The Relationship of Abortion and Violence Against Women: Violence Prevention Strategies and Research Needs*

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ABSTRACT: From the perspective of peace psychology, the role of abortion in acts of violence against women is explored, with a focus on violence-prevention strategies. Setting aside the political debate, this task force report takes the conflict-transformation approach of considering all perspectives that have concern for the right of women to avoid being victims of violence. The evidence that victims of Intimate Partner Violence are disproportionately represented in women presenting for abortion suggests a need for screening at clinics. Coerced abortion is a form of violence and has occurred by government policy in China and as a result of other violence against women: sex trafficking and war situations. Sex-selection abortion of female fetuses, referred to as "gendercide," has reached pandemic proportions and caused a gender imbalance in some countries. Psychology, through empirical research, can make unique contributions to understanding the relationship between abortion and violence and in developing prevention strategies.
Keywords: Abortion, Violence against Women, Intimate Partner Violence, Coerced Abortion, Gendercide.

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Introduction

In recent decades, the United Nations and other human rights organizations have drawn attention to a specific form of violence, *gender-based violence*. The UN Declaration on the Elimination of Violence against Women defined violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women" (1993).

"Gender-based violence includes a host of harmful behaviors that are directed at women and girls because of their sex, including wife abuse, sexual assault, dowry-related murder, marital rape, selective malnourishment of female children, forced prostitution, female genital mutilation, and sexual abuse of female children" (Heise, Ellsberg, & Gottmoeller, 2002, p. S6). As discussed below, we suggest two important additions: coerced abortion (a woman's abortion decision is not made on her own volition and may include threats and pressure from others) and gendercide (sex selection abortion on a massive scale).

While abortion remains a highly controversial public policy issue, we are setting aside that controversy and instead focus on developing a research agenda concerning abortion from a peace psychology perspective. Peace psychology is a division of psychology which focuses on peace among nations and within communities and families, and prevention of destructive conflict and violence through conflict resolution. Psychological knowledge and methods are used to foster communication and research on conflictual topics toward a goal of violence prevention. Regarding abortion, the peace psychology perspective would attempt to find areas of agreement in which researchers from multiple perspectives might be able to collaborate. More specifically, we are interested in examining the relationship between violence and abortion for the purpose of preventing destructive conflict and injury, and empowering women's reproductive decision-making. The relevant scientific literature will be reviewed, gaps in knowledge identified, and suggestions for future research offered. Current research will be discussed in terms of its application toward preventing violence against women.

Intimate Partner Violence

Intimate Partner Violence (IPV) has been estimated to affect 20-25% of adolescent and adult women in the United States (Silverman, Raj, Mucci & Hathaway, 2001; Tjaden & Thoennes, 1998). While IPV may be perpetrated by both men and women and either sex may be victims, our focus is on violence against women. A form of domestic violence (which also includes child abuse and elder abuse), IPV may be inflicted as physical or sexual violence and is often accompanied by emotional abuse (Watts & Zimmerman, 2002). In a violent and/or abusive relationship, the victim may experience reproductive coercion and denied control of her own fertility. The notion of "reproductive coercion" has been defined by Miller and Silverman (2010) as "male partners' attempts to promote pregnancy in their female partners through verbal pressure and threats to become pregnant (pregnancy coercion), direct interference with contraception (birth-control

sabotage), and threats and coercion related to pregnancy continuation or termination (control of pregnancy outcomes)" (p. 2).

In the case of pregnant women, some clinicians have observed that batterers beat their pregnant partners' bellies and display regressions that seem to indicate rage at the fetus they believe competes for their partner's love. Such observations appear to be supported by women who were queried about their beliefs as to why their partners beat them during pregnancy (Campbell, Oliver, & Bullock, 1993). Incidence estimates of IPV during the perinatal period are reported to range from 3% to 17% (McMahon & Armstrong, 2012) and from 1.2% to 51% (Pool, Otupiri, Owusu-Dabo, de Jonge, & Agyemang, 2014). IPV that occurs during pregnancy may be best predicted by the severity and frequency of IPV that occurs over the course of a relationship (Campbell, Oliver, & Bullock, 1993).

