Sexual intimate partner violence (sexual IPV) is a significant social problem that affects millions of adolescent and adult women across the globe (Black et al., 2011; Decker et al., 2015). Though sexual IPV is experienced by women as particularly humiliating, degrading, and shameful, it has been under-researched in comparison to physical and psychological IPV (Kennedy & Prock, 2018; Logan, Walker, & Cole, 2015; Temple, Weston, Rodriguez, & Marshall, 2007; Weiss, 2010). Why might this be? Sexuality and sexual behavior – especially among young, unmarried women – are typically perceived as private, even taboo topics (Chillag et al., 2006; Montemurro, Bartasavich, & Wintemute, 2015). Additionally, male partners’ sexual aggression has been normalized as innate and inevitable, with girls’ and women’s endurance of forced sex understood as part of their natural role (Hlavka, 2014; Tang & Lai, 2008). For example, only in the last 30 years has the United States outlawed rape within marriage, while marital rape remains legal in over 100 countries (Bennice & Resick, 2003; Decker et al., 2015). Finally, IPV researchers have too often ceded the study of sexual violence to sexual assault (SA) researchers, who frequently do not differentiate between partners and non-partners as perpetrators, thus rendering sexual IPV largely invisible within the sexual assault literature (Bagwell-Gray, Messing, & Baldwin-White, 2015).

Sexual victimization within intimate relationships takes many forms, including unwanted but consensual sex, coerced sex, and rape or attempted rape as a result of force, threat of force, or inability to give consent due to intoxication (Hamby & Koss, 2003; Logan et al., 2015). Additionally, technology-facilitated sexual violence (e.g., non-consensual sharing of sexually explicit images via social media, revenge pornography) is an emergent form of IPV, particularly among young people (see Stanley et al., 2018; Walker & Sleath, 2017). In order to focus our review and obtain consistency across global studies of women’s experiences with sexual IPV, which is typically measured by two items on partner-forced sex from the World Health Organization’s (WHO) Demographic and Health Survey (Decker et al., 2015; Kidman, 2017), we limit the inclusion of studies to those that assess for partner rape or attempted rape, unless otherwise noted. We take an intersectional feminist approach both to highlight social location factors (e.g., class, race/ethnicity/cultural context), and to bring marginalized voices to the center (Collins & Bilge, 2016; Crenshaw, 1991; Hancock, 2016; Sokoloff, 2005). We draw
on qualitative, quantitative, and mixed methods studies that have been published since 2000. Because most of the research has been within the US, we separate US studies from those conducted in other countries. Given that even first relationships begun in early adolescence may involve sexual IPV, we include studies across women’s life-course (Kennedy, Bybee, McCauley, & Prock, 2018a; Kidman, 2017). We first provide detailed estimates of the prevalence of sexual IPV; then turn to a discussion of sexual IPV in co-occurrence with other forms of IPV; predictors of sexual IPV; outcomes associated with sexual IPV, including acknowledgment and labeling, self-blame, shame, and anticipatory stigma, and mental health and health; and the process of disclosing sexual IPV, including seeking and attaining help. We highlight critical findings as well as research, practice, and policy implications.

**Prevalence of sexual IPV**

**United States estimates**

Data from the National Intimate Partner and Sexual Violence Survey (NISVS) indicate that just over half of rape survivors (51%) report that their perpetrator was a current or former intimate partner. Nearly one in ten women (9%) have been raped by a partner in their lifetime, with multiracial women experiencing the highest rate (20%), in comparison to Black (12%), White (9%), and Latina women (8%) (Black et al., 2011). Adolescence and young adulthood are highly vulnerable periods: a majority of female IPV and SA survivors (69% and 80%, respectively) report that their first victimization occurred before the age of 25 (Black et al., 2011). Among female adolescents aged 12–17 who have been in a relationship, 3% have experienced attempted rape by a partner (Hamby & Turner, 2013), while 12% of female high school students who have ever dated have been forced to do sexual things they did not want to do by a dating partner within the last year, including kissing, touching, or forced sex (Vagi, Olsen, Basile, & Vivolo-Kantor, 2015). Results from a diverse sample of young women (39% Black, 39% White, 10% Latina, 7% biracial, 5% Asian, 1% Native American) indicate that within girls’ abusive first relationships, begun when they were just under 15 years old on average, sexual IPV occurred 29% of the time, with 37% of the sexual IPV occurring more than five times during the relationship (Kennedy et al., 2018a). Alice, a Chinese American adolescent who was 16 at the start of her first relationship, describes repeated rapes by her boyfriend:

> towards the end I was just not really feeling it anymore. I just didn’t enjoy it with him anymore. And, it was just the same things over and over again but towards the end it was pretty much rape every time. Because it was, it would just be like, he’d start touching me and stuff and I’d be like “Stop.” Wouldn’t stop. And then he would, we’d be on the couch and he’d literally pick me up and then take me to his bedroom and I’d be like, like this on the door frame [acts out pulling on the door frame] “Stop.” And “I don’t want to do this.” And he’d throw me on the bed and take off all my clothes. And then do whatever. And the entire time I’d be like “Stop, no.” And then, [he] wouldn’t.

