**Issues in Domestic Violence: Intimate partner sexual abuse**

**Introduction**

**Case Vignettes**

Cami, a 38-year-old woman is married to Carl. The relationship is frequently physically abusive, and the abuse often extends to violent, forced, sexual intercourse. Cami is fearful of staying, and fearful of leaving.

Elaine, a 35-year-old married woman is seeking counseling due to severe depression. She states that her primary stressor is her marriage to Bill. The couple has one child, and Elaine is a stay-at-home mother. She feels distant from Bill, but stuck in the marriage. Elaine shares that one of the hardest parts of the relationship is that she often feels “coerced” into having sexual relations with Bill. She has clearly said no, but Bill’s guilt inducing tactics and threats to leave her and take their child leave her with no choice but to submit.

Bryn a 25-year-old woman is married to Kelly, who is 40. Kelly has recently been suggesting that they need to “spice up” their sex life by including Kim, a former partner of hers. Bryn prefers monogamy in her relationships, but as a victim of childhood sexual abuse, often has trouble standing up for what she wants and especially saying “no.”

The case vignettes above illustrate the range of intimate partner sexual abuse. When most people think about sexual abuse or violence, they often think of it as an assault by a stranger on an unsuspecting victim. As clinical knowledge of sexual abuse advances, so does our understanding that sexual abuse can occur between two people who know one another, or even two people who have an intimate relationship. The term Intimate partner sexual abuse (IPSA) refers to sexual abuse or assault that occurs between two people who have or have had a consensual sexual relationship. The term Intimate Partner Sexual Violence (IPSV) is more often used in relationships where there are other forms of physical abuse, or when the sexual abuse is accompanied by violence. Partner rape is more of a legal term and is defined as sexual acts committed without a person's consent and/or against a person's will when the perpetrator is the individual's current partner (married or not), previous partner, or co-habitator. Regardless of terminology, intimate partner sexual abuse constitutes a form of power and control seen in other types of domestic violence.

While many people would look at the first case vignette and agree that it constitutes sexual abuse, some would question the other case vignettes. Does coercion constitute abuse? Does requests made of someone that a partner knows cannot easily say “no?” It is helpful to look at the definition of sexual assault. Sexual assault refers to any sexual contact of a person by another
without appropriate legal consent. While physical force may be present, this is not always the case. Lack of voluntary consent for sexual contact, such as through the use of intimidation or threats are equivalent to no consent (Sachs & Gomberg, 2009). Intimate partner sexual abuse can occur in dating relationships, marriages or long-term gay or lesbian relationships. Sachs and Gomberg further (2009) offer a helpful definition of intimate partner sexual abuse stating: “intimate partner sexual abuse will be said to occur when a current or former partner or spouse uses physical force to compel the other to engage in a sexual act; attempts or completes the sex act with one who is unable to understand the nature of the act, decline participation, or communicate unwillingness because of illness, disability, the influence of alcohol or other drugs, or because of remote or proximal coercion, intimidation, pressure, or acquiescence, or when there is abusive sexual contact.” (p. 266).

Marital rape, also known as spousal rape, is non-consensual sex in which the perpetrator is the victim's spouse. While marital rape is a recognized problem in the United States as well as internationally, a major issue is whether it has been criminalized. Marital rape is considered a criminal offense in many countries, however, cultural norms and the perceived stigma discourage women from reporting marital rape. Until 1976, marital rape was legal in every state in the United States. Marital rape is now a crime in all 50 states in the U.S.; however, some states still don't consider it as serious as other forms of rape. Clinicians may want to check whether their home state is one that makes a distinction between marital rape and other forms of rape. State laws also vary with regard to the nature of acts that are considered “abusive sexual contact.”

While society sometimes minimizes the importance of intimate partner sexual abuse, research does not concur with this view. In fact, research finds that it is as problematic, if not more problematic, than abuse by a stranger, although it is sometimes difficult to fully assess this form of abuse due to underreporting. For examples, Mager et al., (2014) found that both genders reported a less than 8% incidence of intimate partner sexual abuse. There is also some evidence that children’s adjustment to intimate partner violence is more challenging (through externalizing behaviors, internalizing behaviors and overall adjustment) when IPV is conceptualized broadly rather than narrowly and includes looking at intimate partner sexual abuse (Vu et al., 2016).

