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Male reproductive control of women who have experienced intimate partner violence in the United States

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ABSTRACT

Women who have experienced intimate partner violence (IPV) are consistently found to have poor sexual and reproductive health when compared to non-abused women, but the mechanisms through which such associations occur are inadequately defined. Through face-to-face, semi-structured in-depth interviews, we gathered full reproductive histories of 71 women aged 18–49 with a history of IPV recruited from a family planning clinic, an abortion clinic and a domestic violence shelter in the United States. A phenomenon which emerged among 53 respondents (74%) was male reproductive control which encompasses pregnancy-promoting behaviors as well as control and abuse during pregnancy in an attempt to influence the pregnancy outcome. Pregnancy promotion involves male partner attempts to impregnate a woman including verbal threats about getting her pregnant, unprotected forced sex, and contraceptive sabotage. Once pregnant, male partners resort to behaviors that threaten a woman if she does not do what he desires with the pregnancy. Reproductive control was present in violent as well as non-violent relationships. By assessing for male reproductive control among women seeking reproductive health services, including antenatal care, health care providers may be able to provide education, care, and counseling to help women protect their reproductive health and physical safety.

Introduction

Intimate partner violence (IPV) is associated with unwanted pregnancy, women not using their preferred contraceptive method, sexually transmitted infections including HIV/AIDS, miscarriages, repeat abortion, a high number of sexual partners, and poor pregnancy outcomes (Alio, Nana, & Salihu, 2009; Center for Impact Research, 2000; Coker, 2007; Fisher et al., 2005; Maman, Campbell, Sweat, & Gielen, 2000; Taggart & Mattson, 1996; Williams, Larsen, & McCloskey, 2008). The proximal determinants of unwanted pregnancy—forced sex and partner's unwillingness to use contraception—have been documented in relationships that include IPV (Campbell, Woods, Chouaf, & Parker, 2000; Lathrop, 1998). Other behaviors that further undermine women's ability to prevent an unwanted pregnancy in abusive relationships include women's lack of negotiating power to insist on contraceptive use, abusive partners' interference with women's use of contraception, and partners' refusal to pay for contraception (Branden, 1998; Heise, Moore, & Toubia, 1995). While these behaviors expose women to the risk of pregnancy, this body of work has not focused on whether men's intentions were to make the woman pregnant.

Pregnancy itself is a vulnerable time for women in abusive relationships. Previous work has documented the increased risk of violence during pregnancy (Gelles, 1988), with unintended pregnancies carrying an even greater risk of violence than intended pregnancies (Gazamararian et al., 1995). This violence may be the result of the partner's jealousy and resentment towards the unborn child (Campbell, Oliver, & Bullock, 1993; Mezey, 1997), and/or the partner's increased feelings of insecurity and possessiveness during the pregnancy (Bacchus, Mezey, & Bewley, 2006). Women report that financial worries and their reduced physical and emotional availability during pregnancy may lead their partners to physical violence (Bacchus et al., 2006). Another reason for violence that has not been systematically explored in the pregnancy and IPV literature is whether the partner may be using violence to make a woman resolve a pregnancy the way that he desires.

While many reproductive health correlates of IPV are known, and male control over various aspects of women's reproductive autonomy have been identified within as well as outside of physically violent relationships, the extent of male involvement in

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explicitly promoting pregnancies and controlling the outcomes of such pregnancies has not been conceptualized as a type of abuse. We posit that it is ideal for women to have reproductive autonomy which we use to mean a woman's ability to make independent decisions about her reproduction. We define interference with this autonomy *reproductive control*. Reproductive control can be exerted upon women from sources other than their partners including parents, peers, and the medical establishment. Reproductive control by a partner is the present focus of inquiry.

Reproductive control occurs when women's partners demand or enforce their own reproductive intentions whether in direct conflict with or without interest in the woman's intentions, through the use of intimidation, threats, and/or actual violence. It can take numerous forms: economic (not giving the woman money to buy contraception or obtain an abortion), emotional (accusing her of infidelity if she recommends contraception or denying paternity of the pregnancy), as well as physical (beating her up upon finding her contraception or threatening to kill her if she has an abortion). This masculine exercise of power crosses the three main domains of gendered relations as described by Connell (1987): labor, as coerced childbearing reifies women's domestic responsibilities; power, through exerting authority over women's sexual experiences and biologic vulnerability; and cathexis, through men's appropriation of women's sexual, emotional and intimate experiences and mandating child-rearing.

