Experiences of Reproductive Coercion in Queensland Women

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Abstract

Reproductive coercion is any interference with a person’s reproductive autonomy that seeks to control if and when they become pregnant, and whether the pregnancy is maintained or terminated. It includes sabotage of contraceptive methods and intervention in a woman’s access to healthcare. Current research on reproductive coercion has reported inconsistent rates, predominantly within US samples. Our study sought to explore prevalence and associations with reproductive coercion in an Australian context through a sample of 3117 Queensland women accessing counselling and information regarding pregnancy options. At first contact with counsellors, 5.9% of women disclosed reproductive coercion; and the rate was 17.8% among those who made contact more than once regarding their pregnancy. Overall, reproductive coercion tended to occur in the context of other forms of domestic violence (55.6%). Mental health issues were reported by 36.6% of women affected by reproductive coercion, compared to 14.1% of women with no reproductive coercion present. Rates of disclosure for reproductive coercion, violence, and mental health issues were much higher among women who made a repeat contact to the counsellors about their pregnancy. These findings demonstrate the importance for health services to ensure that appropriate screening (and re-screening) for reproductive coercion is completed as a distinct part of screening for violence during a healthcare relationship.

Keywords: pregnancy, reproductive coercion, domestic violence, intimate partner violence, mental health
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Reproductive coercion (sometimes referred to as pregnancy coercion) is generally considered to be part of intimate partner violence, and is underlined by a woman’s compromised ability to use- or have access to- safe contraceptive methods (Clark, Allen, Goyal, Raker, & Gottlieb, 2014). It is used to maintain power and control within a relationship, with perpetrators drawing on physical, psychological, sexual, economic, and other strategies to reproductively coerce (Miller, Jordan, Levenson, & Silverman, 2010). For example, a woman may be threatened with physical harm if she does not become pregnant, continue a pregnancy, or terminate a pregnancy; or she may be psychologically intimidated to prevent her terminating a pregnancy. Behaviors associated with reproductive coercion include sabotaging birth control such as throwing away contraceptive pills, forced unprotected sex, or intentional misuse of condoms; or financially preventing the woman from obtaining forms of contraception. Unsurprisingly, clear associations have been found between reproductive coercion, unintended pregnancy, and domestic violence, as well as higher rates of abortion among women in domestic violence situations (Coker, 2007; Cripe et al., 2008; Fisher et al., 2005; Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006; Leung, Leung, Chan, & Ho, 2002; Pallitto et al., 2013; Sarkar, 2008). Although there is no clear or consistent definition of reproductive coercion (for an overview, see Marie Stopes Australia, 2018), for the purpose of this paper and data collection, we use the following definition:

Reproductive coercion is any perpetrator behavior aimed at establishing and maintaining power and control over a person, by interfering with their reproductive autonomy, denying them control, decision-making and access to
options regarding reproductive health choices. These behaviors may include pregnancy pressure, contraceptive sabotage, and pregnancy outcome control.

Reproductive coercion: Prevalence and associations

Reproductive coercion can occur both with and without the presence of other forms of violence and control, with population estimates placing overall rates of prevalence at approximately 9% of women in America and rates of 18.5% among partnered women in rural France (Black et al., 2010; Clark et al., 2014; McCauley et al., 2014; Miller & Silverman, 2010; Moore, Frohwirth, & Miller, 2010; Rosenbaum, Zenilman, Rose, Wingood, & DiClemente, 2016). However, rates as high as 40% have been found among women attending sexual and reproductive health services in low socio-economic communities (Nikolajski et al., 2015). Reproductive coercion has been less commonly investigated outside of Western samples, with only one published study, to the authors’ knowledge, conducted within a developing country. That study primarily focused on general intimate partner violence and associations with contraceptive use among married couples and did not provide an estimate of reproductive coercion (Forrest, Arunachalam, & Navaneetham, 2018).

