ELSEVIER

Women's Health Issues 19 (2009) 335–343

WOMEN'S HEALTH ISSUES

www.whijournal.com

VIOLENCE IN THE LIVES OF WOMEN IN ITALY WHO HAVE AN ELECTIVE ABORTION

Patrizia Romito, PhD[a,*], Vicenta Escribà-Agüir, PhD[b,c], Laura Pomicino, MA[d], Chiara Lucchetta, MA[e], Federica Scrimin, MD[e], and Janet Molzan Turan, PhD[f]

[a]*Department of Psychology, University of Trieste*
[b]*Centre for Public Health Research, Valencia, Spain*
[c]*CIBER Epidemiología y Salud Pública (CIBERESP), Spain*
[d]*University of Trieste, Trieste, Italy*
[e]*Institute for Maternal and Child Health- IRCCS "Burlo Garofolo," Trieste, Italy*
[f]*Department of Obstetrics, Gynecology, and Reproductive Sciences, University of California, San Francisco, California*

Received 1 March 2009; revised 16 July 2009; accepted 16 July 2009

Background. **Violence is an important health problem for pregnant women, with numerous studies showing that it may compromise maternal and infant health. Many women who seek an elective abortion (EA) live in difficult personal and social circumstances, in which violence often has a central role, yet few studies have analyzed the relationships between violence and having an EA.**

Objectives. **To analyze the role of family and partner violence among women seeking an EA, exploring the role of women's age, and controlling for sociodemographic factors.**

Methods. **An unmatched, case-control study was carried out in the Trieste Public Hospital, including all consecutive EAs ($n = 445$) and live births ($n = 438$). With an anonymous questionnaire, we collected information on sociodemographic characteristics, current violence (psychological, physical, and sexual) perpetrated by a partner or by other family members, and past violence.**

Results. **Compared with postpartum women, EA women were significantly more likely to report any type of current and past violence. Among women younger than 30 years old, adjusting for relevant social factors, partner psychological violence and family violence were strongly associated with EA, whereas among women 30 years old or older, there was no association with partner and family violence after adjustment.**

Conclusion. **These results highlight the role of violence in the lives of women, especially younger women, seeking an abortion, and the need for sensitive screening for partner and family violence among these women. Health professionals should be able to recognize violence among women seeking an EA and to support them.**

Introduction

Violence, mostly partner violence, is now considered to be among the most important health risk factors for women of reproductive age (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). Intimate partner violence (IPV) is a frequent occurrence: In a population-based study in the United States, 17.6% of women had experienced physical or sexual IPV in their lifetime (Coker, Davis, & Arias, 2002). In Italy, population data are not available; studies among patients show that prevalence is lower, but still substantial. In a sample of family doctors' female patients (aged 18–85 years), lifetime prevalence of IPV was 18%; in the last year, 4% of women had suffered physical or sexual IPV, and 8.3% psychological violence (Romito, Molzan Turan, & De Marchi, 2005); among hospital emergency department patients,

Supported by a grant from the Istituto di Ricovero e Cura Burlo Garofolo, Trieste. Janet Molzan Turan's work on this article was also supported, in part, by grant # *K01MH081777* from the U.S. National Institute of Mental Health (NIMH).

* Correspondence to: Prof. Patrizia Romito, Department of Psychology, University of Trieste, via S. Anastasio 12, 34100 Trieste, Italy; Phone: 0039 040 558 2772; Fax: 0404528022.

E-mail: romito@univ.trieste.it.

1049-3867/09 $-See front matter.
doi:10.1016/j.whi.2009.07.004

8.4% were currently experiencing physical or sexual violence by a partner or ex partner (Romito & Gerin, 2002).

Studies considering the role of violence in women's sexual and reproductive health have shown that IPV adversely affects sexual risk taking, contraceptive use, unplanned pregnancy, risk of sexually transmitted disease, and sexual function (Coker, 2007; Gazmararian et al., 1995; Winghood & Di Clemente, 1997). Other studies have shown that violence during pregnancy may compromise maternal and infant health (Coker, Sanderson & Dong, 2004; Murphy, Schei, Myhr, & Du Mont, 2001).

Yet, to date, fewer studies have analyzed the relationships between past and current violence and an elective abortion (EA). There are various possible links between these two events. Current violence limits the woman's agency concerning sexual intercourse and contraception (Fanslow, Whitehead, Silva, & Robinson, 2008), making an unwanted pregnancy more likely; in some cases, an unwanted pregnancy may be the result of rape (Wu, Guo, & Qu, 2005). In addition, a victim of violence may be more likely to terminate an unwanted or mistimed pregnancy than another woman, either by choice or forced by the aggressor (Bajos, Ferrand & the GINE Group, 2002). Past violence as experienced in childhood or adolescence within the family context is associated with risky sexual behavior and with having a violent partner (Fergusson, Horwood, & Lynskey, 1997), both circumstances increasing the probability of an EA.

