

# Sexist Ideology and Endorsement of Men's Control Over Women's Decisions in Reproductive Health

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Aino Petterson<sup>1</sup> and Robbie M. Sutton<sup>1</sup>

## Abstract

Feminist scholars have argued that men's control over women's reproductive autonomy is a central feature of male dominance. Building on recent research that shows sexist ideology informs support for restricting women's reproductive autonomy, we examined the relation of sexism and the belief that men should be able to restrict the behavior of women. Study 1 ( $N = 366$  undergraduate psychology students in the United Kingdom) and Study 2 ( $N = 281$  Amazon Mechanical Turk workers in the United States) showed that controlling for various demographics and ideological measures (e.g., right-wing authoritarianism, support for abortion rights), hostile sexism was related to support for men having the right to prevent their pregnant partner from having an abortion. Further, hostile sexism was related to the endorsement of men's right to withdraw financial support for the child if a woman chooses not to terminate her pregnancy. Hostile sexism was also uniquely related to support for men's right to veto their female partner's decisions during pregnancy and childbirth. The present studies show that hostile sexism is associated with perceptions that men have the right to constrain women's reproductive choices. Our findings highlight the adverse pressures on women's reproductive autonomy, including sexist ideology, and may suggest that practitioners should be mindful of this when assisting women in discussing reproductive questions. Further, by creating awareness about the different factors that shape the perception of men's role in reproductive decisions, sexual health educators could potentially help affirm women's autonomy in reproductive health. *Additional online materials for this article (measures used in this study) are available on PWQ's website at <http://journals.sagepub.com/doi/suppl/10.1177/0361684317744531>. Data files, together with syntax detailing the statistical analyses, are available at <https://osf.io/vwjus/>. Online slides for instructors who want to use this article for teaching are available on PWQ's website at <http://journals.sagepub.com/page/pwq/suppl/index>*

## Keywords

sexism, reproductive health, pregnancy, abortion

Two days after his inauguration, President Trump, flanked by six men, signed an executive order restricting funding for reproductive health organizations that provide information about and access to abortions. The image rapidly went viral and was seen by many commentators as an emblem of men's control over women's reproductive decisions. In response, a French feminist group called "52" launched a satirical image of Hillary Clinton and six women enacting legislation to ban all male ejaculations for purposes other than procreation. The parody was described by one of its creators "as a joke to ridicule something that boggles the mind: For centuries, it's been men who dictate women's bodies" (Kirschen, 2017).

Scholars have argued that because men have enjoyed structural power over women, but also depend on their ability to bear children, men have sought to exert control over women's sexuality and fertility (Glick & Fiske, 1996; Rothman, 1994; Rudman, Fetterolf, & Sanchez, 2013). In recent decades, most developed countries have, to varying degrees, supported women's reproductive autonomy through advice and access to safe abortion and contraception (Center for

Reproductive Rights, 2017). Nonetheless, male control continues to be exerted at the institutional level (e.g., in political, religious, and medical institutions dominated by men) and at the intimate, domestic level (e.g., in powers invested in fathers and spouses to influence, veto, and control women's decisions).

Male control over abortion is formally instituted in the laws of some countries, including Turkey, Japan, and South Korea, where spousal authorization is required for women to have abortions (Center for Reproductive Rights, 2017). In both the United Kingdom and the United States, some men have tried to stop their partners from having their pregnancies terminated (British Broadcasting Corporation, 2001; *The*

<sup>1</sup> School of Psychology, University of Kent, Canterbury, Kent, UK

## Corresponding Author:

Aino Petterson, School of Psychology, University of Kent, Canterbury, Kent CT2 7NP, UK.

Email: [a.i.petterson@kent.ac.uk](mailto:a.i.petterson@kent.ac.uk)

*Herald*, 1997). Efforts to achieve male control over women's reproductive autonomy do not stop at abortion: After a law was passed in China stating that a woman did not have any greater priority than a man in deciding to have a child, a man sued his wife for violating his right to have a child (Maximova, 2002). Male control is also evident in other aspects of women's reproductive decision making such as medical screening, interventions during pregnancy, and childbirth procedures, over which men, in different countries, are afforded varying degrees of control (Dudgeon & Inhorn, 2004). For example, in a recent survey of over 27,000 Nigerian women, only 6.2% reported making their own decisions about health care (Osamor & Grady, 2017).

### **Ambivalent Sexism and Women's Reproductive Autonomy**

Despite men's ongoing control over abortion and other reproductive decisions, research has not addressed the attitudes that underpin it. Recently, researchers have examined the ideological basis of opposition to abortion per se, which is an integral aspect of women's reproductive autonomy. This research indicates that opposition to abortion is related to sexist ideology, as described by Glick and Fiske's (1996) ambivalent sexism theory. Hostile sexism embodies negative attitudes toward women, tied to the perception that women use their sexuality and feminism to gain power over men. Conversely, benevolent sexism comprises subjectively positive, but patronizing attitudes that depict women as morally pure and deserving of men's affection and protection (Glick & Fiske, 2001). Sexist ideology has been found to explain "left-right" differences in opposition to abortion (Hodson & MacInnis, 2017), to predict anti-choice attitudes (Huang, Osborne, Sibley, & Davies, 2014), and to be a part of the anti-choice discourse (Duerksen & Lawson, 2017).

Studies have consistently shown that endorsement of ambivalent sexism is associated with negative attitudes toward abortion (Begun & Walls, 2015; Huang et al., 2014; Huang, Davies, Sibley, & Osborne, 2016; Osborne & Davies, 2012). Based on these findings, Huang, Davies, Sibley, and Osborne (2016) have argued that ambivalent sexism serves to restrict women's autonomy in reproductive decisions. However, this research does not provide an answer to the question, who is perceived as having the right to impose restrictions on women's reproductive choices?

Ambivalent sexism has also been associated, beyond the abortion issue, with support for other restrictions on women's reproductive autonomy. Sutton, Douglas, and McClellan (2011) have shown that ambivalent sexism, and especially the subscale benevolent sexism, is related to support for restricting autonomy over women's diet, exercise, and lifestyle choices during pregnancy, even when these decisions (e.g., drinking tap water, working out) have little or no objective effect on fetal welfare or developmental outcomes. Ambivalent sexism has also been found to relate to punitive

attitudes to women whose choices are perceived to put the fetus at risk (Murphy, Sutton, Douglas, & McClellan, 2011). However, this research, like research on attitudes to abortion, investigates support for the placement of restrictions on women's reproductive autonomy but does not address who has the right to place those restrictions and, in particular, whether men are seen as having the right to do so.

