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Reproductive coercion and abuse

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Content warning

If you require assistance or would like to talk to a trained professional about the issues described in this practice guide, please call:

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Overview

This practice guide describes the evidence on reproductive coercion and abuse (RCA). It covers: (a) what RCA is; (b) strategies used by perpetrators; (c) the impacts of experiencing RCA; (d) factors that influence a person's risk of experiencing RCA; and (e) how to ask about RCA victimisation. Finally, some tips are provided for supporting clients who may be experiencing RCA.

Abbreviations

DFV Domestic and family violence

IPV Intimate partner violence

RCA Reproductive coercion and abuse

Introduction

Reproductive coercion and abuse (RCA) refers to any deliberate attempt to dictate a person's reproductive choices or interfere with their reproductive autonomy (Tarzia & Hegarty, 2021). RCA is typically perpetrated against women, and other people with female reproductive organs, in a context of fear and control within an interpersonal relationship (Tarzia & Hegarty, 2021). The most common perpetrators are current or former male intimate partners (Grace & Anderson, 2018; Silverman & Raj, 2014) but other family members can also perpetrate RCA (Moulton, Corona, Vaughan, & Bohren, 2021). One example of this is when women with disability experience coercion from guardians, carers or parents to: (a) influence or control their reproductive decisions, or (b) undergo procedures to prevent pregnancy (Cheng et al., 2021).

It is difficult to know exactly how common the experience of RCA victimisation is because: (a) of inconsistency in the way RCA is measured, and (b) there is no population-representative evidence. Studies undertaken in different settings have produced varied indications. For example, a study in NSW-based family planning services reported 2.3% of clients had experienced RCA (Cheng et al., 2021). In comparison, a study of national pregnancy counselling services reported 15% of clients experienced RCA (Sheeran et al., 2022). As might be expected, a study of victim-survivors of IPV reported more than 30% of participants had had this experience (Hegarty et al., 2022).

It is likely that these numbers are an underestimate of the actual prevalence of RCA. As described further below, some women may not feel they are able to safely disclose the abuse or access support. Additionally, some women who have experienced RCA may not realise that they have been victims of abuse (Burry, Thorburn, & Jury, 2020; Liang, Goodman, Tummala-Narra, & Weintraub, 2005; Rowlands, Holdsworth, & Sowemimo, 2022). These points mean that women experiencing RCA may not access specialist violence services and instead access other services for support, such as sexual and reproductive health or child welfare services. It is important that practitioners across a range of services are aware of RCA and how to best support victim-survivors.

This practice guide synthesises research evidence on RCA. It outlines:

- the definition and the key features of RCA
- strategies and behaviours used by perpetrators to enact RCA
- impacts of experiencing RCA on victim-survivors
- factors that may influence a person's risk of experiencing RCA
- how to ask clients about RCA experiences
- practice tips for supporting clients who may be experiencing RCA.

This practice guide is for non-specialist practitioners: (a) working in areas that increase the likelihood of exposure to women experiencing RCA but (b) do not have specialist training or experience in domestic and family violence (DFV).

What is reproductive coercion and abuse?

RCA refers to a range of behaviours such as pressure, manipulation, emotional blackmail, trickery, threats and the use of various kinds of abuse to dictate a person's reproductive choices or interfere with their reproductive autonomy (Tarzia & Hegarty, 2021). RCA can include physical, psychological, sexual, emotional or financial abuse designed to either promote or prevent pregnancy (Lévesque, Rousseau, & Dumerchat, 2021; Levy-Peck, 2016; Tarzia, Douglas, & Sheeran, 2022; Tarzia & Hegarty, 2021; Tarzia, Wellington, Marino, & Hegarty, 2018). RCA can also include behaviours that relate to whether a pregnancy is carried to full term. In the research literature, these behaviours are only considered to be RCA if they are done with the intent to promote or prevent pregnancy. However, we acknowledge that the intent may not always be obvious to practitioners working with victim-survivors.

Examples of pregnancy-promoting and pregnancy-preventing behaviours are outlined below (Grace et al., 2020; Lévesque et al., 2021; Moulton et al., 2021; Tarzia et al., 2022; Tarzia & Hegarty, 2021; Tarzia, Srinivasan, Marino, & Hegarty, 2020).