In one of the first discussions of intimate partner sexual abuse, early researchers Finkelhor and Yllo (1985), write about the “special traumas” of this type of domestic violence and state, “It is these special traumas that we need to understand in their full and terrible reality.”

This course will examine the issue of intimate partner sexual abuse. Upon completion of this course participants will:
Objectives

1. Define the terms “sexual assault” and “rape”
2. Describe the incidence and prevalence of intimate partner sexual abuse
3. Compare and contrast intimate partner sexual abuse with abuse by a non-intimate partner
4. Compare intimate partner sexual abuse with general domestic violence
5. Describe the physical and mental health effects of intimate partner sexual abuse
6. Discuss intervening in intimate partner sexual abuse, and providing trauma-informed care and trauma-specific interventions.

Definitions, Prevalence and Incidence of Intimate Partner Sexual Abuse

Obtaining prevalence data about sexual assault in the US is problematic due to different survey methodology and definitions of what constitutes assault and/rape. Most studies are thought to grossly underestimate the incidence due to low disclosure rates. While this is true for many types of domestic violence, intimate partner sexual abuse seems to carry a particular difficulties related to stigma. Survivors of intimate partner sexual abuse may experience self-blame, shame, internalized stigma, and anticipatory stigma as well as negative social reactions in response to potential disclosure (Kennedy & Prock, 2016). Victims of intimate partner sexual abuse seem to also express many fears of being revictimized.

Prior to looking at incidence data, it is important to look at some definitions of what constitutes sexual assault, and to expand upon those offered in the introduction. These definitions are important because they determine the scope of inquiry and the questions included in research, affect the wording of questions and guide sample selection.

According to the American Psychological Association, sexual assault can be viewed on a continuum that ranges from forcible rape to nonphysical forms of pressure that compel people to engage in sexual acts against their wishes. Sexual assault takes many forms. It includes acts such as sexual degradation, intentionally hurting someone during sexual intercourse, the use of objects intravaginally, orally, or anally, pursuing sex when someone is not fully conscious or afraid to say no, sexual regulation and monitoring (such as forced inspection of undergarments and regulating partner’s clothing), coercing a person to appear in sexually explicit photographs or movies or forcing an individual to have sex without protection against pregnancy or sexually transmitted diseases.

Intimate partner sexual abuse occurs within heterosexual and same-sex relationships. This includes married couples, individuals who have children in
common, and dating and other romantic or intimate relationships. It occurs in couples of all racial, ethnic and religious groups. It may occur alongside physical and/or emotional abuse, or it may occur as the sole form of violence in the relationship.

In contrast, rape is a legal term. Three elements characterize legal definitions of rape: lack of consent; penetration, no matter how slight or independent of whether ejaculation occurred; and compelling participation by force, threat of bodily harm, or with a person incapable of giving consent due to intoxication or mental incapacitation.

A key, population-based survey is the National Crime Victimization Survey (NCVS), which looks at the incidence of sexual assault. Data are obtained from a nationally representative sample of about 40,000 households comprising nearly 75,000 persons on the frequency, characteristics and consequences of criminal victimization in the United States. According to the 2006 NCVS survey, there were an estimated 272,350 sexual assaults against victims ages 12 and older. This is a decline from previous years; sexual assault has decreased by two-thirds since 1993. The 2006 NCVS survey did not include statistics for victim and offender relationships, but past studies did. In fact, past data has revealed that an estimated 73% of all sexual assaults were committed by someone known to the victim: 38% of perpetrators were a friend or acquaintance of the victim; 28% were an intimate partner; and 7% were another relative.

