IRISH RESEARCH COUNCIL
An Chomhairle um Thaighde in Éirinn

DRCC
Dublin Rape Crisis Centre

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Understanding the Relationship between Reproductive Coercion and Intimate Partner Violence in an Irish Context: A Stakeholder Informed Qualitative Analysis

Research Report

Meg Ryan
Tanya Antony
Shirley Scott

ACKNOWLEDGEMENTS

Trinity Centre for Global Health (TCGH) and the Dublin Rape Crisis Centre (DRCC) would like to thank everyone who participated in the interviews for this research. We are grateful for the time they took to share their experiences.
We would also like to acknowledge the contribution of the Advisory Group who provided invaluable feedback and support throughout the project.

Our advisory group members included:

Eavan Ward, Women's Aid
Poushali Kundu, National Women's Council
Bridget Winters, Pavee Point Traveller & Roma Centre
Patricia Acom, AkiDwA -Network of Migrant Women
Mary-Louise Lynch, SiSi - Survivors Informing Services & Institutions
Shaibia Tafla, Amal Women's Association
Kathryn McGrath, Women's Health Service & Anti-Human Trafficking Team
Daire Dempsey, Transgender Equality Network Ireland (TENI)
Jillian Doyle, Clinical Psychologist

CONTENTS

INTRODUCTION

Trinity Centre for Global Health (TCGH) and the Dublin Rape Crisis Centre (DRCC) received funding from the Irish Research Council New Foundations award to conduct research with the aim of understanding the relationship between reproductive coercion and intimate partner violence in an Irish context. This report summarises the key findings and recommendations from the project. Reproductive coercion (RC) is defined as deliberate attempts to influence or control the reproductive autonomy of another person. This is a form of intimate partner violence (IPV) thought to be linked to poorer sexual reproductive health (SRH) outcomes such as unintended pregnancy and sexually transmitted infections (STIs). However, the links between IPV and RC are poorly understood, and there is a lack of data regarding the nature of the relationship and chronology of occurrence, impacting the development of effective interventions. The goal of this scoping research was to address this gap by exploring the current state of knowledge regarding IPV and RC in an Irish context through an exploratory qualitative study with relevant stakeholders.

THE STUDY

The study design for this research was qualitative in nature, using semi-structured interviews to generate an in-depth exploration of the intersections of IPV and RC informed by stakeholder expertise.

The research team was comprised of the principal investigator (PI) Dr Meg Ryan, based in TCGH, a research assistant (RA) Tanya Antony (TCGH) and Shirley Scott, the policy manager for DRCC. The research team carried out a mapping exercise to identify key stakeholders for a project advisory group (AG) which consisted of members of organizations relevant to SRH and gender-based violence (GBV), including advocacy groups for people with lived experience. AG members were invited to contribute to development of the interview schedule and to review and inform data interpretation.

The PI and RA conducted 8 one-to-one interviews with stakeholders in the field of SRH and GBV prevention. Participant roles included support workers, project managers, team leads, therapists and educational trainers. The interview schedule focused on stakeholders' understandings of the intersections of IPV and RC, their experience working with service users who have experienced IPV and RC, their perspectives on motivation for perpetration of these forms of abuse, and their perspective on the impact of social norms within Ireland on these issues. Stakeholders were also asked about supports and resources available for those experiencing RC and/or IPV.

Data was analysed following Braun and Clarke's (2006) six-step method for thematic analysis and used both an inductive and deductive approach. Data analysis was conducted by the research team, and initial findings were presented to the Advisory Group to assist with data interpretation. Quotes from the interviews have been anonymised and consent from participants will be sought for any academic publications containing their quotes.

**A note on language: While it is acknowledged that IPV and RC can happen to people of any gender, participants in this study predominantly used the terms woman and women to describe individuals and service users affected by these forms of abuse.*
Additionally, this document uses the term "victim/survivor", acknowledging that the individual terms "victim" or "survivor" are preferred in certain contexts, including by individual victims/survivors themselves. While the two terms are often used interchangeably, "victim" is more prevalent in the legal and medical system, and "survivor" is more prevalent in psychosocial support sectors (IASC Definition & Principles of a Victim/Survivor Centered Approach).

EMERGING THEMES

Five key themes emerged from the data analysis, some including specific subthemes.
These include;

1. Understanding the intersections
2. Impact of reproductive coercion
3. Barriers to awareness and disclosure
4. Reproductive coercion and parenthood
5. Sociocultural factors

THEME 1: UNDERSTANDING THE INTERSECTIONS

Participants discussed their understandings of both reproductive coercion and intimate partner violence, identifying salient characteristics of each as well as overlapping elements.