Pregnancy-promoting behaviours:

- Physical violence and threats of physical violence towards the victim-survivor, or their children, if they try to have an abortion, use contraception, attend medical appointments to access contraception or refuse to have sex
- Sabotaging contraception, not allowing the victim-survivor to use contraception, refusing to wear a condom and/or secret non-consensual condom removal during sex with the intention to cause pregnancy (the latter is known as 'stealthing')
- Emotional abuse towards the victim-survivor because the perpetrator wants them to become pregnant or continue a pregnancy
- Sexual violence with the intention to cause pregnancy
- Withdrawal of physical, financial and emotional support until the victim-survivor agrees to become pregnant or continue a pregnancy
- Preventing access to abortion services.

Pregnancy-preventing behaviours:

- Physical violence to force contraception use or induce miscarriage
- Forcing the victim-survivor into permanent methods of contraception
- Emotional abuse, physical abuse and/or threats of physical violence to the victim-survivor, or their children/family, if they do not terminate a pregnancy
- Withdrawal of material, financial and emotional support until the victim-survivor agrees to terminate a pregnancy.

How does RCA impact victim-survivors?

Research suggests that RCA can impact victim-survivors': (a) pregnancy, reproductive and sexual health; (b) service and support accessibility; and (c) psychological and relational wellbeing.

Pregnancy, reproductive and sexual health

Impacts can include:

- unintended or unplanned pregnancy (Grace et al., 2020; Silverman, Gupta, Decker, Kapur, & Raj, 2007), multiple pregnancies with little space between them
- premature labour, miscarriage or stillbirth (Heward-Belle, 2017; Silverman et al., 2007)
- contraction of a sexually transmitted infection (Lévesque et al., 2021)
- babies born with low birth weight (<2500 g) (Fay & Yee, 2020).
- sexual intimate partner violence (IPV). Victim-survivors who have experienced RCA perpetrated by an intimate partner may have experienced sexual IPV, where the perpetrator's intention is to cause pregnancy. Broader research on sexual IPV suggests that women who experience sexual IPV may also be at elevated risk of experiencing genital human papilloma virus (HPV) and cervical cancer and are less likely to receive regular Pap testing or access gynaecological care (Bagwell-Gray & Ramaswamy, 2022).

Service and support accessibility

Perpetrators of RCA can use actual or threatened physical, sexual, psychological and financial abuse to control what a victim-survivor does and where they go. This can result in social isolation, surveillance and the victim-survivor's inability to attend medical or other appointments without the perpetrator. Because of this, victim-survivors may experience:

- difficulties accessing and paying for contraception and pregnancy termination services (Moulton et al., 2021; Tarzia et al., 2022)
- difficulties accessing IPV services and interventions (Moulton et al., 2021).

Psychological and relational wellbeing

Impacts can include:

- stress, anxiety, depressive and post-traumatic stress disorder symptoms (Hegarty et al., 2022; Lévesque et al., 2021; Moulton et al., 2021)
- self-blame, guilt and/or shame (Lévesque et al., 2021; Moulton et al., 2021; Tarzia, Srinivasan et al., 2020)
- loss of control and agency (Lévesque et al., 2021; Moulton et al., 2021)
- fear for personal safety, of not being financially independent, and/or of losing their partner (Tarzia et al., 2018; Tarzia et al., 2022; Tarzia & Hegarty, 2021).

What factors may influence a person's risk of experiencing RCA?

There is some evidence that socio-demographic, cultural and societal, and structural factors may influence a person's risk of experiencing RCA. This is an emerging area of research and the factors outlined in this section are not a conclusive list, primarily due to problems with measuring RCA consistently. Although the presence of these factors may make RCA more likely for some people, it does not guarantee that they will be a victim of RCA.

