knowledge could lead to the complementary development of perpetrator-centered interventions that shift responsibility for ending this abuse away from the victim. **HSW**

REFERENCES

- Bent-Goodley, T. B. (2007). Teaching social work students to resolve ethical dilemmas in domestic violence. *Journal of Teaching in Social Work, 27*(1-2), 7-88.
- Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., et al. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report*. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
- Bubriski-McKenzie, A., & Jasinski, J. L. (2013). Mental health effects of intimate terrorism and situational couple violence among black and Hispanic women. *Violence Against Women, 19*, 1429-1448.
- Campbell, J. C. (2002). The health consequences of intimate partner violence. *Lancet, 359*, 1331-1336.
- Center for Impact Research. (2000). *Domestic violence and birth control sabotage: A report from the Teen Parent Project*. Chicago: Author.
- Chamberlain, L., & Levenson, R. (2012). *Addressing intimate partner violence, reproductive and sexual coercion: A guide for obstetric, gynecologic and reproductive health care settings* (2nd ed.). San Francisco: Futures Without Violence.
- Chen, P. H., Rovi, S., Vega, M., Jacobs, A., & Johnson, M. S. (2005). Screening for domestic violence in a predominantly Hispanic clinical setting. *Family Practice, 22*, 617-623.
- Coker, A. L. (2007). Does physical intimate partner violence affect sexual health? A systematic review. *Trauma, Violence, & Abuse, 8*(2), 149-177.
- Danis, F. S., & Lockhart, L. (2003). Domestic violence and social work education: What do we know, what do we need to know? *Journal of Social Work Education, 39*, 215-224.
- De Bocanegra, H. T., Rostovtseva, D. P., Khera, S., & Godhwani, N. (2010). Birth control sabotage and forced sex: Experiences reported by women in domestic violence shelters. *Violence Against Women, 16*, 601-612.
- Devries, K. M., Mak, J. Y. T., Garcia-Moreno, C., Petzold, M., Child, J. C., Falder, G., et al. (2013). The global prevalence of intimate partner violence against women. *Science, 340*(6140), 1527-1528.
- Fantasia, H. C., Sutherland, M. A., Fontenot, H. B., & Lee-St John, T. J. (2012). Chronicity of partner violence, contraceptive patterns and pregnancy risk. *Contraception, 86*, 530-535.
- Gee, R. E., Nandita, M., Wan, F., Chavkin, D. E., & Long, J. A. (2009). Power over parity: Intimate partner violence and issues of fertility control. *American Journal of Obstetrics and Gynecology, 201*(148), 1-7.
- Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14*, 99-132.
- Goodkind, J. R., Sullivan, C. M., & Bybee, D. I. (2004). A contextual analysis of battered women's safety planning. *Violence Against Women, 10*, 514-533.
- Martin, C., Houston, A., Mmari, K., & Decker, M. (2012). Urban teens and young adults describe drama, disrespect, dating violence and help-seeking preferences. *Journal of Maternal and Child Health, 16*, 957-966.
- Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., et al. (2010). Pregnancy coercion, intimate partner violence and intended pregnancy. *Contraception, 81*, 316-322.
- Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., et al. (2011). A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. *Contraception, 83*, 274-280.
- Miller, E., Decker, M. R., Reed, E., Raj, A., Hathaway, J. E., & Silverman, J. G. (2007). Male partner pregnancy-promoting behaviors and adolescent partner violence: Findings from a qualitative study with adolescent females. *Ambulatory Pediatrics, 71*, 360-366.
- Moore, A. M., Frohwirth, L., & Miller, E. (2010). Male reproductive control of women who have experienced intimate partner violence in the United States. *Social Science and Medicine, 70*, 1737-1744.
- Pallitto, C. C., Campbell, J. C., & O'Campo, P. (2005). Is intimate partner violence associated with unintended pregnancy? A review of the literature. *Trauma, Violence, & Abuse, 6*(3), 217-235.
- Rabin, R. F., Jennings, J. M., Campbell, J. C., & Bair-Merritt, M. H. (2009). Intimate partner violence screening tool for use in a family practice setting. *American Journal of Preventive Medicine, 36*, 439-445.
- Raphael, J. (2005). Teens having babies: The unexplored role of domestic violence. *Prevention Researcher, 12*(1), 15-17.
- Rosen, D. (2004). "I just let him have his way": Partner violence in the lives of low-income, teenage mothers. *Violence Against Women, 10*, 6-28.
- Sherin, K. M., Sinacore, J. M., Li, X. Q., Zitter, R. E., & Shakil, A. (1998). HITS: A short domestic violence screening tool for use in a family practice setting. *Family Medicine-Kansas City, 30*, 508-512.
- SPSS, Inc. (2013). *IBM SPSS Statistics for Windows, Version 22.0*. Armonk, NY: IBM Corp.
- Thackeray, J., Stelzner, S., Downs, S., & Miller, C. (2007). Screening for intimate partner violence. *Journal of Interpersonal Violence, 22*, 659-670.
- Tourangeau, R., & Yan, T. (2007). Sensitive questions in surveys. *Psychological Bulletin, 133*, 859-883.
- Trabold, N. (2007). Screening for intimate partner violence within a health care setting: A systematic review of the literature. *Social Work in Health Care, 45*, 1-18.
- Williams, C. M., Larsen, U., & McCloskey, L. A. (2008). Intimate partner violence and women's contraceptive use. *Violence Against Women, 14*, 1382-1396.

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