Another important source of data is the CDC's 2010 National Intimate Partner and Sexual Violence Survey (NIPVS). This survey presents interview data obtained from 16,507 adults (9,086 women and 7,421 men). The survey found that nearly 1 in 5 women (18.3%) and 1 in 71 men (1.4%) have been raped at some time in their lives, including completed forced penetration, attempted forced penetration, or alcohol/drug facilitated completed penetration. More than half (51.1%) of female victims of rape reported being raped by an intimate partner and 40.8% by an acquaintance; for male victims, more than half (52.4%) reported being raped by an acquaintance and 15.1% by a stranger. Among victims of intimate partner violence, more than 1 in 3 women experienced multiple forms of rape, stalking, or physical violence; 92.1% of male victims experienced physical violence alone, and 6.3% experienced physical violence and stalking.

Another large-scale study that looked at intimate partner sexual abuse is the National Violence Against Women Survey (NVAWS) published in 2000. This survey looked at both sexual assault and rape. According to the NVAWS, each year women experience about 4.8 million intimate partner related physical assaults and rapes. Men are the victims of about 2.9 million intimate partner related physical assaults. Nearly two-thirds of women who reported being raped, physically assaulted, or stalked since age 18 were victimized by a current or former husband, cohabiting partner, boyfriend, or date.
While the studies above do capture data about diverse populations, one group often not included in diversity data are members of the lesbian, gay or bisexual community. Heintz & Melendez (2006) studied 58 LGBT clients within a community-based organization. These individuals completed a survey, which inquired as to sexual violence and difficulties negotiating safer sex with their abusive partners. A large percentage of participants reported being forced by their partners to have sex (41%). Many stated that they felt unsafe to ask their abusive partners to use safer sex protection or that they feared their partners' response to safer sex (28%). In addition, many participants experienced sexual (19%), physical (21%), and/or verbal abuse (32%) as a direct consequence of asking their partner to use safer sex protection. The National Intimate Partner and Sexual Violence Survey (2010) findings suggest higher rates of lifetime IPV experiences (defined as physical violence, sexual violence, or stalking) among lesbians (43.8%), bisexual women (61.1%), and bisexual men (37.3%) – but not gay men (26%) – compared to heterosexual women (35.0%) and heterosexual men (29%). Additional research is needed to determine rates among transgender men and women, but some preliminary findings (Langenderfer- Magruderet et al., 2016) – findings that suggest transgender individuals experience higher rates of IPV than their cisgender, lesbian, gay or bisexual counterparts. Generally high rates of violence, trauma, and discrimination in the lives of transgender individuals may have a compounding effect, which explains the lower number of individuals who seek help.

Another group that may be less evident in these studies are people with disabilities, including physical disabilities, mental disabilities (severe mental illness, dementia). Overall women with disabilities have a 40 percent greater chance of intimate partner violence than those women without disabilities (American Psychological Association, 2016). Brieding and Armour (2015) looked at data from the 2010 National Intimate Partner and Sexual Violence Survey. The researchers found that with regard to sexual victimization, when compared to women without a disability, women with a disability were significantly more likely to report experiencing rape, sexual violence other than rape, stalking and control of reproductive or sexual health. The researchers concluded that that people with a disability are at greater risk of victimization and that primary and secondary prevention efforts might be targeted to those with a disability.

Research finds that teens and young adults are also at risk for intimate partner sexual abuse (Lundgren & Amin, 2015; Taylor & Mumford, 2016). A National Survey on Teen Relationships and Intimate Violence studied 1,804 teens, age 12 to 18 year old youths. Among the participants, 69% reported lifetime adolescent relationship abuse. Although psychological abuse was most common for these youth (more than 60%), the rates of sexual abuse were 18% and combined physical abuse and/or sexual abuse was reported by 12% of respondents (Taylor & Mumford, 2016).
Given current technology trends, it is interesting to also look at whether these may affect intimate partner violence, and for the purposes of this paper, whether it may affect intimate partner sexual abuse. Ross, Drouin and Coupe (2016) looked at the role of sexting coercion as a component of the intimate partner abuse among young adults to determine whether sexting coercion would emerge as a risk factor for psychological, sexual, and attachment problems. Sexting is defined as sending someone sexually explicit photographs or messages via cell phone. In a sample of 885 undergraduates, 40% had experienced some type of coercion. Although there was some overlap between sexual coercion and sexting coercion (21% of participants had experienced both), some individuals had experienced only sexting coercion (8%) and some only sexual coercion (11%). Women were more likely than men to be coerced into sexting. Both sexting coercion and sexual coercion were related to negative mental health symptoms, sexual problems, and attachment dysfunction. Sexting coercion was found to be a cumulative risk factor for nearly all of these negative effects.