National and international research suggests that the following socio-demographic factors may increase a person's risk of experiencing RCA (Carter, Bateson, & Vaughan, 2021; Douglas & Kerr, 2018; Sheeran et al., 2022; Tarzia et al., 2018; Tarzia et al., 2022; Tarzia & Hegarty, 2021; Tarzia, Srinivasan et al., 2020):

- identifying as Aboriginal or Torres Strait Islander
- having experienced social, health or geographical marginalisation
- having a disability
- being pregnant
- experiencing financial hardship
- experiencing other kinds of abuse perpetrated by an intimate partner, including controlling and surveillance behaviours consistent with coercive control, as well as other kinds of sexual, physical, psychological and financial abuse.

Because of problems with measuring RCA and coercive control, it is difficult to assess the overlap between these two types of abuse. However, there is a subset of coercive control research focusing specifically on victim-survivor experiences: (a) during pregnancy, which appears consistent with RCA, and (b) during pregnancy and early motherhood, which suggests this is a time of increased risk for the onset of coercive control victimisation or the escalation of pre-existing coercive control abuse (Alves, Graham-Bermann, Hunter, Miller-Graff, & Schomer, 2017; Buchanan & Humphreys, 2021; Gou, Duerksen, & Woodin, 2019; Heward-Belle, 2017).

Furthermore, some women may be at elevated risk of RCA due to language, cultural and societal factors, such as when (Moulton et al., 2021; Sheeran, Tarzia, & Douglas, 2023; Suha et al., 2022; Tarzia et al., 2022):

- the perpetrator acts as the language interpreter between the woman and practitioners during medical and other appointments, blocking the woman's ability to communicate their service needs or concerns
- rigid patriarchal norms and beliefs see the male partner's needs and rights as having priority over the female partner's needs and rights, relating to:
  - sex and reproduction
  - use of violence against women.

For migrant or refugee women, structural vulnerabilities may be used as a mechanism to control women's reproductive choices, such as their (Tarzia et al., 2022; Suha et al., 2022):

- visa status
- financial insecurity
- lack of knowledge about their legal rights in Australia (e.g. that sexual assault can occur between a married couple and that this is a crime).

How to ask about RCA victimisation

Victim-survivors of various kinds of abuse may not disclose their experiences to practitioners for a range of reasons, and practitioners can sometimes find it difficult to ask clients about abuse (MacDonald & Quinlan, 2022). Using screening questions to ask directly about abuse may increase the likelihood of disclosure and enhance the provision of appropriate support and services to match the needs and experiences of clients (MacDonald & Quinlan, 2022).

It may be useful to start with general questions about the client's relationship with their intimate partner. Questions can be introduced with phrases like (World Health Organization, 2014, p. 11):

- Many women experience problems with their husband or partner, or someone else they live with …
- I have seen women with problems like yours who have been experiencing trouble at home …

If general questions do not result in a disclosure, ask some more direct questions that are detailed and behaviourally descriptive. The following questions are about IPV more broadly, RCA-specific questions are provided later in this section. Some useful direct questions about IPV include (World Health Organization, 2014, p. 11):

- Are you afraid of your husband (or partner)?
- Has your husband (or partner) or someone else at home ever threatened to hurt you or physically harm you in some way? If so, when has it happened?
- Does your husband (or partner) or someone at home bully you or insult you?
- Does your husband (or partner) try to control you; for example, not letting you have money or go out of the house?
- Has your husband (or partner) forced you into sex or forced you to have any sexual contact you did not want?
- Has your husband (or partner) threatened to kill you?

Clients who say they have had any of the above experiences should be referred on to specialist support (World Health Organization, 2014).

Practitioners working in sexual health or family planning services may have an increased likelihood of working with victim-survivors of RCA (Cheng et al., 2021). Any practitioners working in a context where they conduct routine assessment of IPV or domestic and family violence (DFV) may also be more likely to work with clients experiencing RCA. However, DFV screening tools may not necessarily ask about RCA (Cheng et al., 2021). In these contexts, practitioners and program managers might consider the appropriateness of adding some RCA-specific questions.