1.1 DEFINING REPRODUCTIVE COERCION

Participants discussed reproductive coercion as encompassing both contraception sabotage and pregnancy coercion, which is how current screening tools measure RC. However, participants also identified that RC relates to control over decision making about other aspects of reproductive health, and they offered a broad understanding of the concept.

Reproductive control, to me, will also be not to have access to sanitary products or not being allowed to take money out of a financial pot for sanitary projects... women not being allowed to attend maternity appointments, whether that be for pregnancy, postpartum, termination, pregnancy loss, and then as a result, getting maybe an infection or kind of a worse medical issue. (P1)

My understanding of it is like abuse in the sense of trying to control someone's decisions around their reproductive health. So, whether that's like being able to go to the doctor or take contraception or use contraception, having sex and maybe testing or getting medication for STIs, forced abortion, and maybe decisions around the childbirth itself. (P4)

Participants reported that RC was a commonly occurring form of abuse within services.

It's (RC) a problem like it's a worldwide issue. It's not, it's not because we live in, you know, the global north or anything like that, like it happens everywhere and it happens in all kind of economic backgrounds. (P4)

I would be confident there is a high percentage of clients who have experienced that. If someone is in an abusive relationship when they're of reproductive age, I'd say it's an issue for most. (P6)

1.2 OVERLAPS WITH IPV

Participants discussed how they understood intimate partner violence and reproductive coercion to intersect. It was felt that while IPV can happen without RC, RC happened in the context of IPV or was seen as a subset of IPV.

I do think they are kind of always hand in hand [...] no matter what way you look at it, I think it [RC] can be put into a category of domestic violence. (P1)

I think I would probably say you could have the intimate partner violence without the reproductive coercion. However, reproductive coercion is unlikely to come without the intimate partner violence. (P2)

However participants were clear that RC and IPV are interrelated, specifically identifying that they are perpetrated with the same underlying intentions.

I would think that they happen together because it is an issue of power and control over somebody else, which I think at its core, that is what domestic violence is and core. [...] the power and control piece is at this, is at the centre of coercive control itself and the and then like the reproductive side of that would be, it's a form of abuse so it kind of comes under that. (P4)

I think that the goal of both IPV and RC is the same, the ultimate goal is to remove a woman's choice about her life, her decision making, take away her control over her own life and even more vulnerable with RC, with her own body. And the underlying cause of both is really to have that power and control, to limit her independence. (P6)

THEME 2: IMPACT OF REPRODUCTIVE COERCION

Participants described the various ways in which they observed IPV and RC to impact on service users, with psychological impacts and poor mental health outcomes commonly observed;

The toll on people's mental health, I mean if somebody is carrying a pregnancy which they were not ready for, there can be that huge like you know we talk about post-natal depression, you know that pre-natal depression...impacting on the mental health and impacting a person's ability to feel as if they can just live, you know what I mean? I think it can cause people to have suicidal ideations. (P5)

The psychological impact is just something that I suppose if the woman, like, does suffer long term or even irreversible consequences, then that's something, I suppose it's a constant reminder, then, of what has happened to them, like how the reproductive coercion like impacted them. (P8)

These psychological impacts also linked to social impacts, whereby the person being controlled would lose connections and contact with other people in their life, with the experience of abuse also impacting their autonomy, self-esteem and ability to build future romantic partnerships.

It makes them more dependent on the abuser and their worlds continue to get smaller and smaller because their abuser will more than likely cut off contact with other people like friends and family so become very isolated and are very... They're really trapped, I guess, with that person and fearful of them. (P4)

Participants also highlighted the long-term impacts of this abuse on victim-survivors, which included physical health issues and financial impacts.

The majority have had to give up their job to deal with the family court situation or they've lost their job. (P3)

Reproductive coercion can have like long term or even irreversible consequences like health consequences, if it's multiple abortions or whatever like it can impact on your reproductive organs and everything. And then with the forced contraception, sometimes that has long lasting impact as well on their reproductive health and they have to go through specialist care. (P8)

If you look at whether you've been coerced into a pregnancy that you maybe were not ready for you know I think the long-term effects of that in terms of like being responsible for another human, maybe not having the resources to do that. It can put people into homelessness, into poverty. (P5)

THEME 3: BARRIERS TO AWARENESS AND DISCLOSURE

Participants discussed the levels of awareness that both service users and providers had in identifying IPV and RC, the factors that impacted this awareness, and the barriers to disclosing experiences of RC.