Given the statistics in these studies, it is important to address violence/sexual coercion by intimate partners.

Comparing Intimate Partner Sexual Abuse to Abuse by a Non-intimate Partner

Case Vignette
Rowanna, a 42-year-old African American woman is seeking treatment. She has just left an abusive relationship with her husband Mac. Rowanna describes a long history of intimate partner physical and sexual abuse, including multiple rapes. Although she is close to her sisters, she was not able to share what was occurring in the marriage. When her 10-year-old daughter inadvertently witnessed one of the rapes, Rowanna finally had the courage to ask for her older sister’s help, and was able to leave. Rowanna reports nightmares, depression, and fears of Mac “coming to get me.”

Sexual abuse is always traumatic. The literature has shown that people who are sexually abused display a range of problems. While some may display what is considered a trauma reaction, and symptoms of posttraumatic stress disorder (PTSD), others will develop a wider range of difficulties including substance abuse, eating disorders, deliberate self-abuse, social phobias, depression, and anxiety. The aftereffects of chronic trauma may intrude on many life spheres: social and vocational; psychological or emotional; physical; sexual; family; sense of self; and relations with others. Chronic sexual abuse, whether by an intimate partner or another often results in a sense of stigmatization and powerlessness.

Logic would dictate that sexual abuse perpetrated by an intimate partner would
be different from sexual abuse by a non-intimate partner, and this is the case. While some people believe that intimate partner sexual abuse doesn’t have as traumatic an impact as sexual assault by a stranger, this is not the case. In fact, intimate partner sexual abuse is in many ways more problematic than other types of sexual abuse or assault. There are a number of significant differences shown in the earlier literature; recent student has been limited. These differences include:

- **Longer-lasting trauma:** In their study of marital rape, Finkelhor & Yllo (1987) found that rape by an intimate partner often results in more chronic trauma. The researchers found that the significant reasons for this are lack of recognition that intimate partner sexual abuse is problematic and survivors’ ability to share their experiences with others.

- **Higher levels of physical injury:** Intimate partner sexual abuse more often involves higher levels of physical injury than other types of rape or sexual abuse. This may be because those people who are sexually abused by a partner are also physically abused (Myhill & Allen, 2002).

- **Repeated traumas:** Survivors of intimate partner sexual abuse suffer the highest frequency of multiple sexual assaults and repeated abuse. This results in more severe overall symptoms (Myhill & Allen, 2002).

- **Different types of sexual abuse.** Partner perpetrators of intimate partner sexual abuse often select abuse that is designed to humiliate and denigrate the victim. Intimate partner sexual abuse more often includes oral and anal rape when compared with other forms of sexual abuse or rape (Bergen, 1996; Arledge, 2008).

- **The unclear status of intimate partner sexual abuse.** While it is clear cut that rape or sexual abuse by a non-intimate partner is wrong, this is not always the case for intimate partner sexual abuse. Many survivors of intimate partner sexual abuse report being advised by church, family or friends that they should be “grateful that the rapist is a good father” or that “it’s their duty to submit” to the abuse. Women are also often socialized to see rape as involving non-consensual sex between two strangers. It may be difficult to see an intimate partner as a “rapist.” (Arledge, 2008). Even service providers and advocates may falsely believe that consensual sexual acts prior to or following sexual abuse minimize or change the nature of the abuse itself. Some survivors report that they have been told that their intimate partners are entitled to sexual intimacy as part of the relationship.

- **Financial dependency on the abuser.** Many women who are in relationships in which there is intimate partner sexual abuse or other forms of domestic violence cannot leave the relationship due to financial issues. In many
situations, domestic violence victims have been cut off from their own jobs or other means of financial support. This becomes even more difficult when there are children involved in the relationship.

- Complexity of ensuring safety. It is often difficult to work within the system of restraining orders, custody issues, etc. Even mental health professionals are not always aware of the resources available for survivors of domestic violence. Additionally, many states do not have laws that include protections for survivors of intimate partner sexual abuse. Those states that do have protections may mire them in red tape, making them difficult to access.