Because of the relatively limited research in this area, attempts to understand the rates of reproductive coercion that co-occur with commonly understood forms of domestic violence, such as physical or emotional abuse, have been limited and inconsistent. Current prevalence estimates primarily drawn from US samples provide varying rates ranging from as high as 74% to as low as 8.6% of co-occurring reproductive coercion with domestic violence (Clark et al., 2014; Miller et al., 2007; Moore et al., 2010; Northridge, Silver, Talib, & Coupey, 2017). However, this evidence suggests that women who experience violence are two times as likely to have a male partner refuse contraception and experience an unplanned pregnancy, and are more likely to
experience five or more births than women without experiences of violence (Miller, Decker, et al., 2010). On the other hand, data on the prevalence of reproductive coercion in the absence of other forms of domestic violence show somewhat more consistent rates of 45% to 53.4% observed in health care settings (Clark et al., 2014; Northridge et al., 2017). Other population studies of young people have placed the prevalence rate at 20%, which is higher than the general population within the US; and over 35% among younger women in minority groups (Alexander, Volpe, Abboud, & Campbell, 2016; United States Department of Justice, 2017).

Risk factors related to a woman’s risk of reproductive coercion are her age, ethnic background, and relationship status. Overall, younger women (aged 18-20) are at a greater risk for reproductive coercion whether other forms of domestic violence is present or not (Miller et al., 2014; Miller & Silverman, 2010; Northridge et al., 2017). Considerably higher prevalence rates of reproductive coercion appear to be present for women of non-Caucasian backgrounds (Clark et al., 2014; Moore et al., 2010; Nikolajski et al., 2015). Further, women experiencing reproductive coercion are twice as likely to report being single or dating, and six times more likely to report being uncertain or ambivalent about their relationship status than women who did not experience reproductive coercion (Clark et al., 2014). This is in contrast to reports among Australian women who experience domestic violence who are at most risk between the ages of 18-39, when they are separating from partners, about to end a relationship, or have recently ended a relationship (Australian Institute of Health and Welfare [AIHW], 2018).

Little exploration of mental health problems that may co-occur with reproductive coercion have been examined in the literature, with only one such study investigating this issue and finding that reproductive coercion may be a large contributor to adverse mental health (McCauley et al., 2014). More broadly, the literature on domestic violence and mental health
clearly shows interactions, with women experiencing domestic violence, especially while pregnant, more likely to experience an increased risk of depression, post-traumatic stress disorders, and suicidality (Campbell, 2002; Karmaliani et al., 2008). Furthermore, because of the scarcity of research into reproductive coercion, it is unknown at what stages of pregnancy women experiencing reproductive coercion seek healthcare and whether, like women experiencing characteristic domestic violence, they are more likely to access healthcare when gestation is at a later stage than women without experiences of reproductive coercion (Colarossi & Dean, 2014; Foster & Kimport, 2013).

**Reproductive coercion among Australian women**

Within Australia, evidence suggests that one in six women report domestic or sexual violence from a current or former partner, with the likelihood that they will experience this violence three times more likely than men (Australian Bureau of Statistics [ABS], 2016; AIHW 2018). However, prevalence rates of reproductive coercion are unknown. Unfortunately, with no formal assessment of reproductive coercion included within national household surveys on personal safety, and no profiling included within domestic violence data, we still do not know the extent of this problem among Australian women (ABS 2016). Some early data suggests that in clinical abortion settings in Australia, reproductive coercion is disclosed on a weekly, and sometimes daily basis, including both coercion into pregnancy and threats to leave a relationship if the pregnancy was not terminated, with the most common type of response in this setting reported to be the concealment of pregnancies and their termination due to fear of the partner (Marie Stopes Australia, 2018). Indeed, associations between domestic violence, unplanned pregnancy and abortion are well established within the broader literature (Hall, Chappell, Parnell, Seed, & Bewley, 2014; Miller & Silverman, 2010), with higher rates of unplanned pregnancy
and abortion for reproductively coerced women, and within populations of women known to have experienced domestic violence (Miller et al., 2014; Moore et al., 2010).

Because of the current lack of available data on reproductive coercion within Australia, the main purpose of this paper was to understand the prevalence rates of reproductive coercion among women experiencing unintended pregnancy in a sample of Queensland women, both with co-occurring domestic violence and without it, and how these rates compare to current published studies. A secondary aim was to understand if these prevalence rates are heightened among women who are Aboriginal or Torres Strait Islander (ATSI), or culturally and linguistically diverse (CALD). Further, associations with mental health, relationship status, and co-occurring domestic and sexual violence were explored.