A study at an urban sexual health clinic in Western Australia found that clients were more likely to disclose experiences of IPV and RCA victimisation when they were asked directly about these kinds of experiences (Galrao, Creagh, Douglas, Smith, & Brooker, 2022). In this study, clients were asked three RCA screening questions (Galrao et al., 2022, p. 890):

- Has a partner ever placed pressure on you to become pregnant when you didn't want to?
- Has a partner ever pressured you to use contraception (birth control) when you wanted to become pregnant?
- Has a partner ever tried to influence your decision to continue with a pregnancy when you wanted an abortion, or to have an abortion against your will?

Family Planning New South Wales introduced routine RCA screening to clinical consultations, using the questions below as a starting point. If clients answered 'yes' to any of these questions, follow-up questions were asked and support offered (Cheng et al., 2021, p. 350):

- Has your partner or ex-partner ever interfered with your choice or ability to use contraception?
- Has your partner or ex-partner ever forced you to:
  - become pregnant?
  - continue a pregnancy that was unwanted/unplanned?
  - terminate a pregnancy that you wanted to continue?

Before introducing RCA screening, it is important to ensure that practitioners conducting the screening have the time and training required to respond appropriately to possible disclosures of RCA (Cheng et al., 2021; MacDonald & Quinlan, 2022). It is also suggested that these screening assessments are conducted without the presence of others, such as intimate partners, carers or family (Cheng et al., 2021; MacDonald & Quinlan, 2022).

How to support clients who may be experiencing RCA

This section provides some practice tips for supporting clients who may be experiencing RCA. These tips come from the research evidence synthesised in the above sections, as well as from consultation with practitioners working in services that support families experiencing DFV. These tips are a good starting point for supporting clients where RCA is suspected or known to be occurring. This is not an exhaustive or definitive list.

General best practice principles for supporting women victim-survivors of intimate partner or sexual violence also apply to the context of RCA. These include the LIVES model (Listen, Inquire about needs, Validate, Enhance safety and Support and follow up), recommended by the World Health Organization (2014), and the CARE model (Choice and control, Action and advocacy, Recognition and understanding and Emotional connection) (Tarzia, Bohren et al., 2020), which can guide delivery of woman-centred care. Links to more information on these two models can be found in the further reading section at the end of this guide. A summary of key takeaway points is presented in Box 1.

Box 1: Best practice principles for supporting women victim-survivors of intimate partner or sexual violence

The **LIVES model** provides guidelines for practitioners in responding to disclosures of IPV (Tarzia, Bohren et al., 2020). The model highlights five tasks for practitioners responding to the emotional and practical needs of victim-survivors (World Health Organization, 2014).

Listen	Listen to the woman closely, with empathy, and without judging.
Inquire about needs and concerns	Assess and respond to her various needs and concerns – emotional, physical, social and practical (e.g. child care)
Validate	Show her that you understand and believe her. Assure her that she is not to blame.
Enhance safety	Discuss a plan for her to protect herself from further harm if violence occurs again.
Support	Support her by helping her to connect to information, services and social support.

The **CARE model** provides guidelines to ensure practitioners engage with victim-survivors of IPV in a way that is woman-centred (Tarzia, Bohren et al., 2020).

Choice and control	Tailor responses to women's individual circumstances. Facilitate women's empowerment, choice and control.
Action and advocacy	Action and advocacy guided by women's needs Connect women with services in the community for health, safety and wellbeing.
Recognition and understanding	When listening to women, strive to understand the dynamics and context of their situation. Name the abuse and validate experiences.
Emotional connection	Demonstrate kindness, caring, empathy and respect to build trust. Sustain personal engagement and maintain support.

In addition, practitioners should:

- Keep in mind that any woman of reproductive age may be at risk of RCA (Sheeran et al., 2022).
- Provide clients with a confidential and safe environment for disclosure and support (Tarzia, Wellington, Marino, & Hegarty, 2019).
  - Engage clients in a way that does not inadvertently reinforce feelings of shame and/or guilt.
    Context: Perpetrators often try to make victim-survivors feel a sense of shame and/or guilt (Lévesque et al., 2021; Tarzia, Srinivasan et al., 2020).
  - Speak with the client one-on-one (Levy-Peck, 2016). This may require accessing a professional interpreter service when working with women who do not speak English.
    Context: Perpetrators may attend appointments to ensure their demands are complied with and the victim-survivor does not disclose their abuse or ask about contraception, abortion or other support. Perpetrators acting as the language interpreter between the woman and practitioners during appointments can block the woman's ability to communicate their service needs or concerns.
  - Consider whether your role provides the opportunity to screen for RCA victimisation and appropriately respond to disclosures.
- Identify and address barriers to accessing and using contraception where possible.
  - Discuss woman-led forms of contraception (e.g. pills or implants), safe ways of accessing these confidentially, and how to avoid perpetrators tampering with them (Carter et al., 2021; Tarzia & Hegarty, 2021).
  - Women who have been 'stealthed' may require referral to a sexual assault service or support in accessing emergency contraception (i.e. the morning after pill) (Tarzia & Hegarty, 2021).
  - Advocate for clients experiencing gatekeeping from health professionals when seeking emergency contraception. For example, practitioners may need to advocate for young women who experience stigma and discrimination from pharmacists when trying to access the morning after pill after experiencing RCA.
- Familiarise yourself with safety planning for people living with violence or abuse.
  - Can you discuss safety planning with your clients and support them in developing a safety plan (Carter et al., 2021; Tarzia & Hegarty, 2021)?
- Refer clients to specialist services.
  - Can you provide a safe space for the client to contact specialist services without the perpetrator knowing?
- Provide information about the National Domestic Family and Sexual Violence Counselling Service.
- Familiarise yourself with the websites for relevant support services so that you can advise clients about useful information and any safety features of the sites. For example, many websites for people experiencing intimate partner abuse have a quick 'exit' button. Clicking the quick exit button provides a fast way to return to a page like Google if the client thinks they might be caught viewing a site that would increase the risk to their personal safety. Sharing information about this feature may increase the likelihood of clients accessing useful information online later.
- Share your learnings and practice experiences with other practitioners to increase their awareness of RCA and how it is associated with various forms of violence.
  - Context: Greater practitioner awareness of RCA will allow for relevant assessment or referral to take place (Tarzia & Hegarty, 2021).
- Continue learning about RCA and how it overlaps with other forms of violence (see further reading section).

Conclusion

RCA comprises a range of behaviours enacted to either promote or prevent pregnancy or prevent carrying a pregnancy to full term. These behaviours may include restricting access to or forcing the use of contraception or abortion services, 'stealthing' or removing needed support until the victim-survivor becomes pregnant or terminates a pregnancy.

RCA can impact victim-survivors' pregnancy, reproductive and sexual health, service and support accessibility, and psychological and relational wellbeing. An important consideration for practitioners is that some women may be forced to use, or alternatively have difficulties accessing, services relating to reproductive and sexual health or intimate partner violence as a result of RCA. Although research in this area is still emerging, practitioners can support victim-survivors of RCA by applying best practice principles from DFV practice. Practitioners can also consider whether it's appropriate to add screening questions for RCA to DFV screening, give clients safe, confidential and supportive environments for disclosure as well as appropriate referrals to specialist services where needed. Practitioners can also support women experiencing RCA by continuing their professional learning about RCA and sharing their knowledge with colleagues and services.

Reflective questions

After reading this practice guide, consider how the following questions apply to your practice or service.

- Does your role provide the opportunity to enhance client reproductive and sexual health literacy (Tarzia et al., 2018)? Can you provide information about consent and boundaries (Levy-Peck, 2016)? Can you have discussions around shared responsibility for conception in healthy relationships and woman-led forms of contraception?
- How can you support clients on temporary visas? Where can you refer them for further support?
- How can you support women with disability who may experience reproductive coercion from family or carers or intimate partners? What capacity do you have for individualised assessment to account for the client's unique experiences (Alhusen, Bloom, Anderson, & Hughes, 2020)? Are the tools and resources you use or share with clients accessible (Alhusen et al., 2020)?
- Do your organisation's online processes or services pose a potential risk for clients, as perpetrators can use electronic records to monitor service access (Tarzia et al., 2022)?

Further reading

Resources about reproductive coercion and abuse

Reproductive abuse – 1800RESPECT

This website has information about reproductive coercion and abuse, how to access support, and safety plans for people living with violence or abuse.