Research findings indicate women with a history of IPV are significantly more likely to experience unintended pregnancy (Campbell & Soeken, 1999; Pallito et al., 2013) as well as rapid repeat pregnancy (Jacoby, Gorenflo, Black, Wunderlich, & Eyler, 1999; Scribano, Stevens & Kaizar, 2013). Since unplanned and unwanted pregnancy are common reasons for choosing abortion, it is not surprising that IPV has been found to be associated with elective abortion (Fanslow, Silva, Whitehead, & Robinson, 2008; Hall, Chappell, Parnell, Seed, & Bewley, 2014; Pallito et al. 2013; Saftlas et al., 2010; Taft & Watson, 2007). In one study (Leung, Leung, Chan, & Ho, 2002), 27.3% of women stated their experience of abuse influenced their decision to abort. Two other studies (Glander, Moore, Michielutte, & Parsons, 1998; Woo, Fine, & Goetzl, 2005) reported that women who experience IPV are less inclined to discuss abortion with abusive partners due to fear, and Silverman et al. (2010) observed that men who perpetrated IPV were more likely to report conflicts with their female partners concerning abortion. Men who are determined to control partners may insist on abortions their partners do not want (as in the famous case of Lorena Bobbit). Women who opt for abortion willingly or under threat may be experiencing multiple assaults from partners before and immediately after undergoing the procedure, putting their physical and emotional health at risk. Given the consistently observed association between IPV and abortion, there have been calls to screen women for a history of abuse during abortion counseling (Glander et al., 1998; Saftlas et al., 2010; Silverman et al., 2010; Wiebe & Janssen, 2001).

Repeat abortion is associated with a history of physical and sexual abuse (Fisher et al., 2005) and it is estimated that half of U.S. women obtaining abortion have had at least one previous abortion (Jones, Finer, & Singh, 2010). Steinberg and Russo (2008) reported that "multiple abortions were found to be associated with much higher rates of PTSD and social anxiety; this relationship was largely explained by pre-pregnancy mental health disorders and their association with higher rates of violence" (p. 238). Fisher et al. (2005) have suggested "Presentation for repeat abortion may be an important indication to screen for a current or past history of relationship violence and sexual abuse" (p. 637). It has been determined that "reducing IPV by 50% could potentially

reduce unintended pregnancy by 2%-18% and abortion by 4.5%-40%, according to Population Attributable risk estimates (Pallito et al., 2013, p. 3). Therefore, routine screening for current or past abuse of women seeking abortion may be an effective means of reducing violence against them (Glander et al., 1998; Saftlas et al., 2010; Silverman et al., 2010; Wiebe & Janssen, 2001).

Coerced Abortion

"Reproductive control," a concept similar to "reproductive coercion" is defined by Moore, Frohwirth, & Miller (2010) as occurring when partners, parents, peers, or the medical establishment "demand or enforce their own reproductive intentions whether in direct conflict with or without interest in the woman's intentions, through the use of intimidation, threats, and/or actual violence" (p. 2). Forcing a woman to become pregnant or complete a pregnancy against her wishes or forcing her to abort a pregnancy she desires to continue are forms of reproductive control. However, this paper is on the role of abortion in violence against women and therefore focuses on what is generally agreed about coerced abortion. Coerced child bearing is a separate subject deserving of its own attention and research agenda.

Forced abortion has been condemned as a "violation of our human rights" by the International Community of Women Living with HIV/AIDS (ICW, 2008). Research findings suggest that coercion and pressure to abort are not uncommon (Broen, Moum, Bodtker & Ekeberg, 2005; Hathaway, Willis, Zimmer & Silverman, 2005; Rue, Coleman, Rue & Reardon, 2004; Williams, 2000). However, studies report differing rates of coercion or pressure. Clearly then, more research is needed to establish accurate prevalence.

Coercion via Government Policy

In some countries, most prominently China, forced abortion is official governmental policy. Since 1978, Chinese couples are required to obtain "birth permits" to have children and are limited to only one child. Women without the required permit, or who are pregnant for the second or third time, "have been required, persuaded, and even forced by the authorities to abort fetuses no matter how much they want to give birth" (Nie, 1999, p. 463). Cases of women being forced to abort even late in pregnancy have been documented by Women's Rights without Frontiers ("Cases," n.d.) and reported in Congressional testimony (*The Consequences of Coercion,* 2009). Reggie Littlejohn stated "The one-child policy is an issue about which pro-life people and pro-choice people can agree. No one supports forced abortion, because it is not a choice" (*The Consequences of Coercion,* 2009, p. 1). Former Secretary of State Hillary Clinton condemned forced abortion at the Fourth World Conference on Women in Beijing (Clinton, 1995) and Felice Gaer, pro-choice director of the Jacob Blaustein Institute for the Advancement of Human Rights, labeled coerced abortion as fitting "into the definition of torture" (Starr, 2009).

