

Intimate Partner Violence and Reproductive Coercion

Intimate partner violence and reproductive coercion are major social problems in the U.S.

A growing body of research has recognized the connection between intimate partner violence and poor reproductive health outcomes for women. Intimate partner violence may come in many forms — emotional, verbal, physical, or sexual — and it often has serious long-term consequences for the individuals involved, their families, communities, and society as a whole (Chamberlain & Levenson, 2012; Moore et al., 2010).

The term intimate partner violence (IPV) is often used interchangeably with relationship violence or domestic violence. It is used to describe violence in relationships as distinguished from other types of violent experiences. Recent studies have affirmed the connection between IPV and poor sexual and reproductive health outcomes in abused women compared to non-abused women (Moore et al., 2010). This fact sheet explores the problem of IPV, illustrates the magnitude of the problem, presents the reproductive health effects associated with it, and describes what can be done to prevent IPV.

Defining Intimate Partner Violence (IPV) and Reproductive Coercion

Intimate Partner Violence is a pattern of abusive and coercive behaviors that may include physical injury, psychological abuse, sexual assault, isolation, stalking, intimidation, and threats. These behaviors are carried out by someone who is, was, or wishes to be involved in a relationship with an adult or

adolescent, and are aimed at establishing control by one partner over the other (Black et al., 2011).

Examples of physical and psychological IPV include

- pushing, shoving, slapping, and choking
- isolating partners from family and friends
- controlling what a partner can and can't do
- constantly threatening to leave a partner if they don't do what you want (Chamberlain & Levenson, 2012)

Many women who experience IPV also experience reproductive and sexual coercion.

Reproductive coercion involves behaviors that a partner uses to maintain power and control in a relationship that are related to reproductive health, such as explicit attempts to impregnate a partner against her wishes, controlling outcomes of a pregnancy, coercing a partner to have unprotected sex, and interfering with birth control methods. Control over one's partner is at the core of intimate partner violence and reproductive coercion; women experiencing both acts are less likely to have autonomy to make decisions about contraception and family planning (ACOG, 2012; Chamberlain & Levenson, 2012; Gee et al., 2009).

Examples of reproductive coercion include

- hiding, withholding, or destroying a partner's birth control pills
- intentionally breaking condoms or removing a condom during sex

- not withdrawing during intercourse when that was the agreed upon method of contraception
- removing contraceptive patches, rings, or IUDs
- attempting to force/ coerce a partner to have an abortion against their will
- controlling abortion-related decisions (Chamberlain & Levenson, 2012; Silverman et al., 2010)

Sexual control is when someone uses pressure or forces someone to do sexual things that they don't want to do.

Examples of sexual coercion include

- refusing to wear a condom when a partner wants to use one
- pressuring someone to do sexual things when they don't want to
- threatening to end a relationship if a partner doesn't have sex (Chamberlain & Levenson, 2012)

Magnitude of the problem: IPV and Reproductive Coercion

Recent studies show that one in four women in the U.S. experience intimate partner violence in her lifetime (Breiding et al., 2008). It is estimated that more than two million people are victims of IPV each year (Tjaden & Thoennes, 2000). Intimate partner violence caused 2,340 deaths in 2007 (Bureau of Justice Statistics, 2012).

In a nationally representative sample, approximately one in four women reported coerced sex at some point in her life, and more than a third were 15 years old or younger at the time of their first coerced sexual experience (Stockman et al., 2010).

In a college survey, 23 percent of female college students and seven percent of male college students reported at least one experience of unwanted sexual intercourse (Flack et al., 2007).

Among family planning clinic clients, 15 percent of female clients with a history of physical and/or sexual IPV reported birth control sabotage from a partner (Chamberlain & Levenson, 2012).

Reproductive Effects of IPV and Reproductive Coercion

Reproductive coercion may be one mechanism that helps to explain the known association between IPV and unintended pregnancy (Miller et al., 2010c).

IPV is associated with poor sexual and reproductive health outcomes compared to non-abused women (Moore et al., 2010). This includes being at a greater risk of unintended pregnancy, repeat abortions, second-trimester abortions, and sexually transmitted infections (Miller et al., 2010c; Jones & Finer, 2011)

Violence and reproductive health are strongly linked. Unplanned pregnancies increase women's risk for violence and violence increases women's risk for unplanned pregnancies. Women who are IPV victims are more likely to be in relationships with a partner who controls their contraceptive methods.

Practicing contraception is more difficult for women who have experienced IPV because of partner unwillingness to use contraception (Gee et al., 2009). Additionally, women who are exposed to IPV by the man who got them pregnant are more likely than non-abused women to have a second-trimester abortion (Jones & Finer, 2011).

Abusive men are more likely than their non-abusive peers to report being involved in pregnancies ending in abortion. There is a strong association between IPV and involvement in three or more abortions (Silverman et al., 2010).

IPV and reproductive coercion are associated with inconsistent condom use and sexually transmitted infections.

Women in abusive relationships are more likely to take part in risky behaviors like inconsistent condom use, which puts them at greater risk for sexually transmitted infections (STIs) (Coker, 2007). Additionally, women exposed to IPV are less likely to disclose an STI to a partner due to fear. Studies show that young women who are exposed to IPV are more likely to have partners say that the STI was not from them or accuse them of cheating (Decker et al., 2011).

Who is at Risk

Women and men of all sexual orientations, races, ages, and marital and socioeconomic statuses are at risk for relationship violence — however, some groups report higher rates of victimization.