3.1 LACK OF KNOWLEDGE

Participants all reported that service users had difficulty identifying that RC had occurred, in comparison to IPV. This was reported to be due to a general lack of knowledge of the concepts and a lack of legal definition regarding RC.

I think people are realizing that it's there, but they don't actually, because it's not a thing, there is no law on reproductive issues, reproductive control. So then they don't consider it for their own situation. (P3)

And I think if you don't have a good knowledge of what domestic violence is, it's very, very difficult to differentiate between that and reproductive control. (P1)

I don't think there's much of an understanding about reproductive coercion, I don't think. I think if you were to ask somebody what it was, I think they would struggle really understand and I don't know if they would make the connection between that and intimate partner violence. I don't think... there would be, there would be a huge shock to think it is as prevalent as it is. (P5)

This lack of knowledge was also observed within healthcare services, with participants stating that healthcare providers need to possess an in-depth understanding of RC in order to feel comfortable facilitating disclosures.

> *Even the medical, the medical staff aren't aware of what reproductive creation is or what domestic violence is, so if women are coming in and they can't identify that then women aren't getting the support that they need, and this cycle just continues. (P1)*

> *The professionals, they might have good intentions but they actually might not feel they are equipped to respond. So they might not want to explore something, they might sense something, they might say oh there's something going on here but they don't feel equipped to do anything, to open the Pandora's box. (P7)*

3.2 STIGMA AND SHAME

Participants also acknowledged that there can be a stigma and taboo attached to topics of sexuality and reproductive health, both within Ireland and in other cultures. This was found to create a sense of shame around experiences of RC which made it difficult for people to acknowledge these experiences for themselves;

> *I don't think survivors really acknowledge that their experience might be RC. I think they may recognize their entire experience as IPV, but it can be extremely vulnerable I think for people to really recognize their own experience as having been RC, they may not kind of want to go there in their minds. (P5)*

This sense of shame and secrecy also created barriers to disclosure and help seeking.

> *When it comes to building a relationship with a survivor, a lot of the times it's near the end when they disclose anything like that because it's seen as the private and the shame, the extra layer of shame that's related to it. Unfortunately, you know the rest of the times they may kind of hint that there has been things but don't want to talk about it. (P5)*

> *So I just think it's a very delicate topic, it's very difficult for women to talk about as opposed to other types of abuse, other tactics. I just find that it's very surrounded by shame. (P6)*

> *And that's also very difficult for practitioners to ask these questions. It's very difficult for them to explore sexual violence, to explore, rape. How did you become pregnant? So I think that that's a cultural shame about being able to talk about these experiences... I guess that keeps it hidden, doesn't it? So he gets away with it because... that's what he needs. He needs that secrecy. He needs the woman not to disclose. So that fear and that shame keeps it from being disclosed. (P7)*

3.4 INTERSECTIONAL CONSIDERATIONS

Specific barriers to awareness and disclosure relevant to migrant women were identified by participants. These included language barriers, lack of knowledge regarding Irish legislation, and provider discomfort in engaging with women from other cultures on issues of reproductive coercion.

Migrant women especially... they can be a lot more unaware of rights in Ireland... women being really, really unaware of the rape through marriage laws in Ireland. (P1)

And another barrier obviously is from migrant women using a translator. It is awkward enough speaking about sexual abuse or reproductive creation with one person. Never mind having to say to a translator to say back to the woman for the woman to say back to the translator, to say back to me. (P1)

People are afraid to ask somebody from a different culture the questions they're afraid to offend... if it's someone from a different cultural background to the person, they're afraid they're going to offend the person. (P7)

THEME 4: REPRODUCTIVE COERCION AND PARENTHOOD

The ways in which RC as a form of gendered violence intersects with experiences of pregnancy, motherhood and family were highlighted by many participants. Three key subthemes emerged, the first focusing on how RC is perpetrated with specific intentions of causing pregnancy as a means of controlling someone, the second subtheme explores the complexity of subsequent experiences of motherhood and parenting, followed by an acknowledgement of the intergenerational impacts on families.

4.1 PREGNANCY AS A TACTIC OF ABUSE

Participants were clear that perpetrators use pregnancy as a means to exercise power and control over their partner.