### **Male Control Over Women's Reproductive Autonomy**

At first glance, the belief that women should have limits placed on their reproductive autonomy may seem very closely, even tautologically, related to the belief that men should be able to place those limits. We can expect both beliefs to be positively related in many cases. For example, one might expect opposition to abortion rights to be related to the belief that a woman's spouse should be able to veto her decision to have an abortion. At the same time, proponents of abortion rights frequently object to men exerting control over abortion, which they see as a matter of choice for women (Sheldon, 1993). In the example of Donald Trump's executive order, it was precisely men's control in determining women's reproductive health outcomes that many objected to (Kirschen, 2017).

However, there are several reasons to suspect that the relation is more complicated. Opponents of abortion seldom describe their position as being motivated to preserve male control over women. More typically, they couch their position as a desire to protect the fetus, and often the pregnant woman herself, without explicit reference to who should be responsible for restricting abortion (Duerksen & Lawson, 2017; Hodson & MacInnis, 2017). Thus, whether abortion should be restricted, and who has the right to restrict it, may be separate in people's minds.

Recently, a distinction between opposition to abortion per se and the notion that men have rights in reproductive decision-making has been made. Some political groups are advocating for "financial" or "legal" abortion (Taylor, 2016), including some who call themselves "men's rights' activists" (Gibbs, 2006; Sheldon, 2003) and who believe feminist ideology has disempowered men (Schmitz & Kazyak, 2016). Although the details of financial abortion vary, its supporters argue that men should have a right to opt out from the legal and financial obligations of an unwanted child, usually before the child is born (McCulley, 1998). The term "financial abortion" implies an equivalence between a woman's decision to have an abortion and a man's decision not to support a child: If women have the right to the former, the argument goes, men should have the right to the latter. Proponents of the so-called financial abortion often frame it in egalitarian terms (Deveny, 2016; McCulley, 1998). D'Agostino (as cited in Leving, 2016, n.p.) contends, "Since the father will have the responsibility of child support, he should have rights

regarding the birth or destruction of the fetus.” As outlined by Brake (2005, p. 63),

If abortion is permitted, legally compelling child support might be thought unjust because it creates an asymmetry in legal rights and responsibilities between men and women. Such a system rightly allows women to decide whether to become mothers, but does not allow men to decide whether to become fathers.

On one hand, the discourse of financial abortion seems to tolerate or take for granted women’s legal right to an abortion. In practice, it encourages women to have an abortion by creating a strong financial disincentive for women to carry a fetus to term (Sheldon, 2003). In this respect, financial abortion appears to be at odds with opposition to abortion. On the other hand, it promotes men’s agency in reproductive decision-making and diminishes women’s. Thus, the impulse to restrict women’s autonomy in favor of men’s may lead some people to oppose abortion but also to support financial abortion. Nevertheless, since each is an infringement on women’s autonomous decision-making, both are problematic.

### The Current Research

Applying the logic of ambivalent sexism theory, we examined whether men’s perceived right to exert control in reproductive decisions is related to hostile and benevolent sexism. We hypothesized that, insofar as hostile sexism is concerned with male control and freedom from commitment to heterosexual relationships, it opposes women’s autonomy. This will likely be manifested in the desire for men to have control over decisions related to pregnancy and abortion.

In contrast, since benevolent sexism is concerned with the protection of women and endorses men’s commitment to heterosexual relationships, it may fuel perceptions of men’s rights only where they can be justified in paternalistic (protective) terms (Moya, Glick, Expósito, de Lemus, & Hart, 2007). These risks are particularly salient in medical scenarios related to pregnancy and childbirth, which involve decisions about procedures such as pre-natal screening and analgesia during pregnancy. Conversely, since benevolent sexism explicitly suggests that men should make financial sacrifices for their partners, it may actually be antagonistic to financial abortion.

In examining the relation between ambivalent sexism and support for men’s control over women’s reproductive autonomy, it is important to adjust for confounding variables. One factor that may influence how ambivalent sexism is related to the endorsement of men’s control is a person’s stance on abortion rights. By default, support for abortion rights entails the endorsement of women’s right to make autonomous reproductive decisions. Thus, we expected that support for abortion would be negatively related to support for men’s right to prevent their partners from having abortions or exert

control over reproductive decisions in other ways. We also expected that support for abortion rights would, if at all, be positively related to the endorsement of men’s right to withdraw funding if his partner chooses not to have an abortion (i.e., financial abortion) due to the emphasis on the autonomy of the individual (Johnston, 2003). Further, previous research has found higher levels of religiosity and “right-wing authoritarianism” (RWA) to be predictors of sexism and opposition to abortion (Burn & Busso, 2005; Sibley, Wilson, & Duckitt, 2007). Consequently, these should also be adjusted for.

Based on this theoretical framework of the complementary functions of hostile and benevolent sexism, we made the following hypotheses:

**Hypothesis 1:** Hostile sexism, when adjusting for benevolent sexism, will be positively related to the endorsement of men’s control and influence over abortion and other reproductive decisions. We included the belief that men should have both a right to veto abortions and a right to withdraw financial support from partners who choose not to have an abortion.

**Hypothesis 2:** Benevolent sexism, when adjusting for hostile sexism, will be positively related to the endorsement of men’s control and influence only in medical scenarios, where they may serve to protect the woman and her fetus, and will be negatively related to endorsement of financial abortion.

**Hypothesis 3:** Support for abortion rights will be negatively related to men’s perceived rights, except in the case of financial abortion.

## Study 1

### Method

#### Participants and Design

We needed at least 250 participants for stable correlations (Schönbrodt & Perugini, 2013), but we did not limit volunteers to that number. Participants were 394 psychology undergraduate students in the United Kingdom who took part in exchange for course credit. Of these participants, 25 did not complete the questionnaire, leaving 369 in the final sample: 299 women (79.9%) and 70 men (17.8%). Participants were relatively young ( $M = 19.90$  years,  $SD = 3.83$ , age range = 18–53 years). They self-reported their ethnicity: White = 251 (68%), Asian = 49 (13.3%), African American = 9 (2.4%), Hispanic = 5 (1.4%), Native American = 1 (0.3%), Pacific Islander = 2 (0.5%), Other = 51 (13.8%), and Not disclosed = 1 (0.3%). Participants also reported their parental status: No children = 346 (93.8%), Children = 21 (5.7%), and Not disclosed = 2 (0.5%), and their pregnancy status: Pregnant = 2 (0.5%), Trying to get pregnant = 3

(0.8%), Neither = 360 (97.6%), and Not disclosed = 4 (1.1%). For those interested, anonymized data files together with syntax detailing the statistical analyses have been made available online at <https://osf.io/vwjus>.