Coercion in Sex Trafficking

According to Lederer and Wetzel (2014), "The prevalence of forced abortions is an especially disturbing trend in sex trafficking" (p. 73). Women and girls forced into

sex trafficking, and those who choose to work as prostitutes, may experience forced abortion (Abdulraheem & Oladipo, 2010; Acharya, 2008; Diep, 2006; Hoyle, Bosworth, & Dempsey, 2011; Zimmerman, Hossain & Watts, 2011). In 2011, the American Psychological Association (APA) established a task force on sex trafficking and its report acknowledged a need for research on the long-term effects of "forced abortions on survivors' sexual and reproductive health" (APA, 2013, p.21).

Women trafficked for sex are often subjected to multiple abortions, risking health problems (Cwikel, Chudakov, Paikin, Agmon, & Belmaker, 2004; U.S. Justice Department, n.d.). Some women are forced to abort during late pregnancy and to resume sex work only days later (Getu, 2006). According to a sex trafficking expert in Wichita, Kansas in the United States, pregnant women are in demand due to consumer fetishes. As a result, they carry their pregnancies nearly to term and are then forced to abort (personal communication, March 2014). Another expert in human trafficking confirmed this claim that forced abortion is directly related to pregnancy fetishes (personal communication, July 2014).

Trafficking of humans for sex has numerous serious public health implications (Huda, 2006; Lederer & Wetzel, 2014) including "sexually transmitted diseases, pelvic inflammatory disease, hepatitis and tuberculosis. Unwanted pregnancy, forced abortion, and abortion-related complications are other causes of health problems among trafficked persons" (Getu, 2006, p. 149; Zimmerman et al., 2011). Despite the increased risk for life-threatening health consequences, "Traffickers typically do not allow victims to seek health care—unless it is for an abortion, in which case, the cost of the abortion is added to any outstanding debt the woman owes" (Riegler, 2007, p. 243). Of those women who did report having seen a health care provider while being trafficked, only about one- half of them believed the doctor recognized they were sex workers and even then, doctors did not understand that the women were being trafficked (Lederer & Wetzel, 2014).

According to Stephen Wagner, former director of the Human Trafficking Program at the Department of Health and Human Services, "The mortality rate for someone in commercial sexual exploitation is 40 times higher than for a non-exploited person of the same age. Helping a victim return to exploitation more quickly by terminating a pregnancy increases the odds of death" (2011).

Coercion in War

During wartime, women are frequently subjected to sexual violence through rape, sexual slavery, forced pregnancy, forced sterilization, and forced abortion which may be used as a form of genocide (Amowitz & Reiss, 2004; Askin, 2003; Bennett, Bartlett, Olalunde & Amowitz, 2004). While several international treaties outlaw rape during war, they have not proven to be effective in protecting women (Aydelott, 1993). Women living in war zones may experience the compounded trauma of both coerced sex and coerced abortion.

Shame may be a powerful coercive force among women seeking abortion after being impregnated by wartime rape. Shortly after World War II, many Korean women who

were raped by Japanese soldiers died "either from untreated venereal disease, beatings, botched abortions, or the effects of deprivation" (Aydelott, 1993, p. 596). In the 1971 war between Bangladesh and West Pakistan, hundreds of thousands of Bengali women were raped by Pakistani soldiers (Neill, 2013). The racial differences "added to the shame and suffering of Bengali women who became pregnant after being raped, for it was made known in Bangladesh after the war that the Bengali women and the children they bore with Punjabi features would never be accepted back into Bengali culture" (p. 46). As a result, women felt extreme pressure to abort or resorted to infanticide or suicide.

In post war Germany, thousands of women in Berlin were raped by Soviet soldiers (Lichtblau, 2013; Anonymous, 2005). Grossmann (1995) notes that while nonmedical and noneugenic abortion was illegal in Germany, "the other side of harsh wartime regulations limiting abortion and access to contraceptives were secret directives permitting — or coercing — abortions on female foreign workers and women defined as prostitutes and non-"Aryans," as well as on the growing number of German women who became pregnant, via consensual sex or rape, by foreign workers or prisoners of war" (p. 52).

The development of PTSD among women who experience rape is well documented (Faravelli, Giugni, Salvatori, and Ricca, 2004, Kilpatrick, Edmunds, & Seymour, 1992; Rothbaum, Foa, Riggs, Murdock, and Walsh, 1992). When women become pregnant from rape and are forced or feel pressured to abort, they may be further traumatized. Future research is needed beyond individual case studies to determine the extent to which coerced abortion after rape may or may not contribute its own additional measure of trauma.

