Intimate Partner Violence and Women's Sexual Health: Implications for Couples Therapists

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Intimate partner violence (IPV) affects approximately one in four women every year and approximately one third of all female victims of homicide are killed by an intimate partner. The negative physical and mental outcomes of IPV and the sexual manifestations of these outcomes are identified. Furthermore, the implications of these outcomes for couples therapists are identified.

Keywords: *intimate partner violence; domestic violence; sexual violence; couples therapy*

Domestic violence is the willful intimidation, assault, battery, sexual assault, and/or other abusive behavior perpetrated by one intimate partner against another. It is an epidemic affecting individuals in every community, regardless of age, economic status, race, religion, nationality or educational background. Violence against women is often accompanied by emotionally abusive and controlling behavior, and thus is part of a systematic pattern of dominance and control. Domestic violence results in physical injury, psychological trauma, and sometimes death. The consequences of domestic violence can cross generations and truly last a lifetime (National Coalition against Domestic Violence [NCADV], 2007).

According to the NCADV (2007), an estimated 1.3 million women are assaulted by their intimate partners each year, and one in every four women will be abused by a partner during her lifetime. Women between 20 and 24 years of age are most at risk for intimate partner violence (IPV). International in scope, IPV in the UK is reported to occur in one in four households and, in Canada, one half of the women over 16 years report at least one incidence of IPV (D'Ardenne & Balakrishna, 2001). A multinational study conducted by the World Health Organization (WHO) concluded that women from industrialized and nonindustrialized nations around the world are at greater risk of violence from an intimate partner than any other type (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). Although the most common form of IPV, and the focus of this article, is violence perpetrated by men against women, relationship violence also involves women who abuse men and occurs in gay, lesbian, and transgender relationships (Dugan & Hock, 2006).

IPV is an underreported crime, with only about one fourth of physical assaults, one fifth of rapes, and one half of stalkings against women ever reported to the police (NCADV, 2007). These are particularly chilling statistics in light of the fact that approximately one third of female victims of homicide are killed by an intimate partner. Of these homicide victims, 76% were stalked by the person who killed them (NCADV, 2007). Campbell (2002) reports that the rates of murder of female victims of IPV in less industrialized nations may be even higher, but global data are insufficient to determine prevalence. Additionally, approximately 7.8 million women have been raped by an intimate partner, with stalking prior to the sexual assault (NCADV, 2007).

The prevalence of IPV suggests that marital, family, and couples therapists are very likely to work with clients who are currently, or have previously been, in abusive relationships. Therefore, the therapist must be able to identify and respond appropriately to IPV and its negative outcomes. The purposes of this article are to describe the enduring effects, physically and mentally, of relationship violence. As well, the relationships between IPV and women's sexual health will be explicated and the implications of IPV for couples therapists will be discussed.

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NATURE AND OUTCOMES OF INTIMATE PARTNER VIOLENCE

D'Ardenne and Balakrishna (2001) describe the nature of violent relationships as those that develop over time and include mutual dependencies. The emotional ties or bonds between partners, within their marital and sexual relationship, may make it difficult for the female partner to leave the relationship or to disclose the situation to others. The relationships that develop between partners mimic in some ways those of hostage and captor, with the victim losing her sense of autonomy as the perpetrator asserts increasing degrees of physical, psychological, and sexual control (D'Ardenne & Balakrishna, 2001). According to Herman (1992, cited in D'Ardenne & Balakrishna, 2001), the victim becomes increasingly isolated and more dependent on the perpetrator and relies on him for survival and satisfaction of all bodily and emotional needs. The woman who is battered often perceives herself as powerless and with no means of escape. Women in abusive relationships may attribute the blame for those relationships to themselves and their failures. One's ability to sustain and derive support from existing family and friend relationships, as well as the ability to form new, trusting relationships, may be compromised. Additionally, IPV leads to sexual difficulties, even in subsequent relationships.