## Measures

**Sexism.** Participants completed the Ambivalent Sexism Inventory, (Glick & Fiske, 1996), comprising two subscales with 11 items for Hostile Sexism ( $\alpha = .90$ ; e.g., “Women seek to gain power by getting control over men”) and 11 items for Benevolent Sexism ( $\alpha = .86$ ; e.g., “Women should be cherished and protected by men”). Responses were recorded on a 6-point scale ranging from 0 (*strongly disagree*) to 5 (*strongly agree*). In accordance with the coding instructions provided by Glick and Fiske (1996), means for each subscale were calculated after some items were reverse scored. In previous research, the subscales of hostile and benevolent sexism typically demonstrate Cronbach’s  $\alpha$ s of around  $\alpha = .90$  and  $\alpha = .80$ , respectively (Glick & Fiske, 1996).

**Paternal control.** We constructed a new scale for this study since men’s control in reproductive decisions has not been examined in previous research. Participants were asked to read five statements regarding men’s control in decisions related to pregnancy and indicate the extent to which they agreed or disagreed. These items were adapted from various newspaper articles (e.g., Time.com) and comment sections (e.g., news.mensactivism.org) on the internet addressing men’s control and interests in reproductive decisions (see Online Supplementary Materials for a list of items and their sources). Items were designed to mirror commonly expressed views about these issues, such as “A woman should not be allowed to have an abortion if the man involved really wants to keep his unborn child” and “It would be fairer if the man involved had to consent to a woman’s decision to abort his unborn child.” We consciously adopted the term “unborn child” since this term is used by the so-called men’s rights activists, ensuring that the measure would accurately reflect the real-world expressions of these attitudes. One item was removed prior to analysis as, in hindsight, it did not measure paternal control beliefs, leaving four items in the final scale ( $\alpha = .79$ ); this exclusion did not affect results (see Online Supplementary Materials for further details). Participants’ responses were recorded on a 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*).

**Financial abortion and paternal pressure.** One item was devised specifically to measure endorsement of financial abortion and was analyzed on its own: “If a child is born against the father’s will, he should not be obligated to support the child financially.” Participants indicated their agreement on a 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Further, to measure endorsement of men’s entitlement to exert informal, interpersonal forms of

influence (rather than legal authority), we constructed a Paternal Pressure scale composed of four items (see Online Supplementary Materials;  $\alpha = .71$ ). In response to the question, “Generally, in the decision to have an abortion . . .,” participants indicated the extent to which they agreed or disagreed on these four “pressure” items (e.g., “Once the woman has formed a standpoint it is okay for the man to try to change her mind”). A 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) was used to record participants’ responses. The face validity of the measure was supported by discussions between the authors prior to data collection.

**Medical scenarios.** To examine more precisely the specific conditions under which men’s control is endorsed, we created scenarios addressing reproductive decisions in various medical situations. Participants were asked to read eight scenarios related to different medical decisions (e.g., pre-natal screening, C-Section) and indicate the extent to which they agreed or disagreed on an item stem addressing men’s control in these decisions (see Online Supplementary Materials). We removed one scenario from the analyses of the medical scenarios scale following a reviewer comment, since it did not describe a medical scenario per se, but an abortion (the results were the same whether the scenario was included or not), leaving seven scenarios in the final scale (see Online Supplementary Materials). The scenarios in the medical scenarios scale include medical decisions per se (e.g., elective choice to have a C-section) and decisions with alleged medical implications (e.g., painkillers during pregnancy). In response to each scenario, participants indicated their agreement or disagreement (1 = *strongly disagree* to 5 = *strongly agree*) on the item stem “The consent of both the woman and the man involved should be required . . .” ( $\alpha = .91$ ). For example, participants indicated their agreement or disagreement in response to the following scenario: “In the decision to have a C-Section, if the baby is endangered in natural birth . . .”

**Control measures and additional variables.** Participants also completed various control measures that have been found to correlate with hostile sexism and/or benevolent sexism (Burn & Busso, 2005; Huang et al., 2014; Sibley et al., 2007). We included a short form of the RWA; participants responded 1 (*strongly disagree*) to 6 (*strongly agree*) on an 8-item scale ( $\alpha = .81$ ; e.g., “What our country really needs, instead of more ‘civil rights’ is a good stiff dose of law and order”; Altemeyer, 1981). Previous research has reported a Cronbach’s  $\alpha$  of .74 for this scale (Duckitt & Sibley, 2007). Further, different versions of the RWA measure have been found to relate to prejudice consistently across various countries (Zakrisson, 2005). A 4-item scale assessing religiosity was also used ( $\alpha = .93$ ; e.g., “How often do you attend religious services?”; Sullivan, 2001); responses were recorded on a 5-point scale ranging from 1 (*not at all*) to 5 (*a great deal*). The measure has shown high internal consistency ( $\alpha = .90$ ) in past research (Sullivan, 2001). In addition, participants

**Table 1.** Bivariate Correlations and Descriptive Statistics (Study 1).

Variable	M	SD	1	2	3	4	5	6	7	8	9
1. Hostile sexism	2.78	0.95									
2. Benevolent sexism	3.08	0.91	.58***								
3. Paternal control	2.91	0.87	.44***	.34***							
4. Paternal pressure	2.78	0.76	.36***	.28***	.51***						
5. Financial abortion	2.51	1.13	.08	-.11*	.08	.14**					
6. Medical scenario	3.16	1.05	.40***	.41***	.61***	.30***	.02				
7. Religiosity	2.18	1.18	.27***	.35***	.24***	.23***	-.13*	.26***			
8. RWA	2.80	0.89	.59***	.61***	.40***	.33***	-.02	.42***	.39***		
9. AB	5.66	1.69	-.31***	-.30***	-.43***	-.34***	.13*	-.40***	-.38***	-.49***	

Note. *N* = 368. RWA = right-wing authoritarianism; AB = support for abortion rights.  
 \**p* < .05. \*\**p* < .01. \*\*\**p* < .001.

completed a 7-item Support for Abortion Rights scale ( $\alpha = .91$ ; Smith, Marsden, & Hout, 2011). Participants indicated whether it should be possible for a woman to obtain a legal abortion in response to 7 items, for example, “If she became pregnant as a result of rape?” Responses ranged from 1 (*not at all*) to 8 (*very much*). In previous research, Cronbach’s  $\alpha$  typically ranges from .82 to .96 for this measure (Osborne & Davies, 2009, 2012). Participants also completed various demographic measures relating to gender (*women* = 1, *men* = 2), age, ethnicity, nationality, parental status, pregnancy, and socioeconomic status.