The prevalence of IPV among women seeking an abortion is high. In the United States, Glander, Moore, Michielutte, and Parsons (1998) found that 39.5% of these women had a history of IPV; in another study (Woo, Fine, & Goetzl, 2005), 14% of EA patients reported partner abuse in the last year. Rates are higher among women with repeat terminations (Fisher et al., 2005; Wu et al., 2005). The few studies looking at the prevalence of violence in EA as compared with other patients show a higher prevalence among EA women. In a Canadian study (Bourassa & Bérubé, 2007), the probability of current IPV was much higher in the EA group (25.7%) than among women continuing the pregnancy (9.3%); the lifetime prevalence of violence was also significantly higher.

Although the role of violence in the decision to terminate a pregnancy is likely to be important, other social factors are involved. Compared with women continuing the pregnancy, women seeking an EA tend to be younger, have more children, and are more likely to be single, poorly educated, and unemployed (Bankole, Singh, & Haas, 1999; Finer & Henshaw, 2006). In various European countries, immigrants have higher abortion rates than nonimmigrant women (Rash et al., 2007).

Women in Italy have had the right to EA on demand, at no cost, since 1978, providing that the procedure is performed within the first 12 weeks of pregnancy. As in other countries, the abortion rate in Italy was highest in the years just after the act came into effect, and has steadily declined since: From 2003 to 2006, it was 11.1 per 1000 women aged 15 to 44 years, one of the lowest in the industrialized world (Ministero della Salute, 2008). This low rate is most likely explained by fertility control through contraception by Italian women, rather than by any stigma associated with abortion or to religious prescriptions. Today, 31.6% of EAs performed in Italy are among immigrant women (Spinelli, Figà Talamanca, & Lauria, 2000). In Italy, the total fertility rate is also very low, at 1.3 (the rate for Europe is 1.4, and for the developed world is 1.6; Ashford & Clifton, 2005).

A number of factors linked to an EA are also associated with being a victim of IPV. Studies in Europe have shown that having many children and being young, unmarried, poor, poorly educated, unemployed, and an immigrant are associated with experiencing violence by a partner or ex-partner (Condon & Schrottle, 2007; Walby & Allen, 2004). These factors are also linked to IPV during pregnancy (Saltzman, Johnson, Colley, & Goodwin, 2003; Saurel-Cubizolles & Lelong, 2005).

A limitation of the studies showing an excess of violence among women seeking an EA lies in the fact that these social factors are not controlled, making it difficult to disentangle the respective role of these factors and of violence in the path leading to an EA. Another shortcoming is that most studies include only physical and sexual IPV, whereas psychological violence against women is frequent and may be strongly associated with adverse health outcomes (Coker et al., 2002). Additionally, usually only violence by a partner (IPV) is considered, although the perpetrators of violence against women during pregnancy and the postpartum (PP) period may be also other relatives (Gielen, O'Campo, Faden, Kass, & Xue, 1994; Romito et al., 2009).

Age may be a key factor in the complex relationships between violence and abortion, because it is linked not only to EA and IPV, but also to violence by other relatives. In an Italian study (Romito & Gerin, 2002), younger women reported significantly more violence than older women, both by a partner or former partner and by other family members; violence by relatives was reported almost exclusively by women in the 18- to 24-year-old group.

The present study aims to analyze if the role of partner and family violence in the lives of women seeking an EA is different for women aged under 30 years and women aged 30 years or over, controlling for relevant sociodemographic variables, and hopes to overcome some of the aforementioned limits.

Method

An unmatched, case-control study was carried out in the only maternity hospital in Trieste (Italy), where all the births and abortions in the city take place. The

cases comprised all consecutive EAs (445) occurring from March 2006 to July 2007, performed at less than 12 weeks of pregnancy. The unmatched control group included all consecutive live births (438), occurring from March 2006 to August 2006 in the same hospital.

In Trieste Maternity Hospital, EAs are performed on an outpatient basis. Information was collected from women by means of an anonymous, self-administered questionnaire during their stay in the maternity unit, 2 days after giving birth (controls) and in the afternoon after the EA (cases). All eligible women were approached in their hospital room at a time when they did not have visitors, and asked to participate. The study was presented as research on the health of women during pregnancy and confidentiality of the responses was assured. Verbal informed consent was obtained from each participant, and each was given a letter explaining the purposes of the study and information about support resources (telephone hotlines, shelters, and other health and social services). The response rate was 93% among cases and 93% among controls. The study was approved by the Ethics Committee of the hospital.