It's completely intentional... Trying to get them pregnant early on in their relationship. That seems to be quite common. Let's have a baby. You know, it's all about we're mad in love, that that pressure and that... keep them trapped in that relationship. (P7)

Once there is a level of commitment made in the relationship it feels like the perpetrator has gained another layer of control and we would often see that in relation to moving in together or having a child together. And that is something that we often see that the woman may not have felt ready to have a child. (P5)

4.2 COMPLEX EXPERIENCES OF FORCED MOTHERHOOD

Participants describe how experiences of RC that result in pregnancy and childbirth can create complex and challenging experiences of parenting. There was an acknowledgment of cultural pressures that make it difficult for women to admit they did not want to be a mother.

I mean so that's the culture kind of thing, so for a woman to admit that she doesn't want this baby that's very difficult. (P7)

Women are never as confident disclosing that or they are never as confident to say, you know, I got pregnant against my will or I have four children and I didn't want any of them. (P1)

It was also reported that women found it difficult to acknowledge experiences of RC in order to protect their children from feeling unwanted.

I think it's very difficult for women who have experienced RC to negotiate that I still love my child but what happened to me was wrong and it should've been my choice. So I just think it's a very delicate topic, it's very difficult for women to talk about as opposed to other types of abuse, other tactics. So yeah I just find that it's very surrounded by shame. (P6)

4.3 INTERGENERATIONAL IMPACTS OF FORCED MOTHERHOOD AND RC

Participants discussed the potential intergenerational effects of parenting via experiences of RC, with considerations for the impact on family dynamics and attachment.

And that's difficult as well for the woman. If this baby was the outcome of rape, you know. You know that obviously you know higher risk of post-natal depression. You know the bonding with that child and things like that. (P7)

I think it has huge long-term effects and intergenerational as well. I don't think we even realize how RC and IPV have that intergenerational impact, I don't think we're even aware of it. Like so I think there's a lot we need to look at as well but that the perpetrator has an impact on the survivor but that's not where it ends and I think we need to be very mindful of that, you know that there's this cumulative or snowball effect in that (P5)

In either situation, how they may feel about future pregnancies and how the attachment with those pregnancies, with those children. The attachment then with those children can affect their attachment their children and it can be a generational thing as well so it doesn't just stop with that survivor or their children (P5)

THEME 5: SOCIAL NORMS

The final theme explores the impact of sociocultural norms on experiences of RC. Subthemes consist of several factors that participants highlighted as being influential on RC experiences, including ideas about legacy, religion, and attitudes to gender-based violence.

5.1 THE PATRIARCHAL FAMILY

Patriarchal norms regarding family legacy, gender roles and gender preferences for children were described as contributing factors in the perpetration of RC. This sub-theme was identified both within an Irish context broadly, as well as specifically reported in relation to cultural norms within the Traveller community, and for service users with different cultural backgrounds, highlighting relevant intersectional considerations for RC experiences.

When we look at the reasons for somebody to inflict RC would be like again power and control but also I think for men it can be the bloodline, it can be the thing of I want, this is my family I want the legacy to live on or I want my family, I want a boy because I want my name to go on so I think it can be again around social status. (P5)

Many of the stories that I have heard are coming from the historical kind of patriarchy of wife, husband, two children, five children, whatever it is that they want this, it would be now deemed an Instagram family, but in the old days it would just be, you know, a good Catholic family. (P3)

I suppose it's also kind of like being ostracized from the (Traveller) community because you're failing to carry out the process where you get married you have your children, and then this is what happens, and this is what's socially acceptable (P5)

In so far as other cultures that there might be an expectation on women to conceive a boy you know and its bloodline and family name and heritage and legacy and things like that. (P2)

5.2 NORMALISATION OF GENDER-BASED VIOLENCE

Societal normalisation and acceptance of gender-based violence was identified as an enabling factor which perpetuated cycles of abuse and misogyny.

I think it's often something that they've learned that they've grown up with, that they've seen, whether that's at home. Uh, it's maybe the norm, culturally it's accepted. There's a very high tolerance for violence in that society maybe that they've grown up (P4)

It's very supported by the ideologies that exist in society as it is about a woman's body belonging to only her and yeah I think that perpetrators again are quite empowered by some of those other messages. (P6)

When we read the news it says woman raped in Dublin. It doesn't say man sexually assaulted woman in Dublin and I think until those narratives change that it's gonna keep, men are still going to be in the cycle of thinking that they're better than women, that they can control women and that they have a right to control things such as reproductive rights of women. (P1)

5.3 RELIGION AND THE CATHOLIC CHURCH

The sociohistorical legacy of the Catholic church in Ireland on attitudes to sexuality and reproduction were discussed by participants, with all participants identifying the influence of Catholic values which endorsed the repression of female sexuality as a contributing factor to RC.

