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Recognizing the Lasting Effects of Reproductive Coercion on Contraceptive Choices: Considering Trauma in a Pandemic Context

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Intimate partner violence (IPV) is an ongoing pattern of behaviors that seek to establish power and control over a partner's life and may manifest through physically, emotionally, and/or sexually abusive behaviors.[1] In the context of the global coronavirus disease 2019 (COVID-19) pandemic, IPV poses an intensified threat to the health and well-being of women and their families: some studies suggest that rates of IPV have increased by >45% and potentially by as much as 75%.[2,3] Although sexual abuse and sexual assault are often conceptualized as issues separate from IPV, multiple studies reflect that there is significant overlap between these experiences as well as an increase in poor health outcomes among women who experience violent or controlling sexual contacts in the context of an abusive relationship.[4] Reproductive coercion (RC), the controlling and/or elimination of reproductive choice for one partner by the other, is such an experience and a clear source of trauma in intimate partner relationships—yet it is often overlooked.[5] In this issue of the *Journal of Women's Health*, Skracic, Lewin, and Steinberg[6] surveyed women receiving care in nine Delaware Title X clinics about their experiences of RC and current contraceptive practices. The results of this study demonstrate long-term effects of RC on women's contraceptive choices throughout the lifespan.

A diverse sample of women ($n = 240$) was recruited from a state with a high rate of unintended pregnancy—roughly 57% of all pregnancies among women aged 15–44 years in Delaware during 2010 were unintended.[6] Participants were asked to provide information on their current contraceptive method(s), and on their lifetime experiences of RC to establish the association between RC and contraceptive use. This is an important consideration for providers who seek to reduce unintended pregnancy rates because as few as 10% of providers report routinely screening their patients for IPV.[5] The number of patients for RC screening is likely even lower. One study of providers who had received training on a combination IPV and RC screening protocol found that although the training drew attention to these issues, implementation of screening was often constrained by length of visit and the sense that other issues might take priority.[5] Such constraints have serious implications for women's reproductive health, as the study published in this month's issue found that nearly a third (30%) of participants had experienced RC at some point, and over half (52.4%) reported prior unintended pregnancy. In demonstrating the relationship between lifetime RC and contraceptive practice as an indicator of unintended pregnancy risk, Skracic, Lewin, and Steinberg[6] provide a valuable perspective on the importance of identifying RC in reducing unintended pregnancy rates.

The authors further examined how the type of RC experienced—behavioral or verbal—related to the level of efficacy of contraception employed. Behavioral RC refers to active interference with contraception, such as sabotaging condoms or destroying contraceptive pills; verbal RC refers specifically to expressed direction against contraception without direct interference. Contraceptive efficacy is typically classified according to failure rates and ranges from no method or abstinence (failure rate of 85%) to intrauterine devices, sterilization, or implant (failure rate of <1%). The findings demonstrated that women who experienced behavioral RC were more likely to use highly effective methods, and that women's use of such methods also increased with age. This suggests that a woman's choice of method may be related to her history of RC: an insight that might encourage providers to more often discuss RC and by extension IPV with patients. Doing so can increase opportunities to implement trauma-informed care strategies—certain to be of increasing importance given the ongoing COVID-19 pandemic. Trauma-informed care provides a framework through which clinicians can understand, recognize, and respond to the effects of trauma.[7] The impacts of trauma on health are well established,[8] and may be exponentiated with additional traumatic experiences: women traumatized by RC and IPV may also be affected by traumas proceeding from the COVID-19 pandemic.

Understanding and identifying RC and IPV are critical considerations for health care providers within the assessment and management of women's reproductive and sexual health.

Without question, the global COVID-19 pandemic has increased risks for IPV, RC, and other types of traumatic experiences. It is, therefore, more critical than ever that providers are prepared to identify and intervene with individuals who are affected by these and other traumas. Attending to the effects and potential sequelae of RC may be especially important in efforts to reduce unintended pregnancy during the pandemic, as such pregnancies may strain

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already imperiled women and their families. The evidence generated by Skracic, Lewin, and Steinberg's[6] work offers new perspectives on the depth and breadth of RC as a persistent factor in women's health, and one likely to become increasingly relevant as the pandemic continues.

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