



Original research article

Psychometric properties and refinement of the Reproductive Coercion Scale^{☆,☆☆,★}

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Abstract

Objective: Identification and refinement of psychometric properties of the Reproductive Coercion Scale (RCS) for use in survey research and clinical practice.

Study design: Young women aged 16–29 years seeking services in 24 Pennsylvania and 5 California family planning clinics completed questionnaires. Data were pooled for analysis ($n=4674$), and underlying domains were assessed using Horn's Parallel Analysis and Exploratory Factor Analysis. Multidimensional Item Response Theory was used to refine the scale and assess reliability and validity of a short-form RCS.

Results: The full, nine-item RCS had two underlying domains: pregnancy coercion and condom manipulation. Five items were retained in the short form: three about pregnancy coercion (e.g., “told you not to use birth control...”) and two for condom manipulation (e.g., “taken off the condom while you were having sex...”; one of these items is the combination of two original items on damaging the condom that were combined because of similar statistical properties and face validity and a third item on removing the condom was retained on its own). Recent reproductive coercion was reported by 6.7% and 6.3% of the sample with the full and short-form RCS, respectively. Characteristics of women reporting reproductive coercion were similar with both forms.

Conclusion: Findings indicate that reproductive coercion includes pregnancy coercion and deliberate manipulation of condoms to promote pregnancy. Moreover, women experience reproductive coercion across a continuum of severity. We selected items that varied in RC severity and discrimination to generate a five-item short-form RCS for survey research and clinical practice.

Implications: This study assesses the psychometric properties of the RCS, identifying pregnancy coercion and condom manipulation as underlying domains of reproductive coercion. Recommendations for using the RCS in research and clinical practice are discussed.

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1. Introduction

Women of reproductive age are at highest risk for intimate partner violence (IPV) and experience poor reproductive health outcomes including unintended pregnancy [1–4], miscarriage [5] and preterm labor as a result of violence victimization [6]. Researchers have suggested several mechanisms that may underlie the association between IPV and poor sexual and reproductive health including forced or coerced sex and diminished self-efficacy to negotiate condom use with an abusive partner [7–10].

A qualitative study by Miller and colleagues [11] found explicit links between pregnancy-promoting behavior by coercive male partners and unintended pregnancy. Adolescent girls described male partners breaking condoms, refusing to use condoms and destroying birth control pills to promote a pregnancy. Other qualitative studies illustrate tactics including male partners telling women they “do not believe in contraception” and want children [12], with partners attempting to control not only conception but the outcome of a pregnancy [13]. These behaviors are facets of reproductive coercion (RC), defined by the American College of Obstetricians and Gynecologists (ACOG) as “behavior intended to maintain power and control in a relationship related to reproductive health...” [14]. RC includes explicit attempts to impregnate a partner against her will, control outcomes of a pregnancy and interfere with using contraception [15].

Research on RC has rapidly emerged in recent years. Using the Reproductive Coercion Scale (RCS), Miller and colleagues [3] found that almost 26% of a family planning clinic-based sample of 16- to 29-year-old women in Northern California had experienced RC in their lifetime. Another study by the same team in 24 family planning clinics in Western Pennsylvania found that 5% of women in the sample had experienced RC in the past 3 months [4]. In both studies, RC was associated with statistically significant, elevated odds of unintended pregnancy [3,4]. Another clinic-based study by Clark and colleagues [16] found that 16% of women seeking routine care at obstetrics and gynecology clinics had experienced RC, while a recent study found that 8% of almost 6000 college students reported RC, providing evidence beyond the clinical setting [17]. RC has also been assessed in global settings using items modified from the RCS, with evidence that RC may be perpetrated both by partners and extended family [18,19]. Moreover, emerging evidence from samples in the United States and other countries indicate that RC may impact women’s mental health (e.g., posttraumatic stress disorder symptoms, anxiety, stress symptoms), extending the literature on the health impacts of RC [18,20].

Research on the prevalence and sexual and reproductive health impacts of RC has influenced clinical practice guidelines. In 2013, ACOG released a committee opinion recommending that obstetrician-gynecologists incorporate IPV and RC assessment into routine sexual and reproductive

health care [14]. This approach includes universal education about IPV and RC, routine inquiry to normalize the conversation about RC, and brief harm reduction counseling (e.g., providing contraception options that an abusive partner cannot interfere with) [21]. The purpose of the present paper is to assess the psychometric properties of RCS items to elucidate the underlying dimensions of RC and to develop and provide guidance for using a short-form RCS in survey research and clinical practice.

2. Methods

2.1. Data

We used baseline data from two longitudinal randomized controlled trials in 5 California and 24 Pennsylvania family planning clinics [3,22–24]. Procedures were identical for both studies. We recruited English- or Spanish-speaking women aged 16–29 years seeking care at participating clinics. California data ($n=1319$) were collected between August 2008 and March 2009, and Pennsylvania data ($n=3867$) between October 2011 and November 2012. Upon entry to the clinic, trained research staff approached women and assessed them for eligibility. Interested women completed the informed consent process and a 30-min computer-based survey via audio computer-assisted self-interview. Participants received \$15 for their time. We pooled the two datasets and women with missing data on any RCS item were removed, yielding an effective sample size of 4674 women. Study procedures were approved by institutional review boards at UC Davis, Harvard T.H. Chan School of Public Health, and University of Pittsburgh.

2.2. Measures

2.2.1. The Reproductive Coercion Scale

The RCS comprised nine dichotomous (yes/no) items used to assess participants’ experience of recent (past 3 months) RC. Items are presented in tables below.

2.2.2. Intimate partner violence

IPV was assessed using items modified from the Revised Conflict Tactics Scale [25] and the Sexual Experiences Survey [26]. In California, IPV was assessed via four items: (1) have you ever been hit, pushed, slapped, choked or otherwise physically hurt by someone you were dating or going out with; (2) has someone you were dating or going out with insisted (without using force or threats) on having sex with you when you didn’t want to; (3) has someone you were dating or going out with used threats to make you have sex with them; and (4) has someone you were dating or going out with used force (hitting, holding down, using a weapon) to make you have sex with them. In Pennsylvania, three items were used to assess IPV. Physical violence (item #1, above) and sexual violence without force or threats (item #2, above) were identical to the California survey. The final item combined force *or* threats. A dichotomous variable was

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