Reproductive coercion – Marie Stopes Australia

This website has information about reproductive coercion and a link to *Hidden forces,* a paper focusing on Australian and international research on reproductive coercion.

Resources about reproductive and sexual health

SPHERE CRE

SPHERE aims to improve the quality, safety and capacity of primary health care services to achieve better outcomes in women's sexual and reproductive health.

Resources about coercive control

How to support clients exposed to technology-facilitated coercive control

Drawing on the latest research and practitioner insights, this AIFS webinar: (a) describes what technology-facilitated coercive control looks like in practice, (b) provides examples of the different ways that victim-survivors might experience technology-facilitated coercive control, and (c) suggests strategies for face-to-face and telehealth practice.

Extended Q&A for: How to support clients exposed to technology-facilitated coercive control

The introduction of this AIFS webinar summarises some key discussion points and highlights from the December 2022 webinar *How to Support Clients Exposed to Technology-Facilitated Coercive Control*. This introduction is followed by an extended Q&A from the December 2022 webinar panel answering more audience questions.

Technology-facilitated coercive control (TFCC): Evidence-based insights for practice

This AIFS recording provides an overview of key trends in the research literature relating to technology-facilitated coercive control.

The power in understanding patterns of coercive control

This AIFS webinar explores ways that services can use the language of coercive control to support women to expose patterns of abusive behaviour.

Sadie's story: Helping women affected by domestic and family violence navigate a fragmented system

This AIFS webinar focuses on one woman's story of DFV. Sadie (not her real name) is an Aboriginal woman and mother of two. Her story sheds light on how fragmented service systems can often fail to meet women's needs and may even exacerbate the challenges they experience at the intersection of gender and racial inequality.

Defining and responding to coercive control

This policy brief by Australia's National Research Organisation of Women's Safety (ANROWS) is designed to assist policy makers developing legal or policy and practice frameworks to prevent or respond to coercive control in relation to domestic and family violence.

Australians' attitudes to violence against women and gender equality

This ANROWS report documents findings from the 2017 National Community Attitudes towards Violence against Women Survey (NCAS) and considers them in the context of other related research.

Intersecting systems and the needs of families: Family law, child protection and domestic violence

This AIFS webinar reunited the panellists from the AIFS Conference 2022 event Intersecting Systems and the Needs of Families: Family law, Child Protection and Domestic Violence. The panellists discuss this topic with a focus on implications for practitioners working in areas related to DFV, family law and child protection.

Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook

This handbook published by the World Health Organization (WHO) details general best practice principles for supporting women victim-survivors of intimate partner or sexual violence, including information about the LIVES model (Listen, Inquire about needs, Validate, Enhance safety, and Support and follow up).

Women's experiences and expectations after disclosure of intimate partner abuse to a healthcare provider: A qualitative meta-synthesis

A research article with best practice principles for supporting women victim-survivors of intimate partner or sexual violence using the CARE model (Choice and control, Action and advocacy, Recognition and understanding and Emotional connection).

How to ask adult mental health clients about sexual abuse

This AIFS short article outlines: (a) why adult survivors of sexual abuse may not disclose their abuse experiences to mental health practitioners, (b) why practitioners might avoid asking about it, and (c) research findings from mental health practitioner samples on how to safely ask clients about sexual abuse histories.

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How this practice guide was developed

This practice guide is part of a broader evidence package on coercive control for AIFS Child Family Community Australia (CFCA) information exchange. The literature reviewed was identified through a rapid review and synthesis of international empirical coercive control research focused on victim-survivors. The CFCA audience identified the use of coercion and control in intimate partner relationships as a topic they would like more evidence about to inform practice. Qualitative data provided by attendees at previous coercive control related CFCA webinars also informed the topic development.

Six practitioners, service leaders and researchers who are experts in DFV were consulted between February and April 2022. The initial plan for potential evidence-based resources for practitioners was shared with a group of experts for feedback, including this practice guide and an accompanying webinar. The experts also suggested research, policy and practice questions that might be useful to generalist practitioners working with individuals and families impacted by coercive control.

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