Intimate Partner Sexual Abuse Compared with General Domestic Violence

Case Vignette

Janine is a 27-year-old women married to Michael. Janine has been the victim of numerous incidents of physical violence during their years together. She has also been a victim of forced sexual intercourse. While she has difficulty calling these episodes rape, she is quite clear that the sexual abuse is much more devastating to her than the physical violence.

Carly is a transgender woman involved in a dating relationship with Dominick. While there has always been emotional abuse in the relationship, recently the abuse has taken on a sexual nature, with Dominick denigrating Carly's sexual performance, stating that she does not satisfy him like a “real woman” and suggesting that they need to bring another person into the mix so that he can be fully satisfied.

Intimate partner sexual abuse often seen in relationships in which there are other forms of domestic violence. In Campbell's (2002) study of domestic violence survivors, 46% reported sexual abuse by a physically abusive partner. Women who were also sexually abused by partners reported more negative health symptoms, gynecological problems, and increased risk of being murdered by a partner. There was also a greater likelihood that these women would experience depression, and the risk increased with the number of sexually abusive events that the women identified. Campbell theorizes that a possible mechanism of increased risk for health problems include the shame and stress reported with forced sex manifesting as especially high levels of stress and depression known to depress the immune system. Coker et al.'s (2000) study of family practice patients found that in relationships in which there was domestic violence coupled with sexual abuse, there was a greater degree of overall violence.

Another dynamic to consider is the reason that abusers use sexual violence. More than other forms of domestic violence, sexual abuse, such as rape, has the power to violate or humiliate victims. Abusers may also rape partners to
impregnate them in order to force them to remain in or return to the relationship (Easteal & McOrmond-Plummer, 2006). They may also force their partners into unprotected sex to infect them with STDs (Wilson, 2005).

These studies confirm the likelihood that perpetrators that use sexual violence are a more dangerous subgroup of abusers.

Health Impact of Intimate Partner Sexual Abuse

Intimate partner sexual abuse puts women at risk for a number of physical and mental health problems.

Physical Health

Women who are abused are frequently treated within health-care systems (Campbell, 2002). Intimate partner sexual abuse has long-term negative health consequences for survivors, even after the abuse has ended. According to several authors (El-Bassell et al., 1998 Wingood, and Declemente, 1997), women who were victims of intimate partner sexual abuse were more likely to present with sexually transmitted illnesses. They were also less likely to use condoms and more likely to engage in other high-risk sexual behaviors.

A number of other studies also looked at physical/health consequences of intimate partner sexual violence. These studies found that some common sequelae of intimate partner violence included (Campbell, 2002, Coker et. al, 2000; Sanchez et al., 2016; Stewart, Vigod, & Riazantseva 2016):

- General health problems
- Abdominal and stomach pain
- Digestive problems
- Higher incidence of urinary tract infections
- Lowered immunity to illnesses
- Vaginal infection discharge, and itching
- Sexually transmitted disease AIDS or HIV-1
- Vaginal bleeding, severe menstrual problems, dysmenorrhea
- Pelvic pain, genital area pain
- Fibroids or hysterectomy
- Painful intercourse and sexual dysfunction
- Headaches, migraines
- Fainting, passing out
- Seizures, convulsions
- Back pain, chronic neck pain
- Sleep disturbance, nightmares
Stress-Related Sleep Disturbance and Poor Sleep Quality during Early Pregnancy
Pregnancy Complications
Temporomandibular joint disorder (TMJ)
Hypertension
Risk of death

The physical effects of intimate partner sexual abuse are related to the chronic nature of this abuse and the body being under constant stress. It is similar to the effects seen in childhood survivors of sexual abuse. For both adult and childhood sexual abuse, constant stress causes the body’s natural alarm system to be on overdrive. This is often referred to as the “fight or flight response.” The body reacts by releasing adrenaline and cortisol. Long-term activation of the stress-response system, and the subsequent overexposure to cortisol and other stress hormones, can disrupt almost all the body's processes.