Negative Physical Outcomes

Battering and or forced sex may result in enduring health problems manifested as poor health status and poor quality of life long after the abuse has ended (Campbell, 2002). Bonomi, Anderson, Rivara, and Thompson (2007) identify 14 possible physical symptoms resulting from IPV. The list includes "joint pain, back pain, insomnia, fatigue, abdominal pain, severe headache, numbness in hands or feet, diarrhea, constipation, shortness of breath, facial or jaw pain, dizziness, nausea or vomiting, and chest pain" (Bonomi et al., 2007, p. 992). Based on a review of literature, Campbell (2002) identified health consequences for which women that have been abused are at higher risk. These risks include gastrointestinal symptoms and disorders as well as cardiac symptoms commonly associated with chronic stress. Blows to the head and incomplete strangulations that result in loss of consciousness may also lead to serious medical problems. Additionally, abuse during pregnancy increases the risk of injury or death to both mother and fetus.

Forced sex leads to a range of gynecological problems, including vaginal, anal, and urethral trauma (Campbell, 2002) and increased risk for sexually transmitted diseases (STDs), including HIV and AIDS (Coker, 2007). Forced sex may also lead to the development of chronic pelvic pain, pain during intercourse or menstrual bleeding, menstrual irregularities, infertility, or eventually hysterectomy (Coker, 2007). Unintended pregnancies and STDs may also result from sexual assault, as part of the power and control of the perpetrator is exerted through denial of barrier methods of birth control. According to Coker (2007), there is a positive correlation between unwanted pregnancies and attempts of self-induced abortions. A self-induced abortion may lead to infections, or in some cases, death. Twenty-seven percent of the women in McFarlane and Malechi's (2005) study reported increased use of alcohol, illicit drugs, or nicotine following their first sexual assault.

Battered and abused women seek health services at higher rates than nonbattered women (Campbell, 2002). However, less than one fifth of women injured by their intimate partners seek health care assistance for the trauma related injuries (NCADV, 2007). Because those who do seek health services often do not present with obvious trauma-related injury, Campbell (2002) stresses the importance of screening for abuse in all health-care settings. As Campbell notes, women who have been abused by their partners will seek health care services at a higher rate than either justice or social services.

Negative Mental Outcomes

Women who experience IPV are also at risk for developing acute and chronic mental-health disorders. According to Campbell (2002), depression and posttraumatic stress disorder (PTSD) bear significant comorbidity, creating the most prevailing mental health sequelae of IPV. Golding's (1999) meta-analysis of mainly U.S. studies reported IPV as a more significant risk factor in the development of depression and PTSD than childhood sexual assault. Golding also found support for higher substance abuse rates among women who experience partner violence than in the general population.

In addition to these clearly defined disorders, D'Ardenne and Balakrishna (2001) call attention to the *Diagnostic and Statistical Manual of Mental Disorders–Fourth Edition* (American Psychiatric Association, 1994) classifications that reference codes for IPV, which include "committing physical abuse" (V61.12), "sexual abuse" (V62.83), "victims of physical abuse" (999.81) and "victims of sexual abuse partner from a partner" (995.83). These codes do not define disorders, but "other conditions which may be the focus of clinical attention" (D'Ardenne & Balakrishna, 2001, p. 230). Symptoms for disorders or codes frequently reported by victims include suicidal ideation, the inability to establish intimacy and trust, grief, shame, and social isolation.

Negative Sexual Outcomes

The sexual outcomes for women who experience IPV are complicated. For example, nonconsensual sex, often accompanied by humiliation, threat, and control, are considered to be abuse and part of a dysfunctional relationship rather than a sexual dysfunction (D'Ardenne & Balakrishna, 2001). However, the resulting trauma from IPV may directly influence a woman's sexual health and lead to the development of dysfunction. Coker (2007) conducted a review of 51 manuscripts published between 1966 and 2006 to identify the established relationships between IPV and sexual health. She found support for relationships between IPV and four dimensions of sexual health: sexual risk taking (e.g., inconsistent

condom use or nonmonogamous partners), unplanned pregnancy or induced abortion, STDs, and sexual dysfunctions. Coker limited her review of the relationship between violence and sexual health to IPV and focused on two indicators of sexual dysfunction: satisfaction, pleasure, and desire, and sexual pain. Women who have experienced IPV in the form of forced or nonconsensual sex are at increased risk for painful intercourse, vaginal bleeding, fibroids, STDs, genital irritation, chronic pelvic pain, and urinary tract infections (Campbell, 2002). Vaginal and rectal bleeding as well as pelvic inflammatory disease are also common for women who experience sexual abuse (McFarlane & Malechi, 2005).