Questions and measures

Besides sociodemographic information (age, number of living children, education, employment, living or not with a partner, financial problems, and nationality), we asked questions about current and past violence. We included three questions to evaluate psychological, physical, and sexual violence during the last 12 months, adapted from the Abuse Assessment Screen Questionnaire (McFarlane, Parker, Soeken, & Bullock, 1992), asking the woman in each case to identify the aggressors. Similar questions were asked concerning violence in childhood or adolescence. For current partner violence, we constructed a variable that categorized women according to whether they had experienced no violence, only psychological violence, or physical/sexual violence. For current family violence, because most of it was psychological and no sexual violence was reported, we constructed a variable combining psychological and physical violence. For past violence, we constructed a synthetic variable including any kind of violence experienced in childhood or adolescence.

For women who had an EA, we asked three questions concerning their agency, both in the decision to become pregnant and in opting for an abortion. First, among the questions inquiring about the context in which the pregnancy occurred, women were asked if "it was the partner who wanted her to become pregnant." Second, in a list of items concerning the reason for having an EA, women were asked if "the partner wanted a child, but they did not." Third, another question inquired if the woman had been pressured not to have an abortion.

Statistical analysis

After descriptive analyses, we fitted logistic regression models to estimate the associations between violence and EA vs. childbirth. Because in a previous study (Romito & Gerin, 2002) we found that the patterns of family violence were different according to women's age, we ran separate multivariate logistic regressions for women under 30 and women 30 years and older, adjusting for the other demographic and social factors known to be associated with both violence and EA: education, employment, economic problems, living alone, number of children, and nationality (Condon & Schrottle, 2007; Saltzman et al., 2003; Saurel-Cubizolles & Lelong, 2005; Walby & Allen, 2004). We chose these age categories on theoretical and statistical grounds: In Italy, the mean age for having a first child is over 29 years (Istat, 2008); with a lower age cutpoint, there were not enough PP women in this age group to run meaningful statistical analyses.

Adjusted odds ratios and 95% confidence intervals were the measures of association obtained after fitting these models. Analyses were conducted using SPSS software version 15 (SPSS, Inc., Chicago, IL).

Results

Description of the sample

The social and demographic characteristics of the women are presented in Table 1. As compared with PP women, EA patients were significantly more likely to be young, have no previous births, have a low educational level, lack regular employment, report financial problems, be living alone, and be non-Italians. The social characteristics of the EA and the PP samples correspond to national data concerning, respectively, women having an abortion and those giving birth in Northern Italy (Istat, 2008; Ministero della Salute, 2008). Non-Italian women in this sample belonged to 38 different nationalities, most from Eastern European countries.

The distributions of women according to current and past violence are shown in Table 2. Women seeking an EA were more likely to report any kind of violence. The percentages of women exposed to psychological violence by a partner in the last 12 months were 11.0% in the EA group and 2.5% among PP women; 4.6% versus 0.9%, respectively, experienced physical violence, and 1.8 versus 0.5 experienced sexual violence. Using the current definition of IPV, including physical or sexual violence, 5.5% of women with an EA were exposed to IPV compared with 1.1% of PP women (data not shown).

The percentages of women reporting current psychological family violence were 6.2% among EA women and 1.1% among PP women; 1.6% of EA and no PP women reported family physical violence. The percentages of women who experienced violence in

Table 1. Social and Demographic Characteristics of the Women Interviewed

	Elective Abortion			Childbirth	
	n	%	*p*	*n*	%
Total	445	100		438	100
Educational level			<.001		
University	54	12.2		137	31.3
High school	198	44.7		199	45.4
Less than high school	191	43.1		102	23.3
Employment status			<.001		
Regular employment	207	46.7		283	64.6
Irregular/unemployed/ student	177	40.0		75	17.1
Housewife	59	13.3		80	18.3
Financial problems			<.001		
No	277	63.2		363	83.1
Yes	161	36.8		74	16.9
Number of previous live births			.019		
0	299	67.6		257	59.1
1	109	24.7		144	33.1
≥2	34	7.7		34	7.8
Age (yrs)			<.001		
13–29	258	58.0		324	74.0
≥30	187	42.0		114	26.0
Living alone			<.001		
No	403	90.6		433	98.9
Yes	42	9.4		5	1.1
Nationality			<.001		
Italian	328	73.7		391	89.3
Non Italian	117	26.3		47	10.7