We expected that compared to women with no current experience of reproductive coercion, Queensland women disclosing reproductive coercion would (1) have prevalence rates of reproductive coercion higher than the overall US population estimate as our sample is from a pregnancy advice and counselling service, and that this rate would be higher among ATSI and CALD women; (2) be more likely to experience co-occurring domestic violence; (3) be more likely to have mental health issues; (4) be younger (to directly compare to the US sample, women aged 16-19 years old were compared to women aged 25-29); (5) be single or in a casual relationship; and (6) have higher gestation at time of first contact with a counselling and service for unplanned pregnancy. Finally, we expected that women experiencing reproductive coercion who report co-occurring experiences of other forms of domestic violence would report more mental health issues and show a greater proportion of first contacts with counsellors at later stages of pregnancy (post-12 weeks) compared to women experiencing reproductive coercion without co-occurring domestic violence. We also expected that these women would be most
likely to identify as separated, rather than single or in a causal relationship compared to women who report experiencing reproductive coercion in the absence of other forms of domestic violence. As both the domestic violence and reproductive coercion literature identify that younger women are most at risk for these forms of violence, given the broader range of ages identified among the domestic violence literature, we predicted that those who report co-occurring domestic violence would be older than women who report reproductive coercion in the absence of other forms of violence.

Method

The following data were collected between January 2015 and June 2017 by an independent organization providing unbiased information and counselling on all unplanned pregnancy options in Queensland, Australia (i.e., abortion, adoption, and parenting), post abortion counselling, and support to access an abortion.

Nature of service and data collection

Data used in this paper were gathered by counsellors in their contacts with or on behalf of a person seeking support in relation to an unplanned or unwanted pregnancy. Each session was manually recorded via a standard form for each contact. No identifying information of the contacts were recorded to maintain privacy. These data document a wide scope of issues that may affect a woman during their pregnancy, and records only the absence or presence of these issues from information known regarding their circumstances at each contact with the counsellors. Whilst it is recognized that reproductive coercion is one of the behaviors underpinning domestic violence, reproductive coercion was identified independently of other forms of domestic violence. Consequently, where there was no other identified intention of
control (i.e., control and violence within other aspects of the relationship not related to pregnancy), reproductive coercion was not identified as co-occurring with domestic violence.

Contacts with each woman are captured as either the ‘first contact’ or a ‘repeated contact’; however, given the absence of identifying information, multiple contacts with an individual cannot be linked. As such, we cannot accurately report variables in terms of proportion of women across all contacts with the counsellors, only in their disclosure at either ‘first’ or ‘repeated’ contacts. Therefore, we have taken care and caution in comparing and interpreting the data in this paper. Ethics for this research was obtained through the university's human research ethics committee.

Participants

Over the data collection period, 3117 women were recorded at first contact, and 3644 repeat contacts were made by these women with counsellors due to an unintended pregnancy. Ages were recorded within brackets and ranged from ‘13 years and under’ to ‘over 45 years of age’. Of all women who contacted counsellors, 67.9% sought information regarding abortion, 5.5% requested post-abortion counselling, 4.3% wanted parenting information, and 2.3% were seeking information about adoption. Overall, these contacts comprised of phone calls (77.9%), emails (13.9%), face to face contact (3.2%), and text messages (5.1%). Available postcode data reveal that women contacted this organization from across Queensland including far north and regional areas, from Cape York, Central, and Western Queensland, to metropolitan areas in the South East.
Results

Analytic Strategy

Because of the various limitations in the data set, significance testing was only conducted in relation to a woman’s first contact with the counsellors to maintain independence of sampling. To ensure significance testing of results were not inflated, any repeated contacts to counsellors were explored via percentages of overall contacts. All analyses were performed in SPSS version 24 (IBM, 2016). Table 1 provides a breakdown of percentages and sample sizes for comparison across groups for each explored variable at first contact.

Reproductive coercion and domestic violence

Reproductive coercion was reported among 5.9% of women at first contact, and 17.8% of the repeat contacts. Those who identified reproductive coercion at first contact were equally likely to identify co-occurring domestic violence (55.2%), compared to those who identified reproductive coercion independent of violence. However, those who identified experiencing domestic violence were more likely to identify the presence of reproductive coercion (21.1%) than women with no other form of domestic violence reported (3.1%), $\chi^2(1, N = 3117) = 237.86, p < .001$. For women who contacted counsellors more than once (repeat contacts), 34% identified co-occurring reproductive coercion and only 5.7% of those identified only reproductive coercion with the absence of other forms of domestic violence.

