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Part 3: Reproductive Health Effects

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General Reproductive Health Effects of Abuse

There is a substantial body of research describing the dynamics and effects of IPV on the health of women and adolescents. Abusive and controlling behaviors range from sexual assault and forced sex, to more hidden forms of victimization that interfere with a partner's choices about sexual activities, contraception, safer sex practices, and pregnancy. In a systematic review of the impact of IPV on sexual health, IPV was consistently associated with sexual risk taking, inconsistent condom use, partner nonmonogamy, unplanned pregnancies, induced abortions, sexually transmitted infections, and sexual dysfunction (Coker, 2007).

IPV can be a barrier to women and teens accessing reproductive health care.

- In one study, adolescent girls who experienced IPV were nearly 2½ times more likely to have forgone health care in the past 12 months compared to nonabused girls (Miller et al., 2010).

Sexual victimization increases the likelihood of adolescent risk behaviors and other health concerns.

- Population-based data indicates that adolescents who experienced forced sexual intercourse were more likely to engage in binge drinking and attempt suicide (Behnken, Le, Temple, & Berenson, 2010)

Contraceptive Use and Birth Control Sabotage

Women who have experienced IPV are more likely to report a lack of birth control use because their partners were unwilling to use birth control or wanted to get them pregnant (Gee, Mitra, Wan, Chavkin, & Long, 2009). Abused women are also more likely to have not used birth control because they could not afford it and are more likely to have used emergency contraception compared to nonabused women. As with other forms of controlling behavior in abusive relationships, partners interfere with women's birth control use.

> **"IT GOT SO BAD, I TRIED TO KILL MYSELF**
> I tried jumping off the bridge, and stuff like that; cause I just couldn't deal with it anymore. I couldn't deal with it. I stopped talking to all my friends. I had a ton of friends from [my hometown], and I wasn't allowed to talk to any of them."
>
> *Miller, Personal Communication September 30, 2010*

Recent research conducted by the Harvard School of Public Health, University of California at Davis School of Medicine, and Futures Without Violence indicates that a significant portion of women and adolescent girls seeking reproductive health care services have experienced some form of IPV and/or reproductive and sexual coercion. In family planning clinics, 15% of female clients with a history of physical and/or sexual IPV reported birth control sabotage (Miller et al., 2010).

The following studies document birth control sabotage:

- Among teen mothers on public assistance who had experienced recent IPV, 66% disclosed birth control sabotage by a dating partner (Raphael, 2005).
- The odds of experiencing interference with attempts to avoid pregnancy were 2.4 times higher among women disclosing a history of physical violence by their husbands compared to nonabused women (Clark et al., 2008).
- Among women with abusive partners, 32% reported that they were verbally threatened when they tried to negotiate condom use, 21% disclosed physical abuse, and 14% said their partners threatened abandonment (Wingood & DiClemente, 1997).

Condom Use

Numerous studies have linked IPV victimization with inconsistent condom use or a partner refusing to use a condom (Wingood, DiClemente, McCree, Harrington, & Davies, 2001; Teitelman, Ratcliffe, Morales-Aleman, & Sullivan, 2008; Wu, El-Bassel, Witte, Gilbert, & Chang, M., 2003; Collins, Ellickson, Orlando, & Klein, 2005). Adolescent boys who perpetrate dating violence are less likely to use condoms, particularly in steady relationships (Raj et al., 2007), while girls experiencing dating violence are half as likely to use condoms consistently compared to girls who were not abused (Wingood et al., 2001). The connection between IPV and condom use is not limited to physical violence. In a national study of adolescents, girls' current involvement in a verbally abusive relationship was associated with not using a condom during the most recent sexual intercourse (Roberts, Auinger, & Klein, 2005).

"LIKE THE FIRST COUPLE OF TIMES
the condom seems to break every time. You know what I mean, and it was just kind of funny, like, the first 6 times the condom broke. Six condoms, that's kind of rare, I could understand 1 but 6 times, and then after that when I got on the birth control, he was just like always saying, like you should have my baby, you should have my daughter, you should have my kid" (Miller et al., 2007).