**Sample and Procedure**

An analysis of missing data showed that less than 4.17% of all items for all 394 cases were missing and 95.83% of the items were not missing data for any case. Considering individual cases, 84.52% of participants had no missing data. Finally, no item had more than 5.3% of missing values. Little’s Missing Completely at Random test was employed to examine whether data were missing completely at random. Little’s test resulted in a Chi-Square of  $\chi^2(1,610) = 1,475.75, p = .992$ , indicating that there were no identifiable patterns in the missing data. Consequently, we used listwise deletion to deal with missing data in subsequent analyses.

The study received full ethical approval from the Ethics Committee of the authors’ university (20153473). Before the study commenced, participants were informed that they were to take part in a study on “Men’s rights in decisions related to pregnancy and abortion” that would take about 15 min to complete. To reduce the likelihood that individuals would experience emotional distress, the informed consent stated that “if you have experienced trauma or loss associated with pregnancy, abortion, or childbirth you may find this survey to be upsetting and therefore should consider not taking it.” After giving their consent, participants completed the measures detailed below in the order listed. The contact details of the researchers, as well as psychological support services, were also provided in the debrief form.

**Results**

Independent *t*-tests (*N* = 368) revealed that, compared to women (*n* = 298), men (*n* = 70) showed greater endorsement of hostile sexism,  $t(366) = -2.46, p < .05, d = .33$  ( $M_{men} = 3.03, SD = 0.92, M_{women} = 2.72, SD = .95$ ); paternal control,  $t(366) = -2.77, p < .01, d = .36$  ( $M_{men} = 3.17, SD = 0.93, M_{women} = 2.85, SD = .85$ ); and paternal pressure,  $t(366) = -2.81, p < .01, d = .38$  ( $M_{men} = 3.01, SD = .72, M_{women} = 2.73, SD = .76$ ). Compared to men, women demonstrated marginally greater support for abortion rights,  $t(366) = -1.79, p < .10, d = .24$  ( $M_{men} = 5.33, SD = 1.70, M_{women} = 5.73, SD = 1.68$ ). Gender was therefore included in subsequent analyses.

To investigate interrelations between variables, bivariate correlations were calculated (Table 1). As predicted, hostile sexism was positively associated with endorsement on the Paternal Control scale, the Paternal Pressure scale, and the Medical Scenarios scale. Hostile sexism was unrelated to endorsement of the financial abortion item at zero-order. Benevolent sexism was positively associated with endorsement on all measures, apart from the financial abortion item, with which it was negatively correlated.

To provide a more stringent test of our hypothesis that hostile sexism is a positive predictor of endorsement of men’s control and influence in reproductive decisions, a two-stage hierarchical multiple regression with listwise deletion was performed for each of the four outcome measures. The regression statistics for each measure are summarized in Table 2. Gender and age were added as predictors in the first step, as these are assumed to be causally prior to ideological belief systems and religiosity. For the Paternal Control scale, in the first step, gender and age accounted for 1.9% of the variance, and the overall model was significant,  $F(2, 363) = 4.56, p = .011, \Delta R^2 = .03$  (Step 1). Adding hostile sexism, benevolent sexism, religiosity, RWA, and support for abortion rights in the second step accounted for 29.2% of the variance, and the overall model was significant,  $F(7, 358) = 22.55, p < .001, \Delta R^2 = .28$  (Step 2). In Step 2, support for abortion rights and hostile sexism were the only significant

**Table 2.** Summary of Hierarchical Regression Analyses for Variables Predicting Endorsement of Men's Control in Reproductive Decision (Study 1).

Variable	Paternal Control			Financial Abortion			Medical Scenarios			Paternal Pressure		
	$\beta$	<i>t</i>	<i>sr</i> <sup>2</sup>	$\beta$	<i>t</i>	<i>sr</i> <sup>2</sup>	$\beta$	<i>t</i>	<i>sr</i> <sup>2</sup>	$\beta$	<i>t</i>	<i>sr</i> <sup>2</sup>
<b>Model 1</b>												
Gender	.14	2.62*	.02	-.01	-0.14	.01	.07	1.38	0	.15	2.79**	.02
Age	-.07	-1.24	0	-.01	-0.24	.01	-.10	-1.93	0	-.02	-0.36	.01
<b>Model 2</b>												
Gender	.07	1.56	0	-.01	-0.22	.01	.02	0.33	0	.10	2.01*	.01
Age	-.04	-0.91	0	-.02	-0.36	.01	-.07	-1.61	0	-.001	-0.02	.01
RWA	.07	1.12	0	.09	1.17	.01	.09	1.33	0	.06	0.91	.01
REL	.02	0.47	0	-.09	-1.63	.01	.04	0.77	0	.06	1.15	.01
AB	-.28	-5.45***	.08	.13	2.23*	.01	-.24	-4.54***	.04	-.20	-3.51**	.03
BS	.04	0.58	0	-.22	-3.20**	.03	.17	2.82**	.01	.03	0.42	.01
HS	.28	4.75***	.06	.23	3.33**	.03	.15	2.57*	.01	.22	3.47**	.03

Note. *n* = 366. RWA = right-wing authoritarianism; REL = religiosity; AB = support for abortion rights; BS = benevolent sexism; HS = hostile sexism. \**p* < .05. \*\**p* < .01. \*\*\**p* < .001.

predictors of endorsement on the Paternal Control scale. Support for abortion rights was a negative predictor of paternal control, while hostile sexism was a positive predictor.

For the Financial Abortion item, adding gender and age did not account for any variance and the initial model was not statistically significant,  $F(2, 363) = .03, p = .967, \Delta R^2 = 0$  (Step 1). Adding hostile sexism, benevolent sexism, religiosity, RWA, and support for abortion rights in the second step accounted for 5.1% of the variance, and the overall model was significant,  $F(7, 358) = 3.80, p = .001, \Delta R^2 = .07$  (Step 2). Benevolent sexism was a negative predictor of support for financial abortion, while both hostile sexism and support for abortion rights were positive predictors.

For the Medical Scenarios scale, adding gender and age in the first step accounted for 1.1% of the variance, and the overall model was statistically significant,  $F(2, 363) = 3.11, p = .046, \Delta R^2 = .02$  (Step 1). In the second step, adding hostile sexism, benevolent sexism, religiosity, RWA, and support for abortion rights accounted for 26.7% of the variance, and the overall model was significant,  $F(7, 358) = 19.96, p < .001, \Delta R^2 = .26$  (Step 2). Support for abortion was the strongest, negative predictor of endorsement on the Medical Scenarios scale. Hostile sexism and benevolent sexism were the only two other significant predictors in the second step, both predicting higher endorsement on this measure.

