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**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.

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 second case vignette. Does coercion constitute abuse? 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.
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 societal views sometimes minimize the consequences of intimate partner sexual abuse, research finds that it is as problematic, if not more problematic, than abuse by a stranger. 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

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/or 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 stigma. Victims of intimate partner sexual abuse seem to also express many fears of revictimization.
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, and coercing an individual to have sex without protection against pregnancy or sexually transmitted diseases.

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 age 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 (NIPSVS). 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
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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.

A final 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.

Given the statistics in these studies, it is important to address sexual assault and rape 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,
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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:

- 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).

- 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.

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 (McCauley et. al, 1995: Campbell, 2002, Coker et. al, 2000):

- General health problems; lowered immunity to illnesses
- Digestive
- Eating disorder symptoms Abdominal and stomach pain
- Higher incidence of urinary tract infections
- 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
- Temporomandibular joint disorder (TMJ)
- Hypertension

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 Yllö (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 Yllö (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)

Another mental health consequence of intimate partner sexual abuse concerns lifestyle changes. Victims often experience a sense that their personal security or
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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.

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 (see Introduction to Domestic Violence).

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.
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**

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.

**Trauma Informed Care**

“Trauma-informed” services (Laskey, 2009) 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.

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.
Elements of Trauma Informed Care

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). Trauma informed care lessen the likelihood of vicarious trauma among mental health professionals.
REFERENCES


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