17 yr. old female who started Depo-Provera without partner's knowledge

Unintended Pregnancies

Due to the high rates of birth control sabotage and pregnancy pressure and coercion in abusive relationships, it is not surprising that IPV is a potential risk factor for unintended pregnancies. The following studies have documented this connection:

- 40% of abused women reported that their pregnancy was unintended compared to 8% of non-abused women (Hathaway et al., 2000).
- A study in Washington State found that women with unintended pregnancies are twice as likely to experience physical, psychological, or sexual abuse around the time of pregnancy than women with intended pregnancies (Washington State Department of Health, 2010).
- Among female clients seen at family planning clinics, one in five women who disclosed physical or sexual IPV also reported having experienced pregnancy coercion by their abusive partner (Miller et al., 2010).
- In a qualitative study of adolescent girls who experienced dating violence, one-quarter (26.4%) reported that their partners were trying to get them pregnant (Gazmararian et al., 1995).
- Adolescent girls currently involved in physically abusive relationships are 3.5 times more likely to become pregnant than nonabused girls (Roberts, Auinger, & Klein, 2005).
- Adolescent mothers who experienced physical partner abuse within three months after delivery were nearly twice as likely to have a repeat pregnancy within 24 months (Raineri & Weimann, 2007).
- In Washington State, 5% of women reporting any form of abuse by a partner before or during pregnancy reported being pregnant again two to six months after giving birth, as compared to 1% of women not experiencing abuse (Washington State Department of Health, 2010).
- In Washington State, nearly 60% of women reporting any form of abuse by a partner around the time of pregnancy reported that the pregnancy was unintended. Approximately 34% of women not reporting abuse experience an unintended pregnancy (Washington State Department of Health, 2010).
- A survey conducted by the National Domestic Violence Hotline (2010) found that 25% of women said their partner or ex-partner had tried to force or pressure them to become pregnant.

The Role of Pregnancy Coercion in Women Terminating or Continuing Their Pregnancies

The relationship between violence and continuing or terminating a pregnancy goes both ways. A woman who wants to continue her pregnancy may not be allowed to, and a woman who wants to terminate her pregnancy may be coerced by her partner to carry her pregnancy to term. A significant proportion of women seeking abortions have a history of lifetime or current IPV. Reproductive and sexual coercion behaviors such as forced sex, insisting on unprotected sex, and/or refusing to allow a woman to use birth control may result in several unintended pregnancies followed by multiple coerced abortions.

> **"HE REALLY WANTED THE BABY—**
> he wouldn't let me have—he always said, 'If I find out you have an abortion,' you know what I mean, 'I'm gonna kill you,' and so I was forced into having my son. I didn't want to; I was 18. I was real scared; I didn't wanna have a baby. I just got into [college] on a full scholarship, I just found out, I wanted to go to college and didn't want to have a baby but I was really scared. I was scared of him."
>
> *26-year old female (Moore, Frohwirth, & Miller, 2010)*

- Among women seen at abortion clinics, 14% to 25.7% have experienced physical and/or sexual IPV in the past year (Evins & Chescheir, 1996; Woo, Fine, & Goetzl, 2005; Weibe & Janssen, 1001; Bourassa & Berube, 2007).
- Women and teens seeking abortions are nearly three times more likely to have been victimized by an intimate partner in the past year compared to women who are continuing their pregnancies (Bourassa & Berube, 2007).
- Women presenting for a third or subsequent abortion were more than 2.5 times as likely as those seeking a first abortion to report a history of physical abuse by a male partner or a history of sexual abuse/violence (Fisher et al., 2005).

