

## Asking women about intimate partner sexual violence

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This Resource Sheet aims to provide current information to those working in health care settings about how to approach the discussion of intimate partner sexual violence with their female clients and patients.

### Key points for health care service providers

#### Why discuss intimate partner sexual violence?

- Forty to forty-five per cent of women who are physically abused by their intimate partners are also forced into sexual activities by them (Campbell & Soeken, 1999).
- Women who have been sexually assaulted by their partners experience a number of serious risks that are different and more serious than women who experience physical violence alone. These include:
  - a greater risk of being killed by their partner;
  - stress-related symptoms;
  - increased likelihood of gynaecological; and
  - detrimental emotional and mental health effects.
- It can't be assumed sexual violence will be revealed—even when physical violence is disclosed, the sexual aspect may not be.
- Some victim/survivors may not even be certain that their partner's behaviour constitutes sexual abuse.
- Communication with a health care provider can make a difference in whether women access support services.

#### When is it necessary to ask about intimate partner sexual violence?

- There is debate about the benefits of screening all women for intimate partner violence and sexual violence.
- Screening all women may identify hidden sexual violence—although there is debate about the benefits versus possible detriment.
- Screening for sexual violence in cases where intimate partner violence of any kind is acknowledged or suspected is an alternative approach.
- Depression or poor mental health, frequent medical appointments, low self-esteem, stress, unexplained injury, and physical symptoms such as gynaecological problems are possible indicators of the presence of intimate partner violence.

- As there are serious health risks to mother and child when intimate partner violence is experienced during pregnancy, asking about intimate partner and sexual violence could form part of a pregnant patient's initial check-up.
- Never raise the issue of sexual violence when other family members or people (aged over 3) are present.

### What to say about intimate partner sexual violence

- It is important to ask about sexual violence specifically, not just physical violence.
- Find out more—understanding the dynamics of intimate partner sexual violence underpins an appropriate response from health care providers.
- It is important to overcome personal barriers such as embarrassment or fear that the question might be misinterpreted.
- There are screening tools with examples of questions to approach the subject of intimate partner violence, including sexual violence. Some are linked at the end of this publication. These can be adapted as appropriate.
- Consider pre-warning patients/clients about limits to confidentiality such as mandatory reporting obligations for child abuse.<sup>1</sup>
- Indicate that they can choose not to answer questions.
- Introduce the subject and make the client feel that the questions are routine. Some examples:
  - These questions are now a regular part of my consultations for female patients.
  - I now ask these questions routinely because I have found that many of my clients/patients live with violence at home.
  - I am now going to ask a few questions about your relationship because in my experience many patients have found it useful to discuss aspects of their home life that may impact on their general wellbeing.
- Don't be apologetic for asking the questions or indicate in any way that you do not think the woman is experiencing abuse. This makes disclosure more difficult.
- Use plain language. Some examples:
  - Is your partner understanding when you don't feel like sex?
  - Do you ever feel forced or pressured to have sex with your partner?
  - Has your partner ever pressured you into sex when you don't want to, or pressured you to do something you don't like?

### How to respond to disclosures of sexual violence

- Referral to appropriate support services is vital. Be familiar with local and national sexual assault and family violence services and consider contacting the services yourself rather than just giving out the number. You could also offer patients the use of a telephone to enable them to safely make a call in private.
- Be vigilant about maintaining privacy—it could be a safety issue.
- Consider who has access to file notes (e.g., court subpoenas) and plan how disclosures will be documented in light of this.
- Believe the disclosure—by listening, by allowing the victim/survivor to use their own words, by providing a sympathetic response and refraining from asking investigative type questions.
- Be compassionate and respectful.
- Be sensitive to the effects of trauma—victim/survivors often suffer complex trauma.
- Be non-judgmental (many victim/survivors avoid disclosure for fear of being judged).
- Ensure the victim/survivor maintains control over the next step such as whether they choose to use support services.

<sup>1</sup> This can be a contentious issue—particularly if you believe there may be children at risk of harm. Each state and territory should have guidelines around mandatory reporting and these should be considered.