*Mental Health*

Case Vignette
*Caroline was taken by a friend to a rape crisis center following a particularly brutal sexual assault by her boyfriend. Her friend told the counselor that it was not the first time that this had occurred. Caroline appeared numb and disconnected, telling the counselor that she was not sure why her friend was concerned and that “everything was fine” and “everyone is making such a big deal about this.”*

Victims of intimate partner sexual assault have been violated both physically and emotionally. Due to the close nature of the relationship between victim and abuser, the mental health effects of intimate partner sexual violence are especially great. Finkelhor and Yllo (1987) state: “In addition to the violation of their bodies, victims are faced with a betrayal of trust and intimacy.” They also point out the tendency for victims to blame themselves, as well as the complex dynamics that involve many victims “loving the offender but hating the offense.” As a result, intimate partner sexual assault victims often “suffer long-lasting physical and psychological injuries.”

In addition to Finkelhor and Yllo (1987), the psychological sequelae of intimate partner sexual abuse have been documented by a number of researchers (Campbell, 2002; Sachs & Gromberg, 2009; Silva et al., 1997; Winfield et al., 1990;). According to Sachs and Gromberg (2009) victims of intimate partner sexual abuse/rape often develop symptomatology that consists of disruptions to normal physical, emotional, cognitive, behavioral, and interpersonal characteristics. Some of these disturbances include memory impairment, dulled sensory, affective and memory functions, sleep disturbance (insomnia, wakefulness, night terrors), self-blame and guilt, and activity avoidance. Together these are termed *rape trauma syndrome* (RTS). This term was first used by
Burgess and Holmstrom in 1974 and is similar to posttraumatic stress disorder. Additionally victims of intimate partner sexual abuse may struggle with chronic depression and suicidality, marked anxiety and panic. There may also be mood swings, obsessive qualities and somatoform disorders (physical symptoms with no identifiable cause). In terms of PTSD diagnosis, rape survivors represent the largest non-combat group of individuals with posttraumatic stress disorder (Campbell and Wasco, 2005). With intimate partner rape/intimate partner sexual abuse, the duration of trauma may vary. Ongoing abuse can result in more severe symptoms and/or chronic posttraumatic stress disorder. Campbell et al., (2008) has found that this may be especially true for survivors who have experienced cumulative trauma (such as trauma from childhood abuse).

Another mental health consequence of intimate partner sexual abuse concerns lifestyle changes. Victims often experience a sense that their personal security or safety is damaged. They may have difficulty trusting others (often a challenge for clinicians) or feel hesitant to enter new relationships. They may also isolate themselves from families, friends and others.

Common coping mechanisms seen in survivors may make it difficult to initially comprehend the impact of the abuse. An example of this can be seen in the case vignette. Some common coping mechanisms/defense mechanisms include minimization (pretending that “everything is fine”), suppression (refusal to discuss the abuse) or intellectualization (detached analysis what happened, often with focus on the victim’s role in the abuse.) Victims of intimate partner sexual abuse may also rely on maladaptive coping mechanisms, such as deliberate self-harm, drug, or alcohol abuse or use of eating disorder symptoms.

Finally another dynamic seen in intimate partner sexual abuse is the Stockholm Syndrome (see de Fabrique et al., 2007). Described as a victim’s emotional “bonding” with their abuser, Stockholm Syndrome develops subconsciously and on an involuntary basis.

Overall mental health sequelae of intimate partner violence includes (Sanchez et al., 2016; Stewart, Vigod, & Riazantseva 2016; Overstreet et al., 2015; Ullman & Sigurvinssdotir, 2015):

- Eating disorder symptoms
- Depression/Suicidal ideation
- Dissociation
- Anxiety
- Posttraumatic stress disorder
- Substance abuse (Legal and illegal drugs, alcohol)
- Impulsivity and suicidality
- Self-harm behaviors
- Sexual risk behaviors
Non-specific physical complaints and chronic pain syndromes
Risk of revictimization
Possibility of vicarious traumatization (to children)

Understanding the Dynamics of Intimate Partner Sexual Abuse

While this document highlighted many of the differences between intimate partner sexual abuse and other forms of domestic violence, the dynamics of intimate partner sexual abuse is similar to other forms of domestic abuse. The National Center For the Prosecution of Violence Against Women (2005) in its publication on understanding the dynamics of intimate partner sexual abuse, does highlight an important similarity between intimate partner sexual abuse and other forms of domestic violence, namely the need for authority/power seen in perpetrators.