> **"MY BOYFRIEND WAS TRYING TO PUSH**
> me to have an abortion...He said, 'you won't keep that thing,' and he threatened to kill me. Then he said he would kill the child…Several times I felt like I wanted to kill myself. I felt like if I had an abortion, I would have to kill myself...When we first met, he said he wanted a family, wanted to marry me, then he changed his mind after I was pregnant."
>
> *(Hathaway, Willis, Zimmer, & Silverman, 2005)*

Sexually Transmitted Infections (STIs) and HIV

Experiencing IPV and/or childhood sexual abuse dramatically increases the risk of STIs and HIV among women and girls (Maman, Campbell, Sweat, & Gielen, 2000; Saewyc et al., 2006; Steel & Herlitz, 2005). According to the American Foundation for AIDS Research, violence is both a significant cause and a significant consequence of HIV infection in women (AmFAR, 2005). A history of IPV is a common denominator in studies of HIV-positive women (El-Bassel, Gilbert, Wu, Go, & Hill, 2005; Gielen, McDonnell, Burke, & O'Campo, 2000; Henry, Kidder, Stall, & Wolitski, 2007). The following studies demonstrate the complex relationship between STIs/HIV and victimization:

- Women experiencing physical abuse by an intimate partner are three times more likely to have a STI while women disclosing psychological abuse have nearly double the risk for a STI compared to nonabused women (Coker, Smith, Bethea, King, & McKeown, 2000).
- More than one-half (51.6%) of adolescents girls diagnosed with a STI/HIV have experienced dating violence (Decker, Silverman, & Raj, 2005).
- Women who are HIV-positive experience more frequent and severe abuse compared to HIV-negative women who are also in abusive relationships (Geilen et al., 2007).
- Qualitative research with adolescent girls diagnosed with STIs and disclosed a history of abuse suggests that the powerlessness they feel leads to a sense of acceptance that STIs are an inevitable part of their lives, stigma, and victimization (Champion, Shain, & Piper, 2004).

IPV perpetration and victimization are associated with a wide range of sexual risk behaviors. Drug-involved male perpetrators of IPV are more likely to have more than one intimate partner, buy sex, not use condoms, inject drugs, and coerce their partners into having sex (Gilbert, El-Bassell, Wu, & Chang, 2007).

> **"THE GUY I WAS GOING OUT WITH**
> introduced me to drugs. He had me out there selling my body to get all the drugs and stuff for us, you know? He got to beating on me because I didn't want to get out there no more in the streets doing it, and that's when he broke my cheekbone and everything. That's when I got infected [with AIDS] by him because he kept forcing me to have sex."
>
> *(Lichtenstein, 2005)*

For women, being in an abusive relationship increases the likelihood of:

- Multiple sex partners (Wu et al., 2003)
- Inconsistent or nonuse of condoms (Wu et al., 2003; Henney et al., 2007)
- Unprotected anal sex (El-Bassell et al., 2005)
- Having a partner with known HIV risk factors (Wu et al., 2003)
- Exchanging sex for money, drugs, or shelter (Henney et al., 2007)

Pregnancy, Birth, and Beyond: The Impact of Survivorship

Impact of Trauma on Pregnancy and Birth

When a woman has experienced sexual assault, intimate partner violence, or stalking, it may have a profound impact on her experience of pregnancy and childbirth. A recent study found that women hospitalized for injuries from an assault by a partner were at greater risk for giving birth to low-birth weight infants than women hospitalized for injuries from car crashes (Aizer, 2011). Physical and sexual abuse are strongly linked to increased prenatal depression rates (Rich-Edwards et al., 2011) and poor pregnancy outcomes (Sharps, Laughon, & Giagrande, 2007). Disturbingly, "abuse during pregnancy is especially dangerous and is a risk factor for lethal abuse" (Kendall-Tackett, 2007, p. 346). Abusive partners are not likely to provide the kind of practical and emotional support women need during pregnancy and birth; moreover, abusers often isolate their partners from family and friends who might provide needed support.