Table 2. Current and Past Violence Experienced by the Women Interviewed

	Elective Abortion			Childbirth	
	n	%	*p*	*n*	%
Total	445	100		438	100
Current male partner violence					
Psychological			<.001		
No	389	89.0		425	97.5
Yes	48	11.0		11	2.5
Physical					
No	418	95.4	<.001	432	99.1
Yes	20	4.6		4	0.9
Sexual			.056		
No	428	98.2		434	99.5
Yes	8	1.8		2	0.5
Current family violence					
Psychological			<.001		
No	411	93.8		431	98.9
Yes	27	6.2		5	1.1
Physical			.008		
No	431	98.4		436	100
Yes	7	1.6		0	.0
Violence in childhood or adolescence					
Psychological			.005		
No	392	89.9		414	95.0
Yes	44	10.1		22	5.0
Physical			.077		
No	389	89.2		404	92.7
Yes	47	10.8		32	7.3
Sexual			.074		
No	413	94.3		422	96.8
Yes	25	5.7		14	3.2

childhood or adolescence were also higher among women seeking an EA.

Table 3 shows the relationships of the synthetic violence variables with EA versus PP status, stratified by women's age. Among women under 30 years of age, current partner violence, current family violence, and violence in childhood were all significantly more frequent among women with an EA than among PP women. Among older women, only partner violence was significantly more frequent among women with an EA; family violence was rare in this age group.

Concerning EA women's agency in getting pregnant and having an abortion: 2% of those without partner violence, 7% of those with psychological violence, and 13% of those with physical or sexual violence reported that the conception had occurred because "the partner wanted her to become pregnant" ($p = .002$); 4.5%, 3.6%, and 21.7%, respectively, said that they decided to have an abortion because "the partner wanted a child, but they did not" ($p = .002$).

Multivariate results

The multivariate analyses revealed different patterns concerning violence for younger and older women (Table 4). In the under 30 years age group, the adjusted odds of having an EA were significantly higher—at 15.3—for women experiencing current psychological partner violence ($p < .05$), whereas partner physical/sexual violence was no longer associated with EA after adjustment. Women experiencing current family violence, mostly psychological, had also significantly higher odds—15.2—of having an EA ($p < .05$). Education, employment, nationality and number of previous live births were also associated with the probability of an EA.

In the 30 years and over age group, neither current partner violence nor family violence was associated with EA after adjustment. All the social factors considered—education, employment, financial problems, living alone, nationality, and number of previous live births—increased the probability of an EA.

Discussion

Results from this Italian study are unique in showing the role of partner and family violence in the lives of women—and especially of younger women—seeking an abortion.

Considering the whole sample, women having an EA are significantly more likely than women giving birth to report any current or past violence. They were also more likely to be poorly educated, without stable employment, with financial difficulties, living alone, and immigrants.

Table 3. Current and Past Violence Experienced by the Women, by Women's Age

	Elective Abortion			Childbirth	
	N	%	*P*	N	%
Women <30 years old ($n = 301$)					
Total	187	100		114	100
Current male partner violence					
None	154	85.1		109	95.6
Only psychological	16	8.8		1	0.9
Physical or sexual	11	6.1		4	3.5
			.009		
Current family violence					
Psychological or physical family violence					
No	158	86.3		113	99.1
Yes	25	13.7		1	0.9
			<.001		
Violence in childhood or adolescence					
Any violence					
No	140	76.1		102	89.5
Yes	44	23.9		12	10.5
			.004		
Women ≥30 years old ($n = 582$)					
Total	258	100		324	100
Current male partner violence					
None	229	90.2		315	97.8
Only psychological	12	4.7		6	1.9
Physical or sexual	13	5.1		1	0.3
			.001		
Current family violence					
Psychological or physical family violence					
No	253	99.2		318	98.8
Yes	2	0.8		4	1.2
			.590		
Violence in childhood or adolescence					
Any violence					
No	220	87.6		283	87.9
Yes	31	12.4		39	12.1
			.931		

Analysis of the relationships between violence and EA versus birth, stratified for women's age, reveals a more complex picture. Only among women under 30 years of age are the differences between EA and PP women significant, with EA women reporting more partner, family, and childhood violence than new mothers. Among the women 30 years of age or older, only partner violence is significantly more frequent among women having an abortion. Noticeably, family violence is a frequent occurrence only among younger women with an abortion (13.7%), whereas it is almost nonexistent among older women and women giving birth.

Multivariate results confirm that violence may play a different role according to the women's age. Among the younger women, taking into account demographic and social factors, psychological partner violence and family violence, mostly psychological, remained associated with EA status: The adjusted odds of having an EA versus giving birth were 15.3 for women exposed to psychological partner violence and 15.1 for those exposed to family violence; partner physical/sexual violence was no longer associated with EA after adjustment. Education, employment, nationality, and number of previous live births also increased the probability of an EA; the odds of having an EA were higher also for women with financial problems and living alone, although, probably because of the small numbers of women involved, the associations became nonsignificant after adjustment.