For the Paternal Pressure scale, gender and age accounted for 1.7% of the variance in the first step, and the overall model was significant,  $F(2, 363) = 4.09, p = .017, \Delta R^2 = .02$  (Step 1). When hostile sexism, benevolent sexism, religiosity, RWA, and support for abortion rights were added in the second step, this accounted for 18.5% of the variance, and the overall model was significant,  $F(7, 358) = 12.81, p < .001, \Delta R^2 = .18$  (Step 2). Gender and hostile sexism positively predicted support for paternal pressure, while support for abortion rights negatively predicted endorsement on this measure.

## Study 1 Discussion

Our results provide the first evidence in support of the Hypothesis 1 that hostile sexism, adjusting for benevolent sexism, is positively associated with the endorsement of men's control and influence in reproductive decision-making. Specifically, hostile sexism positively predicted endorsement of men's control over abortion (e.g., that a man should consent to the decision to have an abortion), financial abortion (e.g., that a man should not be obligated to provide financial support for an unwanted child), men's control in medical scenarios (e.g., the consent of the man should be required for a woman to have painkillers during childbirth), and paternal pressure (e.g., exerting pressure to change a woman's decision about abortion). The variance accounted for by hostile sexism held even when controlling for support for abortion rights, suggesting that the relation between endorsement of male control in reproductive decision-making is distinct from opposition to abortion. That is, the endorsement of men's control in reproductive decision-making is not solely driven by the desire to prevent abortions. Further, the results provided support for the Hypothesis 2 that benevolent sexism, adjusting for hostile sexism, is a significant negative predictor of support for financial abortion and a positive predictor of endorsement of men's control in medical scenarios. Finally, our Hypothesis 3 was supported in that support for abortion rights negatively predicted endorsement of men's control on all measures except the Financial Abortion item, which it was positively related to.

## Study 2

In Study 2, we addressed some limitations and extended the scope of Study 1. First, the main objective of Study 2 was to replicate the findings of Study 1 with a different and more representative sample of the general public. The participants

in Study 1 were British undergraduates and therefore had very limited experience with pregnancy-related decisions. Women were also heavily overrepresented in Study 1, making inferences about potential gender differences unreliable. Furthermore, it was central to establish whether findings were generalizable beyond the UK. In the United States, abortion is the source of much controversy and attitudes are more varied (Saad, 2016). Laws differ on a state-by-state basis and are generally more restrictive than in the UK (Guttmacher Institute, 2017; The Abortion Act, 1967). For the second study, we used Amazon Mechanical Turk (MTurk) to recruit from the United States. Consequently, the sample was not only demographically different, but also from a country with a different set of laws and cultural and political practices surrounding women's reproductive autonomy. In Study 1, endorsement of paternal control, financial abortion, medical scenarios, and paternal pressure were measured using 5-point scales. This led to concerns that participants might have been inclined to endorse the midpoint of the scale (Garland, 1991), which we wanted to address in Study 2. We also wanted to address potential order effects that may have been present in the first study by randomizing the order in which the measures were presented to participants. Third, we extended the study to include attitudes to paternal control over obstetric decisions in childbirth and developed a measure to assess those attitudes.

## Method

### Participants and Design

Participants were 299 Amazon MTurk users, who took part in exchange for MTurk credits at the rate of 13 cents per minute. Location data indicated that 14 participants were located outside the United States; they were eliminated and the final sample comprised 285 participants: 143 Men (50.2%), 141 women (49.5%), and 1 Other (0.4%). The average age of participants was 36.82 years ( $SD = 11.11$ , age range = 20–72 years). Participants' ethnicity was also recorded: White = 244 (85.6%), African American = 21 (7.4%), Hispanic = 9 (3.2%), Asian = 8 (2.8%), Native American = 2 (0.7%), and Other = 1 (0.4%). In addition, participants reported their parental status: No children = 140 (49.1%) and Children = 145 (50.9%), and their pregnancy status: Pregnant = 10 (3.5%), Trying to get pregnant = 17 (6%), and Neither = 258 (90.5%).

The present study employed the same design as Study 1 with some modifications and additional materials that are described below. Further, due to budget constraints, sample size was set at 300 participants, in line with Schönbrodt and Perugini's (2013) analyses. Finally, the endorsement of paternal control, financial abortion, paternal pressure, medical scenarios, and paternal control in childbirth were measured using 6-point scales, as opposed to the 5-point scales used in Study 1.

### Measures

Participants completed the Ambivalent Sexism Inventory, as in Study 1 ( $\alpha = .95$  for hostile sexism,  $\alpha = .91$  for benevolent sexism). Further, participants completed the Paternal Control scale used in Study 1 with one modification, two reverse worded items were added, for example, "Men have enough say in decisions related to pregnancy and abortion as it is" (see Online Supplementary Materials;  $\alpha = .92$ ). To assess support for financial abortion, participants indicated the extent to which they agreed or disagreed with the same item as in Study 1. Participants also completed the Paternal Pressure scale ( $\alpha = .63$ ) and the Medical Scenarios scale from Study 1. On the Medical Scenarios scale, participants indicated the extent to which they agreed or disagreed with the item "The consent of both the woman and the man involved should be required" in response to seven scenarios ( $\alpha = .93$ ; see Supplementary Materials). On all of the above measures, participants' responses were recorded on 6-point scales ranging from 1 (*strongly disagree*) to 6 (*strongly agree*).

We developed a new measure to examine whether hostile sexism would also predict endorsement of men's control in decisions related to childbirth: Paternal Control in Childbirth scale. A decision about whether to have an abortion or bring the pregnancy to term leads to a specific outcome (i.e., having a child or not). In the choice of delivery method, however, the decision has a limited effect on the outcome (i.e., choosing either water birth or a cesarean both result in a child). Endorsement of men's control in the decisions about childbirth is therefore less about men having a say in determining the ultimate outcome, but rather about men's right to exert influence in the process. Participants responded to eight items assessing men's control in the choice of delivery method (e.g., "The man involved should have an equal right to that of the woman in the choice of delivery method";  $\alpha = .92$ ). Items were developed in discussions between the authors and via web searches listing various methods of childbirth. Items were also presented and discussed at a meeting of the political psychology lab in the School of Psychology at the authors' institution. Participants reported their agreement on 6-point scales ranging from 1 (*strongly disagree*) to 6 (*strongly agree*).