In total, 147 women identified as ATS I at first contact. Of these, 15 (10.2%) identified as experiencing reproductive coercion at first contact with counsellors, with 11 (73.3%) of those women identified as having co-occurring experiences of domestic violence. ATSI women who identified experiences of domestic violence were more likely to identify reproductive coercion (19.6%) compared to ATSI women with no experiences of other forms of domestic violence.
(4.4%). CALD women also showed a small number of disclosures at first contact with 15 (6.1%) of 247 women disclosing reproductive coercion. CALD women appeared equally likely to identify co-occurring violence (46.7%), or the absence of violence. However, those CALD women who experienced violence were generally more likely to identify the presence of reproductive coercion (25.9%), than CALD women with no experience of violence (3.6%).

**Mental health**

Mental health issues that were disclosed at first contact were more likely to co-occur with reproductive coercion (36.6%) than in the absence of reproductive coercion (14.1%), $\chi^2(1, N = 2458) = 66.83, p < .001$. For repeat contacts, disclosure of mental health issues was substantially higher at 60.4% of those experiencing reproductive coercion compared to 35% disclosing mental health issues and no co-occurring reproductive coercion.

At first contact, for those women who disclosed reproductive coercion, a mental health issue was more likely to be disclosed when other forms of domestic violence were also reported (47.5%) compared to when domestic violence was absent (23.2%), $\chi^2(1, N = 183) = 11.57, p = .001$. When no reproductive coercion was present, mental health issues were still more likely, albeit less so, to be present among those who reported experiencing domestic violence (37.4%) compared to those with mental health issues, but with no reports of domestic violence (10.7%), $\chi^2(1, N = 2934) = 193.61, p < .001$.

**Age, relationship status, and gestation**

Compared to women who did not identify reproductive coercion, all women who disclosed reproductive coercion were most likely to be between the ages of 25-29 (22.4%; see Figure 1), identify as separated (40.4%; see Figure 2), and presented to the counselling service when gestation was greater than 12 weeks (25.2%), $\chi^2(1, N = 2458) = 14.36, p < .001$. When
comparing women aged 16-19 to women aged 25-29, there was no difference in the proportion of women of either age group disclosing reproductive coercion, $\chi^2(1, N = 570) = 1.28, p = .26$.

For those who disclosed reproductive coercion that co-occurred with other forms of domestic violence, they were more likely to be older than women who did not disclose other forms of domestic violence. 28.7% of women over 30 reported experiencing both domestic violence and reproductive coercion, compared to 23% of women who only experienced reproductive coercion. 52.4% of women under 30 reported reproductive coercion in the absence of other forms of domestic violence, compared to 45.4% of women under 30 who identified both reproductive coercion and domestic violence. Women identifying co-occurring domestic violence were most likely to identify as separated (58.4%) compared to women who did not disclose other forms of domestic violence, who were most likely to report that they were in an ongoing relationship (26.8%). Women experiencing both domestic violence and reproductive coercion were more likely to make first contact after 12 weeks’ gestation (21%) than reproductively coerced women with no other forms of domestic violence reported (11.7%). See Table 1 for all comparisons. For women who disclosed experiences of reproductive coercion that co-occurred with domestic violence, there was no overall difference for women aged 16-19 compared to aged 25-29, $\chi^2(1, N = 570) = 2.50, p = .11$.

**Discussion**

This study aimed to identify the proportion of women experiencing reproductive coercion in an Australian context and understand how this may co-occur with other forms of domestic violence and mental health issues. Our results revealed that reproductive coercion is occurring among Queensland women, and while a number of women experience this coercion independently of other forms of domestic violence, it most often occurs in its presence. This is
consistent with the understanding of domestic violence as a pattern of behavior involving a range of tactics designed to control the victim (Stark, 2007).

Contrary to our prediction, the overall rates of reproductive coercion in this sample reported at first contact with counsellors were marginally smaller than the US population estimate. Given the lower prevalence rate after first contact with counsellors, we speculate that this result may have been due to the inadequacy of a single contact to establish a relationship with a counsellor to safely disclose this information. Because of this, repeat contacts with the counsellors may provide a better understanding of the rates of reproductive coercion among Queensland women, with a disclosure rate approximately three times higher in this group. However, interpretations of repeat contacts with women should still be cautioned as the nature of this data does not allow for each individual to be connected longitudinally. Therefore, we cannot know how many times an individual woman would have contacted the service regarding a single pregnancy, and likely, women experiencing greater difficulties may have needed to contact counsellors more times than women with fewer difficulties associated with their pregnancy, thus inflating rates of disclosure. On the other hand, as predicted, it was common for women identifying as ATSI or CALD to experience reproductive coercion, with this rate even higher than non-ATSI or CALD women when both domestic violence and reproductive coercion were identified. This result confirms previous research involving non-Caucasian and minority groups’ experiences of both domestic violence and reproductive coercion (Clark et al., 2014; Moore et al., 2010; Nikolajski et al., 2015).