Among older women, neither current partner violence nor family violence were associated with EA after adjustment, whereas all the demographic and social factors included in the model increased the probability of an EA.

These results are striking for several reasons. While it is known that victimization is more frequent among young women (Walby & Allen, 2004), and that young women are more likely to seek an EA (Finer & Henshaw, 2006), our results indicate that for young women, violence may have an important role in the process of opting for an abortion.

Equally noticeably, these results reveal the importance of psychological violence and violence by relatives other than the partner, phenomena that have been neglected in previous studies, which have mostly

Table 4. Multivariate Regression Models for the Association between Elective Abortion and Violence and Social Factors by Women's Age (N = 853)

Variable	Women <30 Years Old ($n = 289$)		Women ≥30 Years Old ($n = 564$)	
	Adjusted OR	95% CI	Adjusted OR	95% CI
Current male partner violence				
None	1		1	
Only psychological	15.31	1.72–135.74*	0.60	0.15–2.36
Physical or sexual	0.61	0.13–2.84	5.76	0.63–52.12
Current family violence				
No	1		1	
Yes	15.19	1.72–134.42*	0.10	0.008–1.29
Violence in childhood/adolescence				
No	1		1	
Yes	1.68	0.70–4.05	0.48	0.23–1.01
Educational level				
University	1		1	
High school	1.72	0.76–3.86	2.13	1.22–3.72**
Less than high school	3.96	1.64–9.55**	3.34	1.81–6.16***
Woman's employment				
Regular employment	1		1	
Irregular/unemployed/student	3.40	1.78–6.48***	1.58	0.86–2.88
Housewife	0.20	0.08–0.53**	0.43	0.22–0.83*
Economic problems				
No	1		1	
Yes	1.68	0.86–3.30	2.52	1.47–4.32***
Living alone				
No	1		1	
Yes	4.39	0.46–41.17	24.19	7.61–76.84***
Nationality				
Italian	1		1	
Other	2.32	1.08–5.02*	3.44	1.73–6.85***
Number of previous live births				
0	1		1	
1	0.72	0.34–1.54	2.34	1.41–3.88***
≥2	8.23	1.89–35.85**	16.78	9.05–31.12***

Abbreviations: CI, confidence interval; OR, odds ratio.
* $p < .05$.
** $p < .01$.
*** $p < .001$.

focused on physical and sexual partner violence. Yet, there is evidence that psychological violence—being called names, humiliated, denigrated, controlled—may have an effect on women's health as great or even greater then physical or sexual violence (Coker et al., 2002; Romito, et al., 2005), and it is not surprising that it can also affect the abortion decision.

As far as abuse by other relatives is concerned, when it is asked about, results show that it is frequent and can be harmful, and not only in a family-oriented country such as Italy (Gielen et al., 1994; Pinnelli, Racioppi, & Terzera, 2007). Romito et al. (2009) found that family violence was even more strongly associated with PP depression than partner violence. John, Johnson, Kukreja, Found, and Lindow (2004), in Great Britain, inquiring about violence among gynecology patients, found that the father ranked high in the list of perpetrators, higher than the husband (the most frequent perpetrators being ex-husbands or ex-boyfriends). In this study as well, perpetrators of family violence were mostly the woman's own parents.

There are several possible explanations for the links between partner and family violence and abortion among younger women. Women's agency in sexual and contraceptive choices is limited by partner violence, and it is not surprising that women resort to abortion when intercourse or the pregnancy have been imposed, or when they know that the partner is not caring or accountable. Moreover, although from our data it seems that violent men tend to force the women to continue the pregnancy, other studies suggest that some violent men may, on the contrary, force the women to get a termination (Bajos et al., 2002). Concerning family violence, a woman who is maltreated as a daughter may prefer to avoid the risk of saddling a child with the unhappiness she is facing; parental abuse may also shatter a woman's self-esteem, leading her to doubt her capacities as a mother (Phillips, 2005; Romito, Crisma, & Saurel-Cubizolles, 2003); it is also possible that, for some very young women, violence by relatives is the consequence, and not an antecedent, of an untimely pregnancy.

The prevalence of partner physical or sexual violence (IPV) against women in the EA group in the last year found in this study, 5.5%, was near to what was found in Canada, 7% (Bourassa & Bérubé, 2007), and lower than what was found in Texas, 14% (Woo et al., 2005). Among PP women, only 1.1% reported IPV, a figure similar to the 1% found in Central and South European countries and in Japan (Garcia-Moreno et al., 2006; Saurel-Cubizolles & Lelong, 2005). Because violence is more common among younger women, the comparison of rates of violence in pregnancy should, to be meaningful, take into account the age structure of the samples.