Most of the literature on sexual assault and the perinatal period focuses on women with histories of childhood sexual abuse, rather than on those who have been sexually assaulted as adults. However, the posttraumatic effects of sexual assault are likely similar to those of childhood sexual abuse, because a major concern in both situations is the triggering of traumatic reactions during pregnancy and birth. Penny Simkin and Phyllis Klaus (2004) have written a vital, practical guide for professionals working with childbearing women with histories of childhood sexual abuse. Most of their strategies and observations also apply to those who have been sexually assaulted as adults. Many aspects of prenatal care and the birth experience may trigger severe anxiety for survivors. Women may avoid necessary medical care because of these fears, or they may be so devastated by their experiences that they have difficulty enjoying and caring for their newborns.

> A peer-reviewed study by outside researchers suggests that doulas provide valuable assistance to pregnant and parenting adolescents by addressing social-psychological issues and socio-economic disparities, and also help pregnant adolescents navigate more successfully through fragmented social and health service systems that are less supportive of low-income adolescents (Gentry, Nolte, Gonzales, Pearson, & Ivey, 2010, as cited in Center for the Study of Social Policy, n.d.)

Specially trained nurse-midwives and doulas (non-medical support people who assist during pregnancy, childbirth, and the postpartum period) can make a world of difference to survivors during this difficult period. Survivors can learn to identify their concerns, communicate effectively with medical personnel, and employ coping strategies that minimize the impact of trauma. Any professional who encounters survivors during pregnancy, childbirth, or the postpartum period can provide more appropriate, trauma-informed services by considering how these experiences may affect a woman or teen who has been victimized. While specific help in the medical setting may be outside an individual's professional role, helping connect survivors to appropriate support people can facilitate a healing experience rather than one that retraumatizes the new mother.

Impact of Trauma on Breastfeeding

Women who have experienced sexual assault (either as an adult or as a child) may have difficulty breastfeeding. If the assault or abuse involved manipulation of the breasts, the baby's nursing may serve as a trauma trigger that provokes feelings of fear, anxiety, depression, or disgust. Intimate partner violence may also interfere with breastfeeding. A large-scale study (Silverman, Decker, Reed, & Raj, 2006) found that women who were physically abused during pregnancy or the year prior were 35%-52% less likely to breastfeed their infants, and 41%-71% more likely to cease breastfeeding by four weeks postpartum.

Women who are in physically abusive relationships, or who have experienced physical abuse at any time in the past, may dislike the closeness required by breastfeeding. New mothers in abusive relationships will likely feel stressed, drained, and unsupported, and these feelings may make it difficult for a woman to be physically and emotionally available for the intense relationship created by breastfeeding. In addition, some survivors (of either sexual or physical violence) are very uncomfortable with physical assistance from a health care provider as they learn to position their babies correctly for nursing. In the very practical sense, an abusive partner may be jealous of the nursing relationship or so demanding of the mother's attention that she will be hard-pressed to find the time to relax and nurse. If a survivor chooses not to breastfeed or is unable to do so, professionals need to be aware that even subtle criticism or stigma may be devastating to these new mothers. While positive support for breastfeeding is certainly a good thing in general, survivors who do not nurse their babies may feel that others judge them negatively. This can have an impact on their ability to parent.

> **"A WOMAN I WAS WORKING WITH HAD** recently had a baby and her partner didn't want her to nurse. He just wanted to control her body and felt a lot of jealousy about the baby. . . . she just was feeling so guilty about not being able to provide for her baby the way she wanted to and the way she thought she should be able to. She said 'I wish I could just nurse when he's not around or hide it, but now I'm not producing any milk and the baby is hungry.' [I talked] about her right to her own body, but also keeping her safe because she didn't feel like she could say 'This is my right to be able to feed my baby.' It wasn't safe for her to do that . . . . A lactation consultant and those kinds of resources, I didn't feel like [those] were viable options [because it wasn't safe for her to nurse]. She just needed to process her guilt."
>
> *Advocate, Needs Assessment focus group*