Another effect of war, limited access to basic resources, may create pressure on women to abort. The abortion rate rose steeply in Sarajevo while occupied by Serbian forces in 1993. Referring to her abortion, a Bosnian woman stated, "I would never do this in peacetime. And God knows I wanted this child, but there is no food for him in my house" (Meehan, 2012). After the 2003 invasion of Iraq resulted in a mass exodus of physicians, prenatal and obstetric care were severely limited. Many Iraqi women felt pressured to abort because they were "unable to get medical care for themselves and their unborn" (Meehan, 2012).

Environmental disasters are often caused by war. Even when they occur independently of war, they may pose another source of pressure for abortion. For example, following the Chernobyl nuclear accident in 1986, there were reports that induced abortion increased in the most contaminated areas (Pershagen, 1988). In Greece, it was estimated that 23% of pregnancies were aborted due to fears of fetal harm from radiation (Trichopoulus et al., 1987). Denmark also saw an increase in the rate of induced abortion in the months following the accident; "anxiety among the pregnant women and their husbands caused more fetal deaths in Denmark than the accident" (Knudsen, 1991, p. 229).

Forced abortion has also been reported to occur among women cadres of the Revolutionary Armed Forces of Columbia also known as the "FARC" (Stanski, 2005). Sexual

relations among male and female cadres are highly regulated. Females are required to use contraceptives, most frequently Norplant implants, injectable contraceptives, birth control pills, and condoms. Pregnancies are not allowed and abortions are forced upon women who do not voluntarily choose to abort. Some of the female members of the FARC, including minors, are also sexually exploited in a number of ways by their older male cadres.

Coercion or Pressure by Individuals

Male partners are frequently cited as the source of coercion (Broen et al., 2005; Hathaway, Willis, Zimmer & Silverman, 2005; Moore, Frohwirth & Miller, 2010) and may coerce women by threatening abandonment or even violence (Chamberlain & Levenson, 2012; Miller & Silverman, 2010). There have been a number of reports concerning women who were assaulted or murdered by the impregnating man because they would not submit to abortion (Blair, 2013; Clark, 2006; Dempsey, 2013; Jungen, 2013; Larrubia, 1998).

Coercion of minors by parents has also occurred. In a study of adolescent abortion, 18% of those minors whose parents found out about their pregnancies from a third party felt they were forced to abort and 6% of that same subset reported subjection to physical violence (Henshaw & Kost, 1992). Adolescent females may be especially vulnerable to coercion by parents, partners, or peers (Barglow & Weinstein, 1973) due to their dependency needs and developmental immaturity.

Coerced abortion has been used by adult men to hide incest or other sexual relationships with minor females (see, for example, Hutton, 2013). Some women, who sought abortion but then changed their minds, have been forced to abort by a provider who refused to stop the procedure (Bruce v. Hodari, 2009; Byer v. Doe, 2013; Gravely v. Stephens, 2013). The much publicized case against Dr. Kermit Gosnell included reports of such cases. The official grand jury report stated: "Gosnell began an abortion on a 29-week pregnant woman and then refused to take dilators out when the woman changed her mind" (Williams, 2011, p. 86). Two other patients who did not want to go through with the abortion were physically restrained, forcibly drugged, and subjected to abortion against their will (DiFilippo, 2011).

Some authors consider it important to distinguish between "coercion" and "pressure." However, the distinction is not often clear and these constructs may be conceptualized more accurately as a continuum. For example, in a study of male perpetrators of IPV, abusive men were significantly more likely to be involved in pregnancies ending in abortion than non-abusive men (Silverman et al., 2010). The extent to which this increase is due to actual coercion or to women feeling pressured was not determined. In some studies, the terms "pressure" and "coercion" are both used seemingly interchangeably, without either term being defined (Moore et al., 2010).