Another, more alarming, hypothesis is that some victims of violence were "switched" from the EA to the PP group—therefore diminishing the strength of the associations between violence and EA—because they were forced, against their wishes, to continue the pregnancy. Forcing the pregnancy and then impeding the abortion may represent an abusive man's strategy to control the woman (Bajos et al., 2002). Among the EA-seeking women in this study, those with partner violence, and especially physical or sexual violence, were more likely to say that the pregnancy was imposed by the partner. Although the small numbers impose great caution in interpreting these data, they suggest that the more seriously victimized women may experience problems in obtaining an abortion.

This study has limitations and strengths. The risk of underreporting of violence cannot be excluded. This risk may be higher in the PP group, owing to the stigma and shame associated with being a victim of violence during pregnancy and a desire to deny negative events leading to the birth of a child. Hopefully, the procedure for data collection—anonymous and self-administered questionnaires, completed when the woman had no visitors or staff in the room—should have minimized this possibility. In addition, the smaller sample sizes for within age group analyses, leading to some unreliability of estimates and wide confidence intervals, represents another limitation of the study.

One challenge of case-control studies lies in the difficulty of finding appropriate, unbiased controls. Women who have just given birth may not be an unbiased control group. In the Trieste region, where the research was conducted, the total fertility rate is even lower than in the rest of the country (Istat, 2008), and abortion services are freely accessible. It is possible that, in a social context where not having children is both culturally acceptable and practically possible, only women who are in nonviolent couple relationships decide to have a baby; this would explain the low rate of couple violence among PP women found in this as well in a previous Italian study (Romito, Molzan Turan, Lucchetta, & Scrimin, 2007). However, there is no other potential control group in which it would be possible to examine the factors associated with violence during pregnancy.

Strengths of our study include the fact that cases and controls were, respectively, consecutive EA and consecutive births; both coming from the same hospital—the only maternity hospital in the city—and were interviewed in the same time period; in addition, the response rate was the same in the two groups, and very high (93%).

Unique strengths of the study consist in having examined the role of psychological violence and of violence by other relatives, in having explored the differences between younger and older women, and in having controlled for women's social characteristics. Moreover, this is one of the very few studies on violence and abortion carried out in Southern Europe. The generalization of the results, and more particularly the interactions between violence, age and abortion, to women in other countries can be only tentative. However, the results of all studies on phenomena shaped by the social, cultural, and psychological environment, such as violence against women and EA, are at least partly context dependent: Whereas most studies find some common elements—such as young age as a risk factor—it is possible that other elements and relationships vary according the specific context of the study.

Many women who seek an EA live in difficult personal and social circumstances, in which violence often has a central role. They may seek abortion as a last resort, a rational and at times empowering choice when they evaluate that safe parenting is precluded (Fergusson, Boden & Horwood, 2007; Jacoby, Gorenflo, Black, Wunderlich, & Eyler, 1999; Russo & Denious, 2001). In other cases, they may be forced under threat of violence by their partners or other relatives either to terminate the pregnancy, or to continue it against their wishes. Limited ability of health professionals to recognize such situations can have life threatening implications for the women involved (Campbell, 1998).

The public health implications of this study are several. There is a need for sensitive screening for partner and family violence, especially among women seeking an EA and among young women (Parsons, Goodwin, & Petersen, 2000). These women often interact with a variety of health providers: social workers, psychologists, nurses, family doctors, anesthesiologists, and gynecologists. All these professionals should be adequately informed and trained to be able to support them, helping them to escape violence, prevent further harm, and maintain or regain control over their lives.

Acknowledgements

The authors thank to the women who participated in the study; the hospital personnel; Lisa Bacchia, Irene Badina, Erinda Bartoli, and Elisa Lombardi, who participated in data collection; and the two reviewers for their insightful and useful comments.

References

Ashford, L., & Clifton, D. (2005). Women of our world (2005) Population Reference Bureau. Available. www.prb.org/2005women. Accessed June 2008.

Bajos, N., Ferrand, M., & , the GINE Group. (2002). *De la contraception à l'avortement (From contraception to abortion)*. Paris: INSERM.

Bankole, A., Singh, S., & Haas, T. (1999). Characteristics of women who obtain induced abortion: A worldview review. *International Family Planning Perspectives*, 25(2), 68–77.

Bourassa, D., & Bérubé, J. (2007). The prevalence of intimate partner violence among women and teenagers seeking abortion compared with those continuing pregnancy. *Journal of Obstetrics and Gyenaecology Canada*, 29, 415–423.