Sexual assault is about power, and, therefore, sex is a weapon and a means of expressing the rapist’s aggression or power. Sexual abusers do not rape out of sexual desire. While some intimate partner abusers limit their violence to sexual assault, the majority of intimate partner sexual assaults occur within a physically abusive relationship. Many intimate partner sexual assaults also involve domestic violence dynamics. One useful tool to understand this dynamic is the Power and Control Wheel created by the Domestic Abuse Intervention Project in Duluth.

Some relationships in which there is intimate partner sexual abuse may also include a cycle of violence. This term “cycle of violence” was developed by Lenore Walker to describe three phases in an abusive relationship: tension building, physical abuse, and the honeymoon phase.

The behaviors of victims of intimate partner sexual abuse may conflict with many sexual assault victims. They may not resist during a rape or assault; frequently delay reporting their rape; and they may continue to have contact with their assailant.

Interventions for Victims of Intimate Partner Sexual Abuse

*Myra is a survivor of childhood trauma, and also a victim of intimate partner sexual abuse. While she has been able to leave her abusive husband, since she has actually been sleeping at night she has noticed nightmares connected to the abuse. While she would like to see about attending therapy, she is fearful that her husband will see their insurance statements reporting that she has been going and will use this against her in terms of custody of the children.*
Although the clinical picture for survivors in intimate partner sexual abuse clearly highlights the seriousness of the abuse, victims of intimate partner sexual abuse rarely seek treatment. When they do, it is important to provide services in an informed way.

Intimate partner sexual abuse is a complex problem. Victims’ issues are multidimensional (e.g., physical, mental, economic, legal, spiritual, emotional), and clinicians will often need to interact as part of a treatment team. This team may include psychologists, social workers, advocates and people in the legal realm.

**Screening for Intimate Partner Sexual Abuse**

This training material has highlighted the shame that victims of intimate partner sexual abuse often experience and the difficulty disclosing such abusive acts. In screening for sexual trauma, the following types of questions may be helpful:

- Have you ever been intimate with your partner when you didn’t want to?
- Have you ever been intimate with your partner because you were afraid of him / her?
- Are there times when sex between you or your partner is unpleasant for either one of you? What happens to make it unpleasant?
- Has your partner ever forced or pressured you into doing things that you weren’t comfortable with? What were they?
- Have you ever “given in” to a sexual encounter with your partner to avoid fighting or being hurt?

**Trauma Informed Care**

“Trauma-informed” care was a term first used by Harris and Fallot (2001), clinicians working in mental health addiction programs who noted the high number of individuals requiring these services who had experiences high rates of physical and sexual violence. They noted that despite the high number of traumatized individuals they were serving, few providers were knowledgeable about trauma and the effects of physical/sexual abuse. Trauma-informed services refers to the idea that providers offering mental health and other services to victims of intimate partner sexual abuse should be informed about, and sensitive to, trauma-related issues present in survivors (Harrison & Fallot, 2001; Laskey, 2009; Anyikwa, 2016).
A “trauma-informed” system is one that includes an understanding of the role that violence plays in the lives of adults, children and adolescents and families or caregivers seeking mental health and addictions services (Harris & Fallot, 2001). One of the primary goals of a trauma informed system is to deliver service in a way that will avoid inadvertent re-traumatization and will facilitate treatment compliance. Trauma-informed institutions make a commitment to staff training and development and to ongoing trauma-informed practice. These aspects of care make this approach particularly ideal for working with survivors of intimate partner sexual trauma.

**Elements of Trauma Informed Care**

In their initial work, Harris and Fallot (2001) identified five requirements for creating trauma-informed services: (1) administrative commitment to change; (2) universal screening for trauma history among participants/clients; (3) training and education on trauma for all staff; (4) hiring staff with a deep knowledge of trauma, referred to as “trauma champions”; and (5) reviewing policies and procedures to ensure they do not replicate abusive dynamics. This initial approach has been expanded and adapted to a number of traumatized communities including people experiencing homelessness, individuals with addiction, children and survivors of domestic violence.