## Intimate partner sexual violence

Women who experience intimate partner sexual violence face risks that are different—and potentially more devastating to their physical, mental and emotional health—than women experiencing solely physical violence (Bennice & Resick, 2003; Guggisberg, 2010).

It has been shown that women who are forced to have sex by their partners may be at a greater risk of being killed by them (Campbell & Soeken, 1999).

There is also evidence that pregnancy may increase the likelihood of experiencing intimate partner violence (Australian Bureau of Statistics, 2006; Burch & Gallup, 2004), including sexual violence (Martin et al., 2004), which makes addressing intimate partner sexual violence an important aspect of pregnancy care. Abuse during pregnancy can have significant health issues for the unborn child (Campbell, 2002; Campbell, Garcia-Moreno, & Sharps, 2004; Jasinski, 2004).

Intimate partner sexual violence may be more difficult for women to talk about than other types of abuse (Howard, Riger, Campbell, & Wasco, 2003). It cannot be assumed that sexual violence will be disclosed. Often, even when the physical violence is revealed, the sexual aspect of the partner's offending is not (Parkinson, 2008). It is therefore not sufficient to ask only about physical violence, as this may not elicit information regarding sexual assault.

Health care providers can offer one of few opportunities to intervene in intimate partner violence, particularly where perpetrators are excessively controlling about their partner's movements and contacts (Coker, Hall Smith, McKeown, & King, 2000). The health care setting may provide a private and safe place to seek help. The patient/client must feel safe and should be seen alone.

Research on the impact of intimate partner sexual violence on women have revealed some concerning statistics on its effects, such as the increase in stress levels and depression, physical injury, and gynaecological problems (Campbell, 2002).

The benefits of universal screening are still inconclusive. Some studies suggest there are no clear benefits, and at worst that it may cause trauma to some women, particularly if the health care provider is unable to respond appropriately (Spangaro, Zwi, & Poulos, 2011). An alternative approach may be to ask about sexual violence in cases where intimate partner violence of any kind is acknowledged or suspected. Either way, asking directly about sexual violence may be a form of intervention in itself by giving women an opportunity to talk (Spangaro et al., 2011).

## Help-seeking behaviour by victim/survivors of sexual assault

Lievore (2005) pointed out that the decision of victim/survivors to disclose sexual assault may not follow a seemingly rational decision-making process. Disclosures may be planned or spontaneous, delivered calmly or erratically. Often disclosures occur in social situations (such as to a friend). Informal social networks such as friends and health providers play a very important role in helping women seek other assistance or formal avenues of address (Lievore, 2005).

### Where do women seek help?

The fact that a high number of disclosures are made to health care professionals is consistent with the fact that women use these services more than men. It is also indicative that professional help is needed to deal with the consequences of the assault/s (Lievore, 2005).

Physicians and health care settings are likely to be identified as helpful by individuals in violent relationships (Phelan, 2007).

General practitioners are the major professional group to whom women disclose intimate partner violence (Hegarty & Taft, 2001).

### Barriers to disclosure and seeking help

There are various reasons why women in a violent relationship may find it difficult to seek help when their partners are sexually abusing them. These include:

- fear of retaliation;
- economic dependence on the perpetrator;
- children or other family members suffering if the relationship breaks down;
- shame;
- fear of not being believed; and
- not being able to frame the behaviour against them as criminal (e.g., people may think they are not entitled to protection from sexual assault when in a relationship with the perpetrator).

These barriers highlight the importance of a supportive and non-judgmental response to victims' disclosures of intimate partner sexual violence.

### Talking about sexuality and relationships

Our society still considers sexuality between partners to be private. A health professional may feel they are invading a client's privacy by asking them about sexual violence. They may feel embarrassed or uncomfortable themselves in talking about sex (Wall, 2012). They may have concerns that clients or patients will misinterpret the questions, particularly where the patient and health care professional are different genders. However, it is important to overcome these barriers.

There is very little literature describing the best way to ask clients specifically about sexual violence. However, there are various resources that discuss ways of fostering disclosure of intimate partner violence and about supporting sexual assault victims more generally. Elements of both are applicable to eliciting information on intimate partner sexual violence. It is important that sexual violence is considered distinctly from physical violence as it may require referral to sexual assault services and specific counselling.