What is clear on both sides of the abortion debate is that both *coercion* (Allanson & Astbury, 1995; Franco, et al., 1989; Gibbons, 1984; Kero, Hogberg & Lalos, 2004; Moniq & Moron, 1982; Paul et al., 2009; Stotland, 2001, 2003; Turell, Armsworth &

Gaa, 1990; Zakus & Wilday, 1987) and *pressure* (Academy of Medical Royal Colleges, 2011; APA, 2008; Broen et al., 2005; Dagg, 1991; Kimport, Foster & Weitz, 2011; Major et al., 2009; Needle & Walker, 2008; Olson, 1980; Pope, Adler & Tschann, 2001; Stotland, 1997; Williams, 2001) are risk factors for women's psychological adjustment to abortion. Therefore, women who are screened for coercion and pressure are more likely to make autonomous decisions, receive needed support, and experience better outcomes. Screening is also likely to help identify women being exploited by traffickers and minors being sexually abused by adult males. Once identified, these women can be offered protection from further violence. In the National Abortion Federation's current textbook for abortion providers, "coercion" is included in a pre-abortion screening tool (Baker & Beresford, 2009).

Gendercide

Sex ratio imbalance was addressed at the Fourth World Conference on Women of the UN Commission on the Status of Women (1995) held in Beijing. Delegates included "prenatal sex selection and female infanticide" in their official definition of "violence against women." Former U.S. President Jimmy Carter (2014), in his recent book concerning women's rights, observed that 160 million fetuses have been aborted because they were female.

Little progress has been made in deterring the practice of gendercide through prenatal sex selection abortion. In an official report accepted by the European Parliament, Liisanantti & Beese (2012) noted the skewed sex ratios in many countries around the world including India, China, Vietnam, Albania, Azerbaijan, Georgia, Armenia, and among children of Asian parents in Great Britain, the United States, and Canada. Focusing on India and China, the authors identified three main factors: 1) falling fertility, 2) wide availability of ultrasound, allowing parents to learn the sex of their fetuses, and 3) a deeply entrenched preference for sons. In India, when ultrasound reveals a female fetus, "it is a societal norm that the family, particularly the mother-in-law and husband force the pregnant woman (to abort) and if she does not cooperate, she faces domestic violence and kicking on the abdomen. This is rampant in rich and poor, illiterate and educated" (interview with Vinita Shaw of the Disha Foundation, 2014).

Investigators are studying the problem of distorted sex ratios in various countries including China, where the ratio is "alarmingly skewed" in favor of males (Nie, 2011, p. 3), India, where males outnumber females by almost 40 million (Goldberg & Dooley, 2011), Vietnam (Becquet & Ceped, 2013), and several countries in Eastern Europe (Guilmoto & Duthe, 2013).

In her book, *Unnatural Selection,* Hvistendahl (2011) recounts how gender imbalances came about through advocates of population control and the development of technology to determine sex before birth. Hvistendahl identifies political individuals and organizations that actively supported using abortion for population control, including aborting primarily female fetuses. In commentary on Hvistendahl's book, Douthat (2011) states, "For many of these anti-population campaigners, sex selection was a

feature rather than a bug, since a society with fewer girls was guaranteed to reproduce itself at lower rates." Douthat also noted Hvistendahl's depiction of the "unlikely alliance between Republican cold warriors worried that population growth would fuel the spread of Communism and the left-wing scientists and activists who believed that abortion was necessary." Foster (1989) commented on population control as military strategy: "policymakers must … employ all the instruments of statecraft at their disposal (development assistance and population planning every bit as much as new weapon systems)" (p. 24). Abortion aimed at female fetuses may be considered by some as an acceptable and effective weapon.

An article in *The Economist* (2010) discussed societal consequences of gender imbalance. In China and India, rising crime rates are correlated with the increase in the ratio of males to females. Specifically, crimes against women such as rape, prostitution, and sex trafficking are becoming more prevalent. Both the United States Department of State (Lagon, 2008) and the Chinese Academy of Social Sciences have identified gender imbalance as a contributing factor to trafficking and forced prostitution (*China Faces Growing Gender Imbalance*, 2010). Thousands of Vietnamese women have been forcibly taken to China, compelled to work in brothels or sold as wives for Chinese men (Giang, 2002; Linh, n.d.). Women who are trafficked in India may be required to sleep with not just one man but "with his brothers as well" (Hvistendahl, 2011, p. 190). This was confirmed by Vinita Shaw who stated that in Haryana, India, it is a common practice for many brothers to share one woman as their wife (personal communication, July, 22, 2014).

Child marriage is increasing as women become increasingly scarce (Burns, 1998; Hvistendahl & Lindquist, 2008). Women sold to be brides often find themselves in abusive marriages. Among foreign wives living in Korea, 25% stated they felt physically threatened by their husbands (*Foreign Brides Rejuvenate Korea's Aging Society,* 2009). Forced marriage has become so common in Asia it is now recognized as a valid reason to petition for political asylum in the United States (Gao v. Gonzales, 2006). In countries where abortion is a form of discriminatory violence against unborn females, it appears to have precipitated even more violence against adult women and girls.