- IPV disproportionately affects women. Women are at significantly higher risk than men of experiencing IPV and of sustaining serious injuries (Black et al., 2010). Approximately 85 percent of abuse victims are female with adolescents (Durose et al., 2005). ;
- Young women aged 20–24 have the highest rates of victimization (Rennison & Welchans, 2000).
- African-American women reported higher rates of victimization than women of other races (Rennison & Welchans, 2000).
- One in three indigenous women living in the U.S. will be sexually assaulted in her lifetime (Tjaden & Thoennes, 2000).
- Fear of deportation may cause immigrant women to be particularly hesitant to report IPV (ACOG, 2012).
- Women living in households with lower income experience much higher rates of domestic violence than women in households with higher annual incomes (Rennison & Welchans, 2000).
- Divorced and separated people experience relationship violence at three times the rate of never married people. Married and widowed people report the lowest rates of victimization (Rennison & Welchans, 2000).
- Few studies have focused on physical and sexual abuse in same-sex male relationships, despite its high prevalence (Brown, 2008). Intimate partner abuse occurs at similar and perhaps higher rates in same-sex male relationships as compared to heterosexual relationships. In a survey of gay and bisexual men, 32 percent reported any form of relationship abuse in a past or current relationship; 19 percent reported physical violence, and 19 percent reported unwanted sexual activity (Houston & McKirnan, 2007).
- While 30.4 percent of women in heterosexual relationships have reported abuse, only 11 percent of women in same-sex relationships have reported similar abuse (National Center for Injury Prevention and Control, 2003).

- Approximately four to eight percent of pregnant women overall are abused by their partners. (Gazmararian et al., 2000). Women with unwanted or mistimed pregnancies are at greater risk of being victims of violence.

- Women with physical disabilities are at a great risk of being victims of violence. Women with disabilities experienced almost twice the rate of all forms of abuse compared to women without disabilities (Smith, 2008).

Profile of Abusers

Most studies that have sought to identify characteristics of abusers have looked at men in heterosexual relationships. There is strong evidence that males who witness IPV during childhood are more likely to become perpetrators themselves as adults (Roberts et al., 2010). Additionally, men and boys without a positive role model are at greater risk for being in an abusive relationship (Kerpelman et al., 2009). Men who abuse alcohol are also more likely to physically assault their partners (Murphy et al., 2005).

IPV Among Adolescents/Teens

Adolescents' romantic relationships have a developmental purpose in their lives. Experiences in romantic relationships facilitate critical areas of personal and interpersonal development (Kerpelman et al., 2009).

For adolescents, examples of IPV include

- monitoring cell phone use including text messages
- telling a partner what he/she can wear
- controlling whether or not a partner goes to school
- manipulating contraceptive use (Chamberlain & Levenson, 2012)

Several studies examining the prevalence of IPV and sexual violence against youth have found that adolescents experience high rates of physical IPV.

One in five U.S. female high school students report experiencing physical and/or sexual intimate partner violence or dating violence (Silverman et al., 2001).

The Center for Disease Control and Prevention's 2011 national Youth Risk Survey reported that nearly one in 10 high school students has been hit,

slapped, or physically hurt on purpose by a boyfriend or girlfriend within the last 12 months. The prevalence of dating violence was higher among black (12 percent) and Hispanic (11 percent) than among white students (8 percent) (CDC, 2012).

Boys and girls who experience sexual dating violence are more likely to

- initiate sex before age 13
- have sexual intercourse with four or more people
- use alcohol or drugs before sex (Kim-Godwin et al., 2009)

Involvement in a verbally abusive adolescent relationship is associated with decreased condom use amongst females who are sexually experienced. Additionally, physical abuse by a partner is associated with pregnancy (Roberts et al., 2005).

One-quarter of female adolescents reported that their abusive male partners were trying to get them pregnant (Miller et al., 2007).

Among sexually active adolescent physically abusive relationships were more likely to become pregnant than non-abused girls (Roberts et al., 2005).

Adolescent mothers who experienced intimate partner violence within three months after delivery have a higher risk of experiencing a repeat pregnancy within two years (Raneri & Wiemann, 2007).

Teen girls who experienced both physical and sexual IPV were more likely than non-abused girls to report an STI diagnosis (Decker et al., 2005).

Adolescent girls who experienced IPV are significantly more likely to have foregone health care in the past 12 months compared to non-abused girls (Miller et al., 2010a).

Studies on the high prevalence of IPV and sexual victimization among female patients seen in health care settings highlight the need for routine screenings.

In an adolescent health clinic-based study, 45 percent of the sample had experienced intimate partner violence (Silverman et al., 2011).

Among a random sample of 1,278 women aged 16-29 in five family planning clinics, more than half reported physical or sexual IPV (Miller et al., 2010b).

What should be done?

Clearly, IPV and reproductive coercion is a serious, widespread problem that must be addressed. Schools, community groups, and health care providers are in an ideal position to identify IPV. Health care providers particularly have an essential role in the prevention of IPV and reproductive coercion by discussing healthy, consensual, and safe relationships with all patients (Miller et al., 2010c).

- Clinic-based interventions show promising evidence that they can increase IPV disclosure by patients. Providers in the interventions can recommend longer-acting, more discreet forms of birth control (Miller et al., 2010c; Gee, 2009).
- In 2011, the Institute of Medicine (IOM) issued guidelines that recommend routine IPV screening and counseling for all women and adolescent girls (IOM, 2011).
- Incorporating healthy relationship curricula into schools can increase the likelihood of healthy relationships into adulthood (Kerpelman et al., 2009).

Intimate partner violence and reproductive health are closely connected issues and one cannot be properly addressed without addressing the other. With IPV affecting rates of unplanned pregnancies, repeat abortions, second-trimester abortions, STIs, and inconsistent condom use, IPV itself is a reproductive health problem. Planned Parenthood is committed to reducing rates of intimate partner violence and reproductive coercion through education, training, screening, and advocacy.

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