Our results also revealed a clear association between reproductive and mental health issues. This association was particularly pronounced among women who repeatedly contacted counsellors (with the caveat of the limitations mentioned above). However, it was generally
much higher for women who disclosed experiencing reproductive coercion compared to those with no identified reproductive coercion both at first and repeated contacts. As expected, mental health issues were greater among women experiencing reproductive coercion alongside other forms of domestic violence compared to women who were only experiencing reproductive coercion in the absence of other forms of domestic violence. The high rates of mental health issues among women who have been reproductively coerced, both with and without other forms of domestic violence, raise further research questions regarding the onset of mental health issues and whether reproductive coercion may increase the complexity or severity of these issues.

Furthermore, it is paramount to understand if access to support from healthcare providers who identify reproductive coercion also screen, and provide assistance, for mental health issues that may co-exist with reproductive coercion.

Our findings revealed a different pattern of results regarding age, relationship status, and gestation to those found in previous research (Colarossi & Dean, 2014; Foster & Kimport, 2013; Miller et al., 2014). Our predictions with respect to age of the woman were partially supported. That is, despite high rates of reproductive coercion with or without other forms of co-occurring domestic violence for women under 30 years of age, those who were older had a greater risk of experiencing other forms of domestic violence alongside reproductive coercion. However, women aged 16-19 displayed no difference in the proportion of disclosure for experiences of reproductive coercion compared to women aged 25-29. Although across all groups, there was a clear pattern of increased risk of reproductive coercion and other forms of domestic violence among those 16 to 29 years of age; it is likely that we did not find the same age ranges affected by reproductive coercion as previous research because Miller et al.’s (2014) study was only able to recruit women aged between 16 and 29 years, compared to the current, broader, sample of
Queensland women. Nevertheless, perhaps younger women are more vulnerable to reproductive coercion that results in unwanted pregnancies that they carry to term; this has been suggested among other samples investigating continuing pregnancies and intimate partner violence (Bourassa & Bérubé, 2007), and may explain their absence in representation among our sample. If this is true, it has significant implications for all pregnancy care settings by necessitating thorough reproductive coercion screening in antenatal settings and in specialist support services to pregnant and parenting young women. More research is needed to further understand and explore pregnancy pressure that may be experienced by young women who may not present in traditional settings for pregnancy.

Parallels were clear with the results of this study on timing of contact with a health service and previous research on domestic violence for timing of terminations of pregnancy (Colarossi & Dean, 2014; Foster & Kimport, 2013). Queensland women who disclosed experiences of reproductive coercion at first contact with counsellors were more likely than women with no reported experience of reproductive coercion to make contact after 12 weeks’ gestation, and this rate was slightly higher for those who disclosed experiencing co-occurring domestic violence. Contacts made at later stages of a pregnancy pose significant barriers for Queensland women who wish to terminate that pregnancy (Jones & Kooistra, 2011). Specifically, medication terminations of pregnancy can be performed up to 9 weeks pregnancy, which is low-risk and can be prescribed by a practitioner who has been trained in medical abortion provision (this includes clinics specializing in abortion and general practitioners). pregnancies later than 9 weeks require surgery to terminate the pregnancy, which substantially increases financial and legal risks for the woman, with both cost and risk rising as pregnancies progress. Further, there are a limited number of doctors capable of performing this lengthier and higher risk procedure,
especially in Queensland where appropriate abortion training for doctors, and their willingness to undertake it, has historically been lacking (de Costa, Russell, & Carrette, 2010; Douglas, Black, & de Costa, 2013; Portmann, 2008). This difficulty to procure a later term abortion is additionally compounded in Queensland (more so in regional areas) given strict abortion laws, which have been left largely unchanged since 1899 at the time of writing this report (Criminal Code Act 1899, s224-226 and s282 [Qld]; R v Bayliss and Cullen, 1986).