There are various reasons victims of intimate partner sexual violence do not disclose or report their experiences, but it has been noted that victim/survivors are more likely to report where they are directly asked about sexual violence in a sensitive and supportive environment (Probst, Turchik, Zimak, & Huckins, 2011).

Enquiry about intimate partner violence itself is a type of intervention that can provide clients with validation that the violence is unacceptable (Anglin, 2009; Spangaro et al., 2009). Regardless of whether a disclosure is forthcoming, the patient may still be helped just by the opportunity to consider the perpetrator's behaviour. Talking about intimate partner sexual violence could help counteract the lack of public acknowledgement and discourse around sexual assault in intimate relationships.

"Framing questions" (Anglin, 2009) can make a patient feel they are not being singled out or judged. Examples include: "I ask all my female patients these questions" or "Because of the prevalence of violence in our community, I now routinely ask my patients these questions". These questions could be tailored for the detection of sexual violence from intimate partners.

### Intimate partner sexual violence and same-sex relationships

Sexual violence is not limited to heterosexual relationships and may be even more isolating for victim/survivors of same-sex partnerships. Often, people in same-sex relationships may already feel marginalised. Disclosure may be even more difficult where there is a lack of understanding that intimate partner sexual violence occurs at around the same rates as it does in heterosexual relationships (Seelau & Seelau, 2005; Turell, 2000). Victim/survivors may have additional concerns about disclosing the abuse if they have never discussed their sexuality with family or friends, or they may

feel concerned about becoming isolated from their community if they disclose (Winters, 2008). One of the key reasons that same-sex intimate partner violence is not reported is a fear that the victim/survivor won't be believed (Leonard, Mitchell, Pitts, & Patel, 2008). This means that victim/survivors in same-sex relationships will need particular reassurance that health professionals will not be judgmental about their sexuality (Winters, 2008).<sup>2</sup>

## Who should ask?

The research on intimate partner sexual violence indicates that health care settings provide an opportunity for support and intervention if patients/clients are asked about it (Bennice & Resick, 2003; Campbell, 2002; Parkinson, 2008). General practitioners especially, are in an ideal position to identify victim/survivors and provide referral or links to support services (Hegarty & Taft, 2001). But, as women experiencing intimate partner violence often have a higher than average use of health services (Campbell, 2002), other health professionals are also likely to be in contact with them and may have an opportunity to ask about sexual violence where abusive partner behaviour is suspected.

### Terminology in the research

#### Screening

Screening describes a particular test or set of questions designed to detect partner violence across an asymptomatic population (e.g., all women) with the aim of preventing further violence (Victorian Community Council on Crime and Violence, 2006). However, there is debate around universal screening and whether victim/survivors in their various presentations can be considered asymptomatic (Anglin, 2009). There are unresolved debates around the risks and benefits of routine screening of women for intimate partner violence (Spangaro et al., 2009) (see also Taft, 2002).

#### Disclosure

Disclosure refers to the client's revelation of intimate partner sexual violence. This can be spontaneous or prompted. It does not necessarily mean that a formal response is set in motion. Supporting or enabling disclosure should become part of the process of caring for women in a health care setting. There will be no set way that women disclose and there may be varying accompanying emotions or no overt display of emotion. Some women may appear calm and rational; others may present the information more chaotically. This lack of consistency in women's disclosure will mean that believing the disclosure, regardless of the manner in which it is delivered, is vital. Disclosures may also be indirect, alluding to certain behaviours that indicate the presence of intimate partner sexual violence without necessarily disclosing outright.

#### Reporting

As distinct from disclosure, reporting generally refers to a formal report about the incident/s being made to police, thereby setting in motion a response from the justice system. Reporting should be the choice of the victim/survivor. The decision to report or not does not necessarily reflect the severity of the abuse, the truth of the victim's disclosure or any other factual issues surrounding the events.

<sup>2</sup> For more information see ACSSA Resource Sheet, *Sexual Violence and Gay, Lesbian, Bisexual, Trans, Intersex, and Queer Communities* (Fileborn, 2012).

## Creating supportive environments in health care settings

Some suggestions are included here to ensure a supportive health care environment for victim/survivors. These suggestions incorporate themes that commonly arise in the sexual assault and domestic violence literature on providing support to sexual assault victims/survivors.