Participants also completed the same control measures as in Study 1, including RWA ( $\alpha = .90$ ; 1 = *strongly disagree* to 6 = *strongly agree*) and 4 items assessing religiosity ( $\alpha = .96$ ) with responses ranging from 1 (*not at all*) to 5 (*a great deal*). As in Study 1, participants reported their agreement from 1 (*not at all*) to 8 (*very much*) on the same measure of support for abortion rights ( $\alpha = .95$ ). Participants also completed the demographic measures identical to those used in Study 1.

### Sample and Procedure

An analysis of missing data for the remaining 284 participants showed that less than .01% of all items for all cases

**Table 3.** Bivariate Correlations and Descriptive Statistics (Study 2).

	<i>M</i>	<i>SD</i>	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
1. Hostile sexism	2.74	1.30										
2. Benevolent sexism	2.81	1.18	.54***									
3. Paternal control	3.21	1.47	.54***	.48***								
4. Paternal pressure	3.23	0.81	.26***	.29***	.39***							
5. Medical scenarios	2.55	1.45	.56***	.53***	.67***	.33***						
6. Financial abortion	2.66	1.84	.18**	-.04	.11 <sup>†</sup>	.11 <sup>†</sup>	.18**					
7. Paternal CB	2.17	1.08	.53***	.39***	.57***	.35***	.73***	.20**				
8. Religiosity	2.07	1.32	.20**	.38***	.41***	.20***	.40***	-.12*	.23***			
9. RWA	2.59	1.25	.61***	.61***	.61***	.29***	.58***	-.01	.42***	.58***		
10. AB	5.95	2.18	-.44***	-.44***	-.69***	-.26***	-.58***	.07	-.45***	-.49***	-.64***	

Note. *N* = 284. Paternal CB = paternal control in childbirth; RWA = right-wing authoritarianism; AB = support for abortion rights.

\**p* < .05. \*\**p* < .01. \*\*\**p* < .001. <sup>†</sup>*p* < .10.

were missing, and 99.99% of the items were not missing data for any case. For individual cases, 99.65% of participants had no missing data. Finally, no item had more than 1% of missing values. Consequently, listwise deletion was employed in subsequent analyses.

The study received full ethical approval from the university Ethics Committee (201614779209544077). On MTurk, participants select the studies they wish to take part in from a list of suggested projects. Participants who wanted to participate in the current study were informed that they were to take part in a study on “Men’s rights in decisions related to pregnancy and abortion” that would take about 15 min to complete. The order in which the measures were presented to participants was randomized and participation was limited to one time in Qualtrics (Version 2016). In addition, we included an attention check to ensure that participants were reading the questions carefully. One of the items in the Paternal Control scale read: “It would be fairer if the man. Please indicate ‘strongly agree’ to show that you are paying attention.” Five participants failed this attention check, and following inspection of their data and response time they were not excluded from the analyses. Further, the results were the same whether they were included or not (see Online Supplementary Materials for these results). The procedure was otherwise identical to Study 1.

## Results

Independent *t*-tests (*N* = 284) showed that men (*n* = 143), compared to women (*n* = 141), demonstrated greater endorsement of hostile sexism,  $t(276.82) = -3.17, p < .01, d = .29$  ( $M_{\text{men}} = 2.98, SD = 1.20, M_{\text{women}} = 2.50, SD = 1.35$ ); benevolent sexism,  $t(282) = -3.79, p < .001, d = .45$  ( $M_{\text{men}} = 3.07, SD = 1.13, M_{\text{women}} = 2.56, SD = 1.17$ ); and paternal control in childbirth,  $t(282) = -3.95, p < .001, d = .47$  ( $M_{\text{men}} = 2.42, SD = 1.08, M_{\text{women}} = 1.92, SD = 1.03$ ). Men also showed marginally greater endorsement on medical scenarios,  $t(282) = -1.83, p < .10, d = .22$  ( $M_{\text{men}} = 2.71, SD = 1.43, M_{\text{women}} = 2.40, SD = 1.46$ ). Compared to men, women

scored higher in religiosity,  $t(272.43) = 2.81, p < .01, d = .33$  ( $M_{\text{men}} = 1.85, SD = 1.19, M_{\text{women}} = 2.29, SD = 1.42$ ). Thus, gender was included in subsequent analyses.

Bivariate correlations were calculated to examine interrelations between variables (Table 3). As predicted, hostile sexism was positively associated with endorsement on the measures of paternal control, financial abortion, medical scenarios, and paternal pressure, as well as the new scale, paternal control in childbirth. As before, benevolent sexism was positively associated with all measures except for financial abortion.

Two-step hierarchical regression analyses were conducted for each measure of men’s control (paternal control, financial abortion, medical scenarios, paternal pressure, and paternal control in childbirth) to test the hypothesis that hostile sexism would be a positive predictor of support for men’s control and influence (see Table 4 for regression statistics). For the Paternal Control scale, gender and age were entered in the first step; however, the overall model was not significant,  $F(2, 278) = 0.48, p = .617, \Delta R^2 = 0$  (Step 1). Hostile sexism, benevolent sexism, RWA, religiosity, and support for abortion rights were added in the second step, and the overall model was significant,  $F(7, 273) = 52.03, p < .001, \Delta R^2 = .57$  (Step 2). Together the variables accounted for 56.1% of the variation. Hostile sexism and support for abortion rights (negative predictor) were significant predictors.

For the financial abortion item, adding gender and age in the first step accounted for 2.2% of the variance, and the overall model was significant,  $F(2, 278) = 4.17, p = .016, \Delta R^2 = .03$  (Step 1). When hostile sexism, benevolent sexism, RWA, religiosity, and support for abortion rights were added in the second step, the overall model was significant,  $F(7, 273) = 3.96, p < .001, \Delta R^2 = .06$  (Step 2). The variables accounted for 6.9% of the variance, and hostile sexism was the only significant predictor in the second step. Benevolent sexism and age were marginal predictors.

For the Medical Scenarios scale, when gender and age were added in the first step, the overall model was marginally significant,  $F(2, 278) = 2.43, p = .09, \Delta R^2 = .02$  (Step 1).