Given the considerable association between reproductive coercion and domestic violence, the results from this research invite further research on their temporal associations. Specifically, it is important to understand when and how domestic violence and coerced reproduction are linked (i.e., does reproductive coercion surface before other forms of domestic violence), and what risk factors may be involved in this interplay. Regardless of the order in which these issues present, the number of women experiencing reproductive coercion both in the presence and absence of other forms of domestic violence has significant implications for screening and responding in health settings. It obliges health providers to ensure that appropriate screening for reproductive coercion is completed as a distinct part of screening for issues that may impact on a woman’s choices and her safety, and is not assumed to overlap with commonly understood domestic violence for all women. It is further important to note that, given that the group of women experiencing reproductive coercion were also most likely to identify as ‘separated’, it is possible that this group of women were attempting to remove themselves from potentially abusive relationships. By seeking information regarding a termination of pregnancy, they may have attempted to ensure any potential child is not raised in a violent environment (Chibber, Biggs, Roberts, & Foster, 2014; Ely & Murshid, 2017).
Conclusion

Queensland women experiencing current reproductive coercion were more likely to have other co-occurring experiences of domestic violence, mental health issues, be separated from their partner, and make themselves known in a health-care setting at a later gestational stage than women without experiences of reproductive coercion. The significant numbers of women experiencing coercion both in the presence and absence of other forms of domestic violence has important implications for screening and responding in health settings and obliges health agencies to ensure that appropriate screening for reproductive coercion is completed as a distinct part of screening for violence. Disclosure of reproductive coercion is more likely to be reported on subsequent contacts suggesting that disclosure may be dependent on a trusting relationship between the woman and the counsellor. It is likely that repeated screening will only improve detection of reproductive coercion with emphasis on asking soon and often.
Footnotes

1 We acknowledge that although persons may have been in contact with counsellors regarding pregnancies who identify as gender-nonbinary, recording of gender within these data have been restricted to binary (male/female) recordings, so for the purposes of consistency with these data we refer only to ‘women’ within this paper.

2 Separate, preliminary, data was available for contacts from July-December in 2017 indicating that from the 45 women who identified reproductive coercion at first contact, 55.6% (n = 25) reported coercion into the pregnancy and 40% (n = 18) reported coercion into an abortion (2 women reported both types of coercion). Of those women who contacted the service more than once, 81.8% were from women reporting coercion into a pregnancy compared to 16.6% of those reporting coercion into an abortion.

3 The sample size of women in each group identifying as Aboriginal or Torres Strait Islander or as culturally and linguistically diverse were too small to analyze through significance testing.

4 Counsellors determined the presence of mental health issues if the woman discloses a pre-existing diagnosed mental health condition. Although uncommon, the partners mental health is also noted in the same criteria. Counsellors have noted that the mental health of the partner is rarely noted, and typically co-occurs with the woman’s own pre-existing mental health condition.
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https://doi.org/10.1016/j.ambp.2007.05.007


R v Bayliss and Cullen [1986] 9 QLD Lawyer Reps 8 (‘Bayliss’)


Table 1

Comparison of measured variables across experiences of reproductive coercion at first contact with an organization regarding unplanned pregnancy options