Campbell, J. (1998). *Empowering survivors of abuse. Health care for battered women and their children*. Thousand Oaks, CA: Sage.

Coker, A., Davis, K., & Arias, I. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine*, 23, 451–457.

Coker, A., Sanderson, M., & Dong, B. (2004). Partner violence during pregnancy and risk of adverse pregnancy outcomes. *Paediatric and Perinatal Epidemiology*, 18, 260–269.

Coker, A. (2007). Does physical intimate partner violence affect sexual health? A systematic review. *Trauma, Violence and Abuse*, 8, 149–177.

Condon, S., & Schrottle, M. (2007). Ethnicité et violences: Regards croisés entre l'Allemagne et la France. In S. Condon, & M. Jaspard (Eds.), *Nommer et compter les violences envers les femmes en Europe* (pp. 147–156). Paris: IDUP.

Fanslow, J., Whitehead, A., Silva, M., & Robinson, E. (2008). Contraceptive use and associations with intimate partner violence among a population-based sample of New Zealand women. *Australia and New Zealand Journal of Obstetrics and Gynaecology*, 48, 83–89.

Fergusson, D., Boden, J., & Horwood, J. (2007). Abortion among young women and subsequent life outcomes. *Perspective on Sexual and Reproductive Health*, 39(1), 6–12.

Fergusson, D., Horwood, J., & Lynskey, M. (1997). Childhood sexual abuse, adolescent sexual behavior and sexual revictimization. *Child Abuse and Neglect*, 21, 789–803.

Finer, L., & Henshaw, S. (2006). Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspective on Sexual and Reproductive Health*, 38(2), 90–96.

Fisher, W., Singh, S., Shuper, P., Carey, M., Otchet, F., MacLean-Brine, D., et al. (2005). Characteristics of women undergoing repeat induced abortion. *Canadian Medical Association Journal*, 172, 637–641.

Garcia-Moreno, C., Jansen, H., Ellsberg, M., Heise, L., & Watts, C. (2006). *WHO* Multi-country study on women's health and domestic violence. Available. Geneva, Switzerland: World Health Organization. http://www.who.int/gender/en.

Gazmararian, J. A., Adams, M. M., Saltzman, L. E., Johnson, C. H., Bruce, F. C., Marks, J. S., et al. (1995). The relationship between pregnancy intendeness and physical violence in mothers of newborns. *Obstetrics and Gynecology*, 85, 1031–1037.

Gielen, A. C., O'Campo, P. J., Faden, R. R., Kass, N. E., & Xue, X. (1994). Interpersonal conflict and physical violence during the childbearing year. *Social Science and Medicine*, 39, 781–787.

Glander, S., Moore, M., Michielutte, R., & Parsons, L. (1998). The prevalence of domestic violence among women seeking abortion. *Obstetrics and Gynecology*, 91, 1002–1006.

Istat. (2008). Natalità e fecondità della popolazione residente—Anno 2006. Statistiche in breve. Roma: Istituto Italiano di Statistica.

Jacoby, M., Gorenflo, D., Black, E., Wunderlich, C., & Eyler, E. (1999). Rapid repeat pregnancy and experiences of interpersonal violence among low-income adolescents. *American Journal of Preventive Medicine*, 16, 318–320.

John, R., Johnson, J., Kukreja, S., Found, M., & Lindow, S. W. (2004). Domestic violence: prevalence and associations with gynaecological symptoms. *British Journal of Obstetrics and Gynecology*, 111, 1128–1132.

McFarlane, J., Parker, B., Soeken, K. L., & Bullock, L. (1992). Assessing for abuse during pregnancy. Severity and frequency of injures and associated entry into prenatal care. *JAMA*, 267, 3176–3178.

Ministero della Salute. (2008). Relazione sull'attuazione della legge contenente norme per la tutela sociale delal maternità e per l'interruzione volontaria di gravidanza (legge 194/78). Available. www.Ministerosalute.it. Accessed June 2008.

Murphy, C. C., Schei, B., Myhr, T. L., & Du Mont, J. (2001). Abuse: a risk factor for low birth weight? A systematic review and meta-analysis. *Canadian Medical Association Journal*, 164, 1567–1572.

Parsons, L., Goodwin, M. M., & Petersen, R. (2000). Violence against women and reproductive health: Toward defining a role for reproductive health care services. *Maternal and Child Health Journal*, 4, 135–140.

Phillips, S. (2005). Violence and abortions: What's doctor to do? *Canadian Medical Association Journal*, 172. 653–467.

Pinnelli, A., Racioppi, F., & Terzera, L. (2007). *Genere, famiglia e salute*. Milano: Angeli.