The role of the family within the eyes of the state and church, it was, you know, women get married, they finish whatever careers they have and their job becomes having a family. (P2)
I think that it has to do with the very strong kind of faith-based guidelines or rules with the church saying that often do kind of reduce the woman's role to being a mother and reduce her access to contraception. I think that just allows people who are perpetrating RC to be able to do that more openly without it being identified as RC. (P6)

The word was taken as absolute gospel from the priest, you know. And they didn't have choice. And then obviously when it came to reproductive health or the pill and, you know reproductive control methods the pill and coil and all that kind of stuff, obviously you know wasn't legal. So there was just an expectation of if you're pregnant you have the baby. (P2)

KEY FINDINGS

- RC is a very commonly occurring form of abuse and often co-occurs with IPV. While IPV may exist in the absence of RC, in the context of intimate partner relationships, RC can be understood as a form of IPV.
- RC has several psychological, physical health, relational and material consequences for victim-survivors. Long-term implications of RC include intergenerational effects on the mother-child relationship, and survivor's reduced self-esteem and autonomy.
- There is a lack of awareness of RC which is largely due to lack of legal definitions and a lack of education and information on the topic. As a result, people rarely recognize their experience of reduced reproductive autonomy as RC.

- RC intersects with other elements of patriarchal social norms such as gender role expectations, pressures around motherhood and parenting, normalisation of GBV and stigma regarding female sexuality and reproductive health.
- Perpetrators of RC often engage in this abuse with the explicit intention of controlling the victim/survivor via their family ties by having a child together. In doing so, they also aim to reduce the survivor's capacity to be independent and pursue a professional and/or social life outside of the relationship.
- Intersectional considerations are important such as understanding experiences of women from other sociocultural backgrounds, and beliefs that may maintain such abuse Further, there are additional difficulties in accessing information on RC and IPV for migrants given the language barrier.

RECOMMENDATIONS

- More research is needed to understand the long term, intergenerational impacts of reproductive coercion.
- Introduction of legislation recognising reproductive coercion as a specific form of gender-based violence is necessary to protect the rights of victim-survivors.
- Provision of accessible information on reproductive rights is needed, with a specific focus on producing material and resources in multiple languages. Resources should be accessible for those with low literacy levels, with information provided in plain text, using alternative formats such as video and audio, digital storytelling and inforgraphics and imagery.
- Specific policies on GBV should be developed which recognise RC, and data collection methods should be implemented within services to capture the prevalence of such experiences.

- Training should be provided to translators and interpreters on reproductive coercion so that they can assist in identification and disclosure of such experiences.
- Training should be provided to medical professionals and service provicers, particularly those working in SRH services, GBV prevention or maternity care settings on how to recognise RC, how to interact with and respond to service users, and how to facilitate and validate disclosures.
- Such training should be culturally and contextually relevant and appropriate, and community engagement should be sought for the development of such trainings.
- Participants acknowledged that there was a desire among professionals for such a training, but that protected time needs to be given by leadership and management to facilitate this.

GLOSSARY

- **Reproductive Coercion (RC)**: Reproductive coercion is defined as behaviour that interferes with the autonomous decision-making with regards to reproductive health (Miller, Jordan, Levenson, & Silverman, 2010; Miller, Decker, et al., 2010; Moore, Frohwirth, & Miller, 2010). Specifically, this may take the form of birth control sabotage (such as removing a condom, damaging a condom, removing a contraceptive patch, or throwing away oral contraceptives), coercion or pressure to get pregnant, or controlling the outcome of a pregnancy (such as pressure to continue a pregnancy or pressure to terminate a pregnancy).
- **Intimate Partner Violence (IPV)**: IPV is broadly defined by the World Health Organisation (WHO) as "any behaviour within an intimate relationship that causes physical, sexual or psychological harm to those in the relationship." (Burelomova, Gulina, & Tikhomandritskaya, 2018). The Istanbul Convention also includes economic violence within its definition of IPV (Şİmşek, 2019).
- **Gender-based Violence (GBV)**: GBV refers to any harm or threats of harm against a person based on their ascribed gender, and includes physical, sexual, emotional violence, or forced marriage (UNICEF, 2021). While GBV is generally perpetrated against women, men and gender minorities may also be victims of GBV (Alessi et al., 2021; Djamba & Kimua, 2015).
- **Sexual and Reproductive Health (SRH)**: Sexual health is a state of well-being, in terms of physical, emotional, social, and mental well-being, relating to sexuality (World Health Organisation, 2006). Reproductive health is a state of complete mental, physical, and social well-being in relation to the reproductive system and the way it functions (United Nations, 1994).