**Table 4.** Summary of Regression Analyses (Study 2).

Variable	Paternal Control			Financial Abortion			Medical Scenarios			Paternal Pressure			Paternal Control in Childbirth		
	$\beta$	<i>t</i>	<i>sr</i> <sup>2</sup>	$\beta$	<i>t</i>	<i>sr</i> <sup>2</sup>	$\beta$	<i>t</i>	<i>sr</i> <sup>2</sup>	$\beta$	<i>t</i>	<i>sr</i> <sup>2</sup>	$\beta$	<i>t</i>	<i>sr</i> <sup>2</sup>
<b>Model 1</b>															
Gender	.05	0.88	0	.09	1.58	.01	.11	1.90 <sup>†</sup>	.01	.08	1.48	.01	.23	3.97***	.05
Age	.03	0.49	0	-.14	-2.34*	.02	-.06	-1.04	0	.03	0.50	0	-.06	-1.02	0
<b>Model 2</b>															
Gender	.04	1.03	0	.05	0.86	0	.08	1.62	0	.06	0.98	0	.19	3.74***	.03
Age	.03	0.69	0	-.10	-1.71 <sup>†</sup>	.01	-.06	-1.37	0	.03	0.45	0	-.04	-0.74	0
RWA	.08	1.19	0	.02	0.16	0	.07	0.95	0	.06	0.56	0	-.03	-0.36	0
REL	.06	1.21	0	-.07	-0.98	0	.11	2.00*	.01	.05	0.66	0	.06	0.92	0
AB	-.48	-9.08***	.13	.10	1.29	.01	-.31	-5.42***	.05	-.11	-1.45	.01	-.30	-4.56***	.05
BS	.06	1.05	0	-.14	-1.82 <sup>†</sup>	.01	.15	2.56*	.01	.13	1.70 <sup>†</sup>	.01	.03	0.41	0
HS	.24	4.25***	.03	.28	3.49***	.04	.26	4.28***	.03	.09	1.07	0	.35	5.17***	.06

Note. *n* = 281. RWA = right-wing authoritarianism; REL = religiosity; AB = support for abortion rights; BS = benevolent sexism; HS = hostile sexism. \**p* < .05. \*\**p* < .01. \*\*\**p* < .001. <sup>†</sup>*p* < .10.

When hostile sexism, benevolent sexism, RWA, religiosity, and support for abortion rights were added in the second step, the overall model was significant,  $F(7, 273) = 39.33, p < .001, \Delta R^2 = .49$  (Step 2). The significant predictors in the second step were support for abortion rights (negative predictor), hostile sexism, benevolent sexism, and religiosity and they accounted for 48.9% of the variance.

For the Paternal Pressure scale, when gender and age was added in the first step, the overall model was not significant,  $F(2, 278) = 1.84, p = .308, \Delta R^2 = .01$  (Step 1). In the second step, when hostile sexism, benevolent sexism, RWA, religiosity, and support for abortion were added, the variables accounted for 9.9% of the variance, and the overall model was significant,  $F(7, 273) = 5.39, p < .001, \Delta R^2 = .11$  (Step 2). Benevolent sexism was marginally significant, while none of the other predictors were statistically significant.

For the endorsement on the Paternal Control in Childbirth scale, adding gender and age in the first step accounted for 4.9% of the variance, and the overall model was significant,  $F(2, 278) = 8.62, p < .001, \Delta R^2 = .06$ . In the second step, when hostile sexism, benevolent sexism, RWA, religiosity, and support for abortion were added, the variables accounted for 35.6% of the variance, and the overall model (Step 2) was significant,  $F(7, 273) = 23.15, p < .001, \Delta R^2 = .31$ . The only significant predictors were hostile sexism, support for abortion (negative predictor), and gender (women were less supportive than men).

### Study 2 Discussion

The results of Study 2 support the hypothesized relations between hostile sexism and endorsement of men’s control and influence in reproduction decisions. Specifically, we found further support for our first hypothesis: Hostile sexism, when adjusting for benevolent sexism, was positively associated with the endorsement of men’s control and influence in reproduction decision-making. Across four measures, hostile

sexism scores were a consistent positive predictor of the support for men’s control and influence in decisions related to pregnancy and abortion. Hostile sexism scores positively predicted the endorsement of paternal control, financial abortion, and medical scenarios. Additionally, hostile sexism was a positive predictor of paternal control in childbirth. Thus, apart from the non-significant relation with paternal pressure (e.g., exerting pressure to change a woman’s decision about abortion), the results corroborated the findings from Study 1. Further, as hypothesized (Hypothesis 2), benevolent sexism was a positive predictor of men’s control only in medical scenarios and a marginally significant negative predictor of men’s right to financial abortion, consistent with Study 1. Finally, in accordance with our third hypothesis, support for abortion rights negatively predicted the endorsement on all measures of men’s control except for financial abortion. However, unlike in Study 1, the negative relation between support for abortion and paternal pressure was not statistically significant. In addition, in Study 1, support for abortion was modestly positively associated with support for financial abortion, while in Study 2, this relation was not significant.

### General Discussion

The current studies provide the first empirical evidence that ambivalent sexism is relevant in the endorsement of men’s control in reproduction decisions. Our work builds on previous research examining correlates of opposition to abortion in several ways. First, the present results replicate past findings that support for abortion is negatively related to hostile and benevolent sexism (Begun & Walls, 2015; Huang et al., 2014). Second, they demonstrate that support for abortion is negatively related to support for men’s right to control and influence women’s reproduction decisions. Third, the results show that nonetheless, support for the alleged rights of men is distinct from support for abortion rights; for example, support for men’s control is consistently related to hostile sexism

when support for abortion rights is adjusted for. While previous research has identified sexist ideology as concerned with restrictions of women's reproductive choices per se (e.g., Huang et al., 2016), the present results illustrate that hostile sexism is central to the perception that it is ok for men to impose these restrictions. Further, in Study 2, hostile sexism was also a positive predictor of men's control in decisions related to childbirth. The endorsement of men's control in these decisions is not merely about having a say in determining the outcome, but exerting influence in the process. Thus, our results support Murphy's (2013) claim that the support for men's control over pregnancy-related decisions may reflect efforts to ensure that women fulfill certain expectations of womanhood.

Across both studies, hostile sexism was the strongest positive predictor of the so-called financial abortion. The financial abortion item seems to reflect the heterosexual hostility facet of hostile sexism—the perception that women are using their sexuality, and in this case their pregnancy, to leverage resources from men (Begun & Walls, 2015). This is in line with research linking hostile sexism to a competitive view of heterosexual relationships, wherein women are argued to exchange sex for men's resources (Fetterolf & Rudman, 2017). In contrast, benevolent sexism was a negative predictor of support for financial abortion across both studies, albeit only marginally in Study 2. Financial abortion enables the man an escape from the financial obligations of an unwanted child and by extension his obligations to the woman. Consequently, it violates the ideals of the protective-paternalism facet of benevolent sexism, where men are viewed as providers and protectors of women and their children (Begun & Walls, 2015; Glick & Fiske, 1996).