<table>
<thead>
<tr>
<th></th>
<th>Reproductive Coercion (n = 183)</th>
<th>No Coercion (n = 2934)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Women %</td>
<td>violence %</td>
</tr>
<tr>
<td></td>
<td>(n=101)</td>
<td>(n=82)</td>
</tr>
<tr>
<td>ATSI (n=15)</td>
<td></td>
<td></td>
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<tr>
<td>CALD (n=15)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>55.2% (101)</td>
<td>73.3% (11)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>36.6% (67)</td>
<td>71.6% (48)</td>
</tr>
<tr>
<td>Age*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;=13</td>
<td>0% (0)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>14-15</td>
<td>1.6% (3)</td>
<td>1% (1)</td>
</tr>
<tr>
<td>16-19</td>
<td>11.5% (21)</td>
<td>9.9% (10)</td>
</tr>
<tr>
<td>20-24</td>
<td>18.6% (34)</td>
<td>16.8% (17)</td>
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<tr>
<td>25-29</td>
<td>22.4% (41)</td>
<td>27.7% (28)</td>
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<tr>
<td>30-34</td>
<td>9.8% (18)</td>
<td>10.9% (11)</td>
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<tr>
<td>35-39</td>
<td>13.7% (25)</td>
<td>15.8% (16)</td>
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<tr>
<td>40-44</td>
<td>2.2% (4)</td>
<td>2% (2)</td>
</tr>
<tr>
<td>45=&gt;</td>
<td>0.5% (1)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Relationship Status*</td>
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<td></td>
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<tr>
<td>Single</td>
<td>15.8% (29)</td>
<td>13.9% (14)</td>
</tr>
<tr>
<td>Separated</td>
<td>40.4% (74)</td>
<td>58.4% (59)</td>
</tr>
<tr>
<td>Married/Defacto</td>
<td>14.2% (26)</td>
<td>9.9% (10)</td>
</tr>
<tr>
<td>Casual</td>
<td>3.8% (7)</td>
<td>2% (2)</td>
</tr>
<tr>
<td>Ongoing</td>
<td>18.6% (34)</td>
<td>11.9% (12)</td>
</tr>
<tr>
<td>Other</td>
<td>0.5% (1)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Gestation in weeks*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;=6</td>
<td>18.0% (33)</td>
<td>12.9% (13)</td>
</tr>
<tr>
<td>&lt;=12</td>
<td>46.4% (85)</td>
<td>52.5% (53)</td>
</tr>
<tr>
<td>Age Group</td>
<td>Reproductive Coercion (n = 183)</td>
<td>No Coercion (n = 2934)</td>
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<tr>
<td>&lt;=16</td>
<td>13.7% (25)</td>
<td>16.8% (17)</td>
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<tr>
<td></td>
<td>9.8% (8)</td>
<td>8.1% (237)</td>
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<tr>
<td></td>
<td>14.9% (56)</td>
<td>7.1% (181)</td>
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<td>6.0% (11)</td>
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<td></td>
<td>6.1% (5)</td>
<td>3.3% (97)</td>
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<td></td>
<td>5.6% (21)</td>
<td>3% (76)</td>
</tr>
<tr>
<td>&gt;20</td>
<td>5.5% (10)</td>
<td>5.9% (6)</td>
</tr>
<tr>
<td></td>
<td>4.9% (4)</td>
<td>1.5% (44)</td>
</tr>
<tr>
<td></td>
<td>0.5% (2)</td>
<td>1.6% (42)</td>
</tr>
</tbody>
</table>

*Note: ATSI = Aboriginal and Torres Strait Islanders; CALD = Culturally and linguistically diverse; *Sum does not equal 100% because some women did not provide or were unsure of these details.*
Figure 1. Age ranges, in years, among women experiencing reproductive coercion at first contact with an organization regarding unplanned pregnancy options.
Figure 2. Frequency of relationship status among women experiencing reproductive coercion at first contact with an organization regarding unplanned pregnancy options.
Author Biographies

Elizabeth Price is an experienced Social Worker and is passionate about issues that affect women’s reproductive health. She has a special interest in the intersection of domestic violence and reproductive coercion with unplanned pregnancy and abortion. She has lead initiatives aimed at enhancing the capacity of abortion providers and healthcare practitioners to respond to the needs women experiencing reproductive coercion.

Leah Sharman is a PhD candidate at the University of Queensland with research interests in women’s health, emotion, and the influence of music on mental health and emotion regulation. Her PhD is focused on understanding the functionality of crying and sadness, and the impact of gendered socialisation in responses to sadness.

Professor Heather Douglas, PhD, is an Australian Research Council Future Fellow and researches in the areas of criminal justice and legal responses to domestic violence and child protection. Heather was appointed a Fellow of the Australian Academy of Law in 2013 and a Fellow of the Academy of Social Sciences in Australia in 2017.

Nicola Sheeran, PhD, is a clinical psychologist and lecturer at Griffith University. She has research interests in women and family mental health and at the intersection of clinical and social psychology, particularly in relation to preterm birth, pregnancy decisions, birth, parenting, complex family situations, substance abuse/addictive behaviours, and interventions in these areas.
Genevieve Dingle, PhD, is a clinical psychologist and senior lecturer at the University of Queensland with a background in biochemistry and pharmacology. Her primary research interests are in understanding social issues affecting health and mental health, with particular focus on how groups and communities influence mental health and wellbeing.