In the context of PTSD symptoms among female survivors of childhood sexual abuse, authors also report intimacy and sexual disorders (Elmone & Lingg, 1996) as well as sleep disturbance, difficulties in maintaining concentration, memory problems, and irrational guilt (Briere, 1989). Similar patterns may present among those who have experienced partner violence. Substance abuse, a recognized form of numbing associated with PTSD, has also been identified as a causal factor in certain sexual dysfunctions (Cobia, Sobansky, & Ingram, 2004). Another mental health outcome, depression, has consistently been associated with problems in sexual functioning (Frohlich & Meston, 2002; Gitlin, 1995; Phillips & Slaughter, 2000). Decreased sexual satisfaction, decreased pleasure, aversion, loss of desire, and arousal difficulties have been reported among women who were not receiving treatment for their depression (Frohlich & Meston, 2002). Not surprisingly, both the physical and mental health outcomes resulting from IPV often reduce a woman's sexual pleasure or desire (Coker, 2007).

IMPLICATIONS FOR COUPLES THERAPISTS

Long-term psychological effects and sexual dysfunction issues are common features of IPV even if violence has stopped. Unresolved issues associated with IPV, whether in the context of previous or current intimate partner relationships, must be identified and addressed to respond effectively to current relationship concerns. Ongoing issues of trust and guilt and more serious symptoms of PTSD and depression may be present. Assessing and treating these issues may be a necessary precursor to successful couple or sex therapy. If physical symptoms persist from traumatic experiences, sex therapy may be premature and unlikely to be effective with the couple. Therefore, it is essential that couples therapists assess for past or present IPV.

Although more than one half of the couples who seek treatment have experienced abuse, this is rarely identified by the couple as the presenting concern (LaTaillade, Epstein, & Werlinich, 2006). Ehrensaft and Vivian (1996, cited in LaTaillade et al., 2006) found that the most common reason for not spontaneously reporting couple violence is that the violence was not considered a problem. Other reasons for nondisclosure may include concern by the woman that she will not be believed, fear for physical safety following the disclosure, and shame at being in a failed relationship (McFarlane & van der Kolk, 1996, as cited in D'Ardenne & Balakrishna, 2001). In light of the prevalence of IPV and its negative outcomes for women, it is likely that those couples seeking therapy will be asking for help with physical or mental health outcomes associated with IPV, including the previously described sexual difficulties. Therefore, assessment for the presence of violence in a relationship is an essential tool for all couples therapists (Blasko, Winek, & Bieschke, 2007).

Through a review of related literature, LaTaillade et al. (2006) found that the number of people acknowledging partner violence as a problem in their relationship increased as the formality of the assessment increased. Consequently, routine, structured, and multimethod assessment procedures are needed to increase the likelihood of detection of IPV (LaTaillade et al., 2006). Self-report instruments to detect abuse need to be completed separately and in privacy. LaTalliade et al. (2006) have published a list of recommended measures for the conjoint treatment of IPV. The instruments suggested measure relationship functioning, physical abuse, psychological abuse, individual psychological functioning, affective functioning, cognitions about relationships, and gender roles. Additionally, these authors recommend separate interviews be conducted with each partner where they may each discuss the violent incident(s) in detail. The assessment protocol should include mechanisms for determining the level of violence, whether either partner is perceived to be in danger, and whether the female partner feels safe living with her partner and participating in conjoint therapy. This information is critical to the decision of whether to pursue conjoint counseling. If the therapist judges that there is a notable risk for violence, alternative therapy options need to be explored.