Trauma informed treatment focuses on understanding the context of a person’s experience. It emphasizes safety, choice, empowerment, and cultural competence. Elements of trauma informed strategies include (Laskey, 2009):

- Focus on trust and safety
- Trauma knowledge, awareness/sensitivity
- Prevention-oriented
- Strengths-based, focused on empowerment and resilience
- Collaborative
- Culturally-competent/sensitive services

An additional requirement of a trauma informed approach is safety. Providers must be aware of safety issues. Victims of intimate partner sexual abuse may need to develop a plan for physical safety. Emotional safety is also important and can be fostered through non-judgmental treatment, informed consent practices and holistic care. This helps to build trust. Additionally it is important to attend to boundary issues, such as consistency, accessibility and clear role delineation.

**Vicarious Traumatization**

Clinicians who work with sexual assault victims may experience vicarious trauma. Symptoms of vicarious trauma are similar to those experienced by individuals with Post Traumatic Stress Disorder and include numbing, hypervigilance, sleep difficulties and intrusive thoughts of traumas described by
victims (Lassey, 2005). Slattery and Goodman (2009) found that in their study of 148 advocates, 47.3% had clinical levels of PTSD symptoms. These researchers found that lack of power within organizations significantly predicted vicarious traumatization. Emotional support from professional colleagues was found to be a protective factor.

Trauma informed care lessens the likelihood of vicarious trauma among mental health professionals. An important element of trauma-informed approaches involves staff support and encourages providers of domestic violence services to engage in: physical self-care, psychological self-care, emotional self-care and spiritual self-care (Center for Substance Abuse Treatment, 2014).

Levels of Support

A trauma-informed system, then, has three levels: the first is focused on the needs of trauma survivors, the second is focused on changing an organization’s culture to support staff and fully integrate trauma-informed practices into its service delivery; and the third level acknowledges the larger societal context in which survivors seek services and organizations operate. This level emphasizes engagement of the survivor within the larger community and community change.

Trauma-Specific Services

As noted previously, many people who have experienced intimate partner sexual abuse have symptoms of clinical or subclinical posttraumatic stress disorder. In addition to treatment within a trauma-informed space, they will also require trauma-specific services such as cognitive-behavioral therapy, complex trauma treatment, psychoeducation and grounding techniques (Courtois & Ford, 2015). Psychoeducation about the nature of intimate partner sexual abuse is particularly helpful, as are specific examples of behaviors that constitute intimate partner sexual trauma (e.g., forcing a partner to view pornography, refusing to use a condom, having intercourse while a partner is asleep or intoxicated). These types of behaviors should also be included in petitions for orders of protection.

Cognitive therapies and cognitive behavioral approaches have been found to be effective across a variety of populations in reducing PTSD and depression (Mendes, Mello, Ventura, Passarela, & Mari, 2008).

While these approaches are very effective with some men and women who have experienced intimate partner sexual abuse it is important to note that there is no “one size fits all” approach. For example, many people who are actively experiencing any form of intimate partner violence have life issues that may supersede their ability to engage in any therapeutic intervention, such as dealing
with the legal system or caring for children. Low-income individuals may lack the financial resources for therapy or childcare. It is also common for abuse perpetrators to use help-seeking activities against the victim, telling victims that they are too “mentally ill” to care for children. Thus more research is needed on how to overcome these barriers.

**Orders of Protection as a Therapeutic Intervention**

Ensuring the safety of any victim of domestic violence is a key aspect of trauma-informed and other domestic violence treatments. While orders of protection are often thought of as legal remedies for intimate partner violence (including sexual violence), recent research indicates that these may also have some therapeutic benefit as well. Wright and Johnson (2012) looked at whether having a civil order of protection may reduce symptoms or improve the psychological sequelae of exposure to trauma. Their findings support theories of “therapeutic jurisprudence,” suggesting that having a civil order of protection can improve mental health outcomes.
REFERENCES