Rash, V., Gammeltoft, T., Kudsen, L. B., Tobiassen, C., Ginzel, A., & Kempf, L. (2007). Induced abortion in Denmark: Effects of socio-economic situation and country birth. *European Journal of Public Health*. [serial online]. Available: http://eurpub.oxfordjournals.org. Accessed June 2008.

Romito, P., Crisma, M., & Saurel-Cubizolles, M. J. (2003). The consequences of parental violence against female children on adult behavior and socio-demographic indicators. *Child Abuse and Neglect*, 27, 1127–1144.

Romito, P., & Gerin, D. (2002). Asking patients about violence: a survey of 510 women attending social and health services in Trieste, Italy. *Social Science and Medicine*, 54, 1813–1824.

Romito, P., Molzan Turan, J., & De Marchi, M. (2005). The impact of current and past interpersonal violence on women's mental health. *Social Science and Medicine*, 60, 1717–1727.

Romito, P., Molzan Turan, J., Lucchetta, C., & Scrimin, F. (2007). Violences envers les femmes autour d'une naissance: Une étude dans une ville italienne. In S. Condon, & M. Jaspard (Eds.), *Nommer et compter les violences envers les femmes en Europe. Actes du colloque scientifique de La Sorbonne—26 septembre 2005, dir Cahrv-Idup-Ined*. Paris: La Sorbonne.

Romito, P., Molzan Turan, J., Neilands, T., Lucchetta, C., Pomicino, L., & Scrimin, F. (2009). Violence and women's psychological distress after birth: An exploratory study in Italy. *Health Care for Women International*, 30, 160–180.

Russo, F. N., & Denious, J. (2001). Violence in the lives of women having abortions: implications for practice and public policy. *Psychology: Research and Practice*, 32(2), 142–150.

Saltzman, L. E., Johnson, C. H., Colley Gibert, B., & Goodwin, M. M. (2003). Physical abuse around the time of pregnancy: An examination of prevalence and risk factors in 16 States. *Maternal and Child Health Journal*, 7, 31–43.

Saurel-Cubizolles, M. J., & Lelong, N. (2005). Violences familiales pendant la grossesse. *Journal de Gynecologie, Obstetrique et Biologie de la Reproduction*, 34(Suppl. 1). 2S47–2S53.

Spinelli, A., Figà Talamanca, I., Lauria, L., & , European Study Group on Fertility and Subfecundity. (2000). Patterns of contraceptive use in 5 European countries. *American Journal of Public Health*, 90, 1403–1408.

Walby, S., & Allen, J. (2004). Domestic violence, sexual assault and stalking: Findings from the British Crime Survey. London: Home Office Research, Development and Statistics Directorate.

Winghood, G. M., & DiClemente, R. J. (1997). The effects of an abusive primary partner on the condom use and sexual negotiation practices of African-American women. *American Journal of Public Health*, 87, 1016–1018.

Woo, J., Fine, P., & Goetzl, L. (2005). Abortion disclosure and the association with domestic violence. *Obstetrics and Gynecology*, 105, 1329–1334.

Wu, J., Guo, S., & Qu, C. (2005). Domestic violence against women seeking an induced abortion in China. *Contraception*, 72, 117–121.

Author Descriptions

Patrizia Romito, PhD, is a professor of Psychology at the University of Trieste, Italy. She has extensive research experience in women's mental health and violence. She is the author of "A deafening silence: Hidden violence against women and children" (2008).

Vicenta Escribà-Agüir, PhD, is a medical doctor and epidemiologist at the Centre for Public Health Research, Valencia and the CIBERESP, Spain. Her current research program focuses on gender differences in health and violence against women.

Janet Molzan Turan, PhD, MPH, is an Assistant Professor in the Department of Obstetrics, Gynecology, and Reproductive Sciences at the University of California, San Francisco. Her current research program examines the effects of stigma and violence on women's reproductive health.

Federica Scrimin, MD, is a gynecologist in the Department of Obstetrics and Gynecology, at the Public Institute for Research, Burlo Garofolo, Trieste, Italy. The main focus of her research is conservative medical or surgical treatments as alternatives to hysterectomy.

Chiara Lucchetta, MA, a psychologist, is completing her training as a cognitive behaviorial psychotherapist and currently works in primary care services in Trieste, Italy. Her main research interests are violence against women and psychosocial counseling.

Laura Pomicino, MA, is a psychologist and PhD candidate in the Department of Reproductive and Developmental Sciences, University of Trieste, Italy. She is currently conducting a RCT to evaluate an intervention for fathers, aiming to promoting wellbeing after childbirth.