An analysis of violence against women conducted in ten countries by the World Health Organization (WHO) recently defined IPV as physical (having been slapped, pushed, hit, kicked, choked, burned, or threatened with a weapon; singling out violence during pregnancy as having been beaten, punched or kicked in the abdomen while pregnant), sexual (having experienced forced sex, coerced sex out of fear of her partner, or having been forced to do something sexually humiliating), emotional (having been insulted, belittled, scared, intimidated, or threatened), and controlling (isolating, monitoring, ignoring, demonstrating jealousy, acting suspicious, or demanding that the woman need permission to do basic day to day activities) (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). This same study defined poor reproductive health outcomes of IPV to include unsafe sexual behavior, pregnancy complications, unwanted pregnancy and unsafe abortion (Ellsberg et al., 2008). In a summary piece, Coker (2007) reviewed 51 articles published between 1966 and 2006 which examine the association between IPV and sexual health. Based on this body of work, she modeled the direct as well as indirect causal mechanisms through which IPV affects sexual health indicators documented to date in the literature. Identified mechanisms include decreased control over one's sexuality as well as decreased contraceptive use which can lead to increased unplanned pregnancy and increased sexually transmitted infections.

The WHO study and Coker's review treat reproductive correlates of IPV as indirect consequences of abuse rather than as measurable dimensions of abusive behavior. Specifically, their models do not account for pregnancy promotion, birth control sabotage, and coerced abortion. Pregnancy promotion has been defined as messages and behaviors that lead females to believe their partner was actively trying to impregnate them (Miller et al., 2007). The Center for Impact Research has defined birth control sabotage as verbal or behavioral sabotage of the woman's use of birth control by her partner (2000). Other literature has shown that this sabotage can be direct (interfering with her contraceptive use) as well as indirect (causing the woman to fear violence if she does use contraception or even brings up the topic) (Blanc et al., 1996; Clark et al., 2008; Njovana & Watts, 1996; Watts & Mayhew, 2004; Wingood & DiClemente, 1997). Abusive men coercing their partners to have abortions has also been documented (Coggins & Bullock, 2003; Hathaway, Willis, Zimmer, & Silverman, 2005), as has males forcing their partners to become sterilized (Hathaway et al., 2005). As coercive control of women is a central motivation of abuse (Campbell & Humphreys, 1993), we argue that reproductive control is another component of power and control in abusive relationships.

This study adds to previous work on reproductive correlates of IPV by defining the different types of reproductive control perpetrated by men, examining the behaviors along a temporal continuum. Those three temporal periods are before sexual intercourse, during sexual intercourse, and post-conception. Pre-sexual intercourse, women may be subject to verbal pressure and threats from their partner that he intends to make them pregnant. In this same time frame, partners may prevent women's access to and use of effective contraception. During sexual intercourse, which can be forced, men can manipulate contraception to render it ineffective which includes not withdrawing when that was the agreed-upon method of contraception or removing condoms. Post-conception, partners can attempt to influence the outcome of the pregnancy for it to end either in an abortion or a birth. More examples of each type of reproductive control as experienced by our sample are provided in Table 1.

Methods

The study, conducted in 2007, collected the reproductive experiences of women who have ever experienced IPV. We employed a purposive sampling strategy, recruiting 75 women with a history of IPV from three sites: a domestic violence shelter, a freestanding abortion clinic, and a family planning clinic providing a full range of reproductive health services including abortion. All sites were located in large metropolitan areas, one in the Midwest and two on the East Coast approximately 150 miles away from one another. The domestic violence shelter provided a sample of women with a known history of IPV while the clinics provided opportunities to identify women seeking reproductive health care who screened positively for IPV.

Women were eligible to participate if they were between 18 and 49 years of age, spoke English well enough to understand the questions and relate their experiences, and answered either of the following questions affirmatively: "Have you ever been hit, slapped, choked, kicked, physically hurt or threatened by a current or former partner?" or "Has anyone ever made you take part in any sexual activity when you did not want to?" At the domestic violence shelter, we assumed that all women 18–49 were eligible for participation and the interviews were scheduled at a time convenient for the women. At the abortion clinic, patients were screened by clinic staff, while at the reproductive health clinic, patients were screened by the study interviewers. At the abortion clinic, women were interviewed before their surgical abortion or during their follow-up visit; while at the reproductive health clinic, women were interviewed after their medical consultation. Interviews were conducted by female members of the study team who had been trained to ask women about violence and sexual health issues. The interviewers were trained to conduct a safety plan to help any respondent in current danger get to a safe place. As a further protection, all the facilities where the interviews were conducted either had a social worker on staff or had staff who were trained in appropriate referral techniques if the individual demonstrated the need for further counseling. Both the safety plan and appropriate referrals for women in immediate danger were used during the fieldwork. Interviewers obtained written informed consent from each respondent prior to each interview. A Certificate of Confidentiality from the National Institutes of Health was obtained to further protect the respondents. The study protocol was approved by the Institutional Review Board of the Guttmacher Institute.