Sexual or Reproductive Coercion and the New Mother

Health care providers generally advise women to abstain from sexual intercourse during the period after giving birth until they have a medical check-up. However, abusive partners may not honor this waiting period, and may pressure their partners to have sex before they are physically or emotionally ready to do so. Because new mothers may not have resumed using birth control, this sexual coercion may also lead to rapid repeat pregnancies. Many studies of rapid repeat pregnancies are notable for their lack of attention to the possibility of coercive relationships and the role of abusive partners. Health care providers need to be aware that premature sexual activity may not have been the choice of the woman involved. Clinicians' sensitivity to this possibility may enable new mothers to communicate about abusive relationships.

Resources

Breastfeeding as a Rape or Sexual Abuse Survivor by Katy. Available online from Pandora's Project at www.pandys.org/articles/breastfeeding.html. This article offers very specific suggestions that will be useful to both survivors and professionals such as pediatricians, lactation specialists, and peer breastfeeding counselors who want to support the breastfeeding survivor.

Intimate Partner Violence (IPV), Breastfeeding, and Nutritional Supplement Programs by Linda Chamberlain. From the Futures Without Violence public health toolkit, *Making the Connection.* Available online at www.futureswithoutviolence.org/section/our_work/health/_making_connection

When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on Childbearing Women by Penny Simkin and Polly Klaus

Special Considerations

Information for Undocumented Survivors

Immigrant or undocumented survivors face increased barriers to their safety and seeking help. These barriers include:

- Lack of language access
- Threat of deportation
- Isolation from community (www.wscadv.org/docs/FR-Immigrant-Victims-Brief.pdf)

Professionals working with these survivors should become familiar with the relief available under the Violence Against Women Act (VAWA). Specifically, the U Visa provides documentation for survivors of specified crimes to remain in the country if they choose to work with law enforcement and the legal system to prosecute the crimes.

In our focus groups, sexual assault advocates mentioned that going through the U Visa declaration process was an opportunity to learn about a survivor's detailed experience of sexual abuse and other forms of violence.

Resources

- For information on eligibility and certification for a U Visa, visit ASISTA's website at www.asistahelp.org/en/access_the_clearinghouse. Asista provides centralized assistance for advocates and attorneys working with immigrant domestic violence and sexual assault survivors.

- Tool Kit for Law Enforcement Use of the U-Visa: www.vera.org/files/U-Visa-Law-Enforcement-Tool-Kit.pdf

- Crossing Borders, Washington State's multi-agency project created to support domestic violence and sexual assault programs to advocate effectively with immigrant, refugee, and limited English-proficient survivors of violence. Crossing Borders' website contains valuable tools and resources for all professionals working with immigrant communities: www.cbonline.org.

Information for Medicaid Coverage (Title X, Take Charge, and Medicaid)

The Title X and Take Charge programs (funded through Medicaid) are designed to provide access to contraceptive services, supplies, and information to low-income people. Due to the current economic conditions and state budget issues, future family planning coverage is uncertain. For the most up-to-date status of Medicaid coverage for family planning services, please go to Washington State's Medicaid website: hrsa.dshs.wa.gov.

Medicaid also provides maternity services, including coverage for abortion, for low-income pregnant people.

Resources

- Department of Social and Health Services (DSHS) Take Charge website: hrsa.dshs.wa.gov/FamilyPlan/Take%20Charge/TC.index.htm

- Take Charge Provider Directory: hrsa.dshs.wa.gov/FamilyPlan/Take%20Charge/TC%20Provider%20Directory.htm

- Planned Parenthood of the Great Northwest's webpage about Take Charge: www.plannedparenthood.org/ppgnw/take-charge-23291.htm

- Search Title X family planning clinics on the Health and Human Services site: www.hhs.gov/opa/

- Find Washington State family planning clinics that accept DSHS insurance and offer a sliding scale fee for the uninsured at the WithinReach website: resources.parenthelp123.org/service/family-planning-clinics