### Privacy

Privacy is a concern in any professional setting but an environment that fosters disclosure will ensure private discussion with the client/patient without the presence of partners, children or other family members (Anglin, 2009).

### Naming the sexual violence

Parkinson (2008) reported that helpful responses from health professionals included naming the sexual violence and identifying it as abusive. Heenan (2004) noted that there is a trend around intimate partner sexual violence, for female victim/survivors to minimise the seriousness of the abuse. In addition, societal and cultural beliefs that intimate partner sexual violence is not as serious as being raped by a stranger may lead to victim/survivors questioning whether their experiences qualify them as deserving assistance (Bennice & Resick, 2003). By naming the intimate partner sexual violence as abuse, it validates the victim's experience and emphasises the need to obtain help or resources.

### Believing

Believing the information is an important factor in providing a positive response (Parkinson, 2008). Do not try to extract facts to determine whether or not the abuse happened. Assume the truth of the disclosure and understand that sexual abuse is a common experience for all kinds of women.

### Compassionate and respectful responses

Parkinson (2008) found that the most helpful responses from health professionals—as identified by victim/survivors—were listening, believing, and understanding that these women were victims of criminal acts.

### Being trauma-informed

Trauma-informed services are those with an understanding of and sensitivity to trauma related issues present in victim/survivors. A trauma-informed service comprehends their clients in the context of their life experiences, culture and history, and responds in a way that will avoid inadvertent re-traumatisation. It should not focus on what is wrong with a person but what has happened to them and should ensure collaboration and consumer participation in treatment (Jennings, 2004).

### Non-judgmental responses

It is important that personal judgments are not directed towards the client. There are many reasons why women may be dependent on a partner, or make an active choice for maintaining a violent relationship. Fear is a very common reason. Sensitivity to the fact that the victim is not responsible for the violence is necessary.

## Knowledge

Understanding sensitive topics such as sexual abuse and obtaining knowledge about intimate partner sexual violence are important for providing a supportive health care response to victims. Displaying information in waiting areas can also indicate to patients/clients that the service provider understands the issues around intimate partner sexual violence and will be supportive (Victorian Community Council on Crime and Violence, 2006).

## Referral

It is important that in asking about sexual violence there is an ability to respond appropriately to disclosures and direct the victim/survivor to specific information, resources and support. When disclosures are made, referral to specialist sexual assault and domestic violence services will assist the patient to access the necessary support required. The National Sexual Assault, Domestic Family Violence Counselling Service provides a national phone number for any assistance with regards to sexual assault.

**1800RESPECT National Sexual Assault, Domestic Family Violence Counselling Service**  
Call 1800 737 732 or visit **1800RESPECT Online** <[www.1800respect.org.au/index.html](http://www.1800respect.org.au/index.html)>

## Referral contact details

The ACSSA website also has a list of contacts and counselling services nationally and by state/territory <[www.aifs.gov.au/acssa/crisis.html#NTV](http://www.aifs.gov.au/acssa/crisis.html#NTV)>.

The National LGBTI Health Alliance website provides state specific contacts for assistance to LGBTI health issues <[www.lgbthealth.org.au/members](http://www.lgbthealth.org.au/members)>.

## Screening and assessment tools

There are a number of screening and assessment tools used by the health profession to detect intimate partner and sexual violence. A compilation of many of these is available in:

*Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings* <[www.cdc.gov/NCIPC/pub-res/images/IPVandSVscreening.pdf](http://www.cdc.gov/NCIPC/pub-res/images/IPVandSVscreening.pdf)>

## Guidelines for sexual health and intimate partner violence

World Health Organization guidelines for medico-legal care for victims of sexual violence <[www.who.int/violence\\_injury\\_prevention/publications/violence/med\\_leg\\_guidelines/en/](http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/)>

The Royal Australian College of General Practitioners website includes a range of guidelines to assist general practitioners in their work, including guidelines around intimate partner violence <[www.racgp.org.au/guidelines/intimatepartnerabuse](http://www.racgp.org.au/guidelines/intimatepartnerabuse)>

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