Suggestions for Future Research on Violence Prevention Strategies

Intimate Partner Violence

- Clarify the wide range of reported incidence of IPV during pregnancy which may be explained by differences in study designs, definitions and study populations (Shah & Shah, 2010).
- Identify the characteristics of male partners that may contribute to induced abortion among victims of IPV (Hall et al., 2014).
- Identify specific intermediate factors that may explain the association between IPV and abortion (e.g. fear, unintended pregnancy, pressure or coercion from male partners, pressure from others, stigma, shame, or other pressures related

to being an IPV victim). While multiple methodological approaches are available, qualitative research may be especially useful in identifying the influence of these intermediate factors.
- Develop and evaluate screening programs for victims of IPV in terms of success in identifying victims and protecting them from further violence including coerced abortion.
- Systematically evaluate the effectiveness of treatment programs for victims and/or perpetrators of IPV (Ellsberg & Heise, 2005; Hall et al., 2014; Stover, Meadows & Kaufman, 2009).
- Engage in large-scale, long-term studies to evaluate interventions aimed at reducing unintended pregnancy among women exposed to IPV (Miller et al., 2011).

Coercion

- Documentation of the extent and incidence of forced or coerced abortion globally.
- An exploration of the concept of "pressure" that identifies specific factors or conditions (e.g., economic, cultural, relational, intrapersonal, societal pressures from war or environmental disaster) that women perceive as causing them pressure to abort.
- Further examination of the long-term effects of coercion and pressure related to abortion on women's mental health.
- Development, implementation, and evaluation of screening tools to protect women from coerced and pressured abortion, and to provide evidenced-based support after abortion. Specifically, research needs to focus on how women should be screened, including (a) timing of screening, (b) method of screening, (c) questions aimed at uncovering coercion, and (d) the context in which screening occurs.
- Evaluations of legal interventions aimed at reducing sex trafficking and thereby reducing the number of sex-trafficked women who are coerced into abortion (e.g. Diep, 2006 notes that Sweden's criminalization of paying for sex services has dramatically reduced the number of women trafficked into Sweden).
- Evaluations of programs that train medical workers in general clinics and in abortion clinics to identify victims of sex trafficking.
- Explorations of the therapy needs of women who have been pressured or coerced into abortion and evaluations of therapy protocols developed for them.

Gendercide

- Identify psychological factors which influence the practice of gendercide.
- with quantitative and qualitative studies of attitudes among both citizens and medical professionals.

- Quantitative and qualitative studies of the immediate and long-term impact of gendercide via sex-selective abortion on women, men, couples, marital relationships, and siblings.
- Evaluations of interventions such as: compliance with international human rights laws (Tiefenbrun & Edwards, 2008), educational and public campaigns to raise awareness and improve the status of females (Manhas & Banoo, 2013), and financial incentives (Liisanantti & Beese, 2012) that may mitigate the practice of sex-selective abortions, thereby protecting unborn females and restoring normal sex-ratios.
- In-depth, qualitative studies to explore the experience of women who choose or are coerced to abort a fetus because of their shared gender. Such studies may be essential to recognize the effects on women's self-esteem, their sense of value as females, their mental health, and to identify women's therapeutic needs.
- Qualitative and quantitative studies to gather data concerning how sex-selective abortion affects women's attachment to and parenting of existing and future children and whether these vary depending on the children's sex.

Conclusion

There is a global awareness that violence against women is a serious and widespread issue and a growing consensus that this issue demands attention and intervention if women are to be protected. Intimate partner violence, reproductive coercion, and gendercide are all recognized forms of violence against women. Induced abortion is also a form of violence against women when it is forced upon women against their will or used to eliminate female fetuses.

Given that a considerable amount of the literature pertaining to IPV, reproductive coercion, and gendercide comes from disciplines other than psychology, the latter has a unique contribution to make on its own or in collaboration with other disciplines. Peace psychology in particular, with its emphasis on the causes of violence, may offer a most useful and appropriate context in which to study these topics and develop violence prevention strategies.

In an effort to be consistent with peace psychology's emphasis on conflict resolution, we have deliberately chosen to focus on areas where consensus is possible and prevention is vital. While heated debate may continue concerning the psychological aftermath of induced abortion, we believe that in the contexts of IPV, coerced abortion, and gendercide, there is a consensus upon which scientific studies and interventions can be developed that will protect women from violence and help those who have been victimized.

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