Unfortunately, there is a lack of professional consensus regarding the best approach to treatment of IPV. For violent offenders who are actively battering, the treatment approach most often involves gender-specific groups focused on anger management and modification of the perpetrator's personal beliefs that support the use of aggression toward partners during conflict (LaTaillade et al., 2006). Babcock and La Taillade (2000, cited in La Taillade et al., 2006) report that such groups are effective with about half of those completing treatment. However, only about one third of the offenders referred to these groups actually complete the treatment (Murphy & Eckhardt, 2005, cited in La Taillade et al., 2006). Although Gondolf (2000) found that approximately 12% of the female partners reported that their life experiences had worsened since their male partner joined a batterer's group, this form of treatment is generally considered safer for the female partners than couples counseling. In fact, because of increased risk for the female partners when there is a high degree of coercion and ongoing violence in the relationship, some states actively discourage funding of treatment programs for IPV in which couples counseling is the primary mode of intervention (Healey, Smith, & O'Sullivan, 1998, cited in Stith, Rosen, McCollum, & Thomsen, 2004).

In addition to the high rates of recidivism and incompletion in batterer groups, Stith et al. (2004) identify several other pertinent issues that are simply not addressed through such groups. There has been increasing support in the literature for subgroups or types of batterers, not all of whom respond to the same treatment approach. Furthermore, in those relationships where both partners use violence, treating only one member of the couple is not likely to stop the violence. Underlying relationship dynamics that inform partners' decisions to stay in the relationship despite the violence are not usually addressed in male batterer groups. Finally, Stith et al. point out that specific relationship dynamics that predict physical aggression (e.g., relationship discord) are not addressed in gender specific groups. To address these concerns, Stith et al. propose a model of conjoint treatment for IPV, incorporating strategies to reduce risk of violence, enhance open and candid communication, and promote accountability for each partner's aggression. Stith et al. conducted a study to determine the outcomes of their domestic-violence-focused treatment program for couples that choose to stay together after mild-to-moderate violence has occurred. Forty-two couples were randomly assigned to either individual couple or multicouple group treatment. Nine couples served as the comparison group. Male violence recidivism rates 6 months after treatment were significantly lower for the multicouple group (25%) than for the comparison group (66%). In contrast, men in the individual couple condition were not significantly less likely to recidivate (43%) than those in the comparison group. In addition, marital satisfaction increased significantly, and both marital aggression and acceptance of wife battering decreased significantly, among both partners participating in multicouple group therapy, but not among those who participated in individual couple therapy or the comparison group.

Bograd and Mederos (1999) also offer guidance for couple therapists who are making decisions about the appropriate treatment approach for IPV. They suggest the therapist first meet with the couple together and then in individual sessions before deciding to use couples therapy. The authors state that therapists should make sure that the following criteria are met before starting couples therapy: (1) both spouses agreed to couples counseling, (2) the man exhibited few incidents of minor violence, (3) the man infrequently used mild psychological abuse and is not intimidating, (4) there is no risk for lethality and the woman is not fearful of the man, (5) the man takes responsibility for his abusive behavior, and (6) the man commits to containing his explosive behavior. If these criteria are not met, the couple should participate in individual or group counseling instead of couples counseling.

Despite lingering concerns in the field about the wisdom of seeing couples conjointly when there has been IPV, McCollum and Stith (2007) state that the research literature and clinical practice experience both indicate that this approach can be safe and effective for at least some couples. The authors suggest best practices in this area of couple's therapy should include seeing couple's treatment of IPV as a clinical specialty necessitating specific training, facilitating a coordinated community response to IPV, modifying the structure of therapy to increase safety, and carefully screening couples and conducting an ongoing assessment of the propriety of conjoint treatment. To date, there is no single treatment approach to IPV that has clear empirical support (Stith et al., 2004).

CONCLUSIONS

Intimate partner violence is a widespread problem that therapists who work with couples are likely to encounter in their practices. The effects are enduring and negatively impact the physical, mental, and sexual health of abused partners. Because of the low rates of voluntary disclosure of IPV, therapists need to be aware of the issues resulting from IPV, mental and physical, and include routine screening for the presence of violence in their standard intake procedures. The assessments, and subsequent referrals or sessions, should be conducted in ways that minimize the risk of harm to clients. Decisions about mode of treatment are directly linked to the extent of violence, the types of violence, and the extent to which intimidation and control are used in the relationship. The negative outcomes of past or current IPV on physical and mental health need to be addressed before treating other couple concerns.

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