The positive relation between benevolent sexism and the endorsement of men's control in medical scenarios also seems to be motivated by protective paternalism and the perception of potential risks toward the woman and fetus (e.g., when the fetus is endangered in natural birth, the woman's health is endangered by the fetus). This corresponds to the theoretical view of benevolent sexism as a subtle mechanism for the maintenance of gender inequality (Glick & Fiske, 2001). Benevolent sexists may be reluctant to endorse blatant expressions of male control. However, in instances where such control can be construed as protective, for example, when it comes to a woman's decision to have painkillers during pregnancy, they may be inclined to endorse it. Previous research has identified protective paternalism in the current anti-abortion discourse, where opponents of abortion rights' arguments for placing restrictions on women's reproductive freedom are framed as a way to protect women from negative emotions or exploitation (Duerksen & Lawson, 2017).

Gender was a significant predictor of support for men's control only on the Paternal Pressure scale (Study 1), the Paternal Control scale, and the Paternal Control in Childbirth scale (Study 2). Men were more likely to endorse men's

control over reproduction decisions compared to women. However, sexist beliefs and support for abortion rights were stronger predictors than gender. The limited role of gender in predicting support for men's control is consistent with other findings showing that ideological variables can take priority over gender (Viki & Abrams, 2002). In the current studies, women may have come to internalize benevolent sexism and therefore perceived expressions of male control in the medical scenarios as justified. Research has shown that women who scored high in benevolent sexism were more likely to accept a male partner's restrictions on their behavior in a hypothesized scenario, when a protective justification (e.g., concerns about the safety of an internship) was offered (Moya et al., 2007). This leads to a seemingly affectionate form of subjugation of women that might serve to legitimize men's exertion of control in women's reproductive choices (Moya et al., 2007; Murphy, 2013). Alternatively, some women may have interpreted the measures in more gender egalitarian terms, perceiving pregnancy-related decisions to be something that should be determined through mutual agreement. Previous research has shown that men and women in Italy have similar levels of influence on the outcome when deciding whether to have a child or not (Testa, Cavalli, & Rosina, 2012). Further research should include measures of gender egalitarian attitudes to examine this possibility.

### Limitations

The current studies make up the first empirical examination of the endorsement of men's control in decisions concerning pregnancy, childbirth, and abortion, and the results should be regarded as preliminary. We note some limitations of the current studies. The studies are cross-sectional, correlational, and use self-report measures. One could construct mediational hypotheses, which has been done in some studies (e.g., Sibley et al., 2007). However, given the cross-sectional design of the present research, we have deliberately limited ourselves to multiple regressions (Maxwell & Cole, 2007). Thus, the findings are restricted in terms of the inferences that can be made about the processes underlying decision-making on this matter in the real world.

Another limitation of the present research is that the measures used to assess endorsement of men's control were designed for this study and have not been validated. Although most measures demonstrated high levels of internal consistency, the reliability of the Paternal Pressure scale was relatively low, with Cronbach's  $\alpha$ s of .71 and .63 across both studies. Further, only 1 item was used to measure endorsement of financial abortion. This, as well as the smaller sample in Study 2, may have contributed to the minor discrepancies in findings between studies. Specifically, hostile sexism and support for abortion predicted scores on the paternal pressure measure in Study 1 but not Study 2, and the relation between benevolent sexism and financial abortion was significant in Study 1 and marginal in Study 2. Further validation and

development of the measures created for this study would be an essential direction for future research.

A further limitation of the present studies is that we relied on convenience samples of British psychology undergraduates (Study 1) and MTurk users (Study 2). Thus, the results may not represent the attitudes of other cultural groups accurately. Moreover, in Study 2, the majority of the sample were White, thus making it difficult to extrapolate findings to other racial and ethnic groups. The experience of other minority groups in the reproduction domain is likely different from that of White Americans. For instance, multi-racial and Non-Hispanic Black women have been found to be among the most likely to report reproductive coercion (Miller et al., 2010).

The results of the present studies suggest that sexist ideology is implicated in the endorsement of men's control and influence in reproduction decisions. Our findings do not speak for or against men's influence and control, nor is the extent to which men should have control an empirical question. However, our results do show that sexist ideology is related to the view that men should have control and influence in these decisions. Hostile sexism positively predicted endorsement of men's control in a broad range of reproductive domains, including abortion, medical scenarios, and childbirth. This relation was independent of opposition to abortion. Further, women seem to be caught in a double bind by hostile sexists' support for men's right to prevent an abortion and the simultaneous reluctance to pay child support, should she refrain from having an abortion. This suggests that the endorsement of men's control in reproductive decision-making is not necessarily about deciding the outcome, but rather about the desire to control women. Future research should examine this possibility.

### Practice Implications

The present findings, in keeping with previous research, demonstrate that women's reproductive autonomy may be subverted by cultural forces, including sexist ideology, that serve to confer power to men. Medical practitioners should be mindful of this when assisting women in discussing reproductive questions. Although research has suggested that men's involvement in reproductive decision-making can be beneficial for maternal health (Yargawa & Leonardi-Bee, 2015), care should be taken to ensure that this involvement does not come at the cost of women's autonomy. Further, the present findings can also be utilized by educators in family planning interventions designed to reduce reproductive coercion (Miller et al., 2016); such interventions could highlight some of the potential factors identified here that may influence reproductive decision-making. By encouraging men to be aware of factors that shape the perception of men's role in reproductive decisions, educators could affirm women's reproductive autonomy and lay the groundwork for balanced, mutual decision-making in heterosexual relationships.

Finally, in a climate that is increasingly hostile toward reproductive rights, activists who work to promote women's autonomy in the reproductive domain can also benefit from these findings. Activists might increase their persuasiveness by highlighting how recent policy moves, for instance, in the United States, may not be informed only by the desire to prevent abortions, but also a desire to limit women's autonomy, and place it in the hands of men.

### Conclusions

The results of the current studies suggest that endorsement of sexist ideology, and hostile sexism in particular, are related to the view that men have a right to exert control over women's reproductive decisions. The acceptance for men's exertion of control may have adverse implications for women's autonomy in reproductive decision-making and could ultimately legitimize reproductive coercion. In light of the present findings, we believe that it is important that practitioners, educators, and activists create awareness around cultural factors that may impact women's autonomy in reproductive health.

### Authors' Note

This research was completed as part of the first author's undergraduate final year project and dissertation for MSc in Political Psychology at the University of Kent.

### Declaration of Conflicting Interests

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### Supplemental Materials

Additional materials for this article are available online. The measures used in this study are available on *PWQ*'s website at <http://journals.sagepub.com/doi/suppl/10.1177/0361684317744531>. Data files together with syntax detailing the statistical analyses are available at <https://osf.io/vwjus>.

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