(Kennedy, Meier, & Prock, under review)

In a national sample of young women aged 18–24 (some of whom were in college, some not in college), 6% of both groups had been physically forced to have sex by a partner within the past year (Coker, Follingstad, Bush, & Fisher, 2016), while results from the National College Women Sexual Victimization Study indicate that 2% of participants had been raped since the
Sexual violence in intimate relationships

beginning of the academic year, with nearly a quarter of the rapes (24%) committed by a partner or ex-partner (Fisher, Daigle, & Cullen, 2010). In a representative sample of adult women, 10% had been forced by a partner to have sex, either via threats of violence or physical force (Basile, 2002). Within samples of adult IPV survivors in shelters or seeking formal help from law enforcement (LE), the rate of sexual IPV is much higher, ranging from 26% to 68% (McFarlane et al., 2005a; Messing, Thaller, & Bagwell, 2014; Weaver et al., 2007). For example, McFarlane and colleagues (2005a) interviewed 148 African American, Latina, and White women seeking a protection order: over two-thirds (68%) had been raped by their partner, with 62% of sexual IPV occurring four or more times during the relationship. Repeated partner rape can be especially brutal, as a woman named Linda attests:

Then he started getting rougher and rougher and then doing things I didn’t want him to do against my will there towards the end. And I didn’t want him to touch me. He touched me anyway, when I said no, he did it anyway. So he just more or less raped me, repeatedly over and over. He generally never asked, toward the end. It was either have sex or get beat to death and then have sex, that’s just how it was.

(Logan, Cole, & Shannon, 2007, p. 87)

Global estimates

While US researchers tend to narrowly focus on either adolescent, young adult (typically college student), or adult sexual IPV, research outside of the US has relied on sexual IPV data gathered as part of the WHO Demographic and Health Survey, which surveys a representative sample of adolescent and adult women of childbearing age (aged 15–49) who are cohabiting or currently/ever married. Drawing on these WHO survey data, across five African countries the lifetime rate of sexual IPV ranged from 10% in Ethiopia, to 27–29% in Uganda, to 34% in urban Nigeria (Barzargan-Hejazi, Medeiros, Mohammadi, Lin, & Dalal, 2013; Ebrahim & Atteraya, 2019; Ogland, Xu, Bartkowski, & Ogland, 2014; Onigbogi, Odeyemi, & Onigbogi, 2015; Tlapek, 2015; Wandera, Kwagala, Ndugga, & Kabagenyi, 2015). There are within-country regional differences, however: a representative sample of women in southwest, predominantly rural Ethiopia reported a lifetime prevalence of sexual IPV of 50% (Deribe et al., 2012). Data from six Asian countries indicate a lifetime prevalence ranging from 5% in Sri Lanka, to 10% in China, to 37–46% in urban Pakistan and rural Bangladesh, respectively (Ali, Asad, Mogren, & Krantz, 2011; Dalal & Lindqvist, 2012; Jayasuriya, Wijewardena, & Axemo, 2011; Naved, 2013; Pandey, 2016; Tang & Lai, 2008). Across a region stretching from eastern Europe to the Middle East, the rate of lifetime sexual IPV ranged from 3% in Azerbaijan and Ukraine, to 6% in the West Bank/Gaza Strip, to 21% in the Kurdistan region of Iraq (Al-Atrushi, Al-Tawil, Shabila, & Al-Hadithi, 2013; Barrett, Habibov, & Chernyak, 2012; Haj-Yahia & Clark, 2013; Ismayilova & El-Bassel, 2013).

Turning to particular groups of survivors, a meta-analysis of WHO Demographic and Health Survey data from adolescent and young adult women across 30 low- and middle-income nations revealed that 12% were raped during their first sexual experience, ranging from 2% in Timor-Leste, to 13% in Kenya, to 29% in Nepal (Decker et al., 2015). Within a sample of Norwegian high school students, 19% of those who had been in a relationship had experienced sexual IPV (including both forced and pressured sex), while the lifetime prevalence of sexual IPV among young women attending college in Nigeria was 7% (Hellervik & Øverlien, 2016; Umana, Fawole, & Adeoye, 2014). Finally, the pregnancy and postpartum period may be a time of increased vulnerability to IPV in general (Taillieu & Brownridge, 2010). In two studies
that assessed sexual IPV during a recent pregnancy, prevalence ranged from 17% among Iranian women to 30% of Ethiopian women (Abate, Wossen, & Degfie, 2016; Farrokh-Eslamlou, Oshnouei, & Haghighi, 2014).

The co-occurrence of sexual IPV with other forms of IPV

**United States studies**

Researchers have determined that sexual IPV oftentimes occurs in relationships characterized by other forms of IPV, such as physical and psychological abuse, coercive control, and stalking. State-level results from the Youth Risk Behavior Survey (YRBS), which assessed lifetime partner rape along with physical IPV over two years among US high school students, indicate that sexual and physical IPV are strongly correlated (Kim-Godwin, Clements, McCuiston, & Fox, 2009); one in ten girls (9–10%) experienced physical IPV only, 4% sexual IPV only, and 5–6% both physical and sexual IPV (Silverman, Raj, Mucci, & Hathaway, 2001). More recent national YRBS data echo these results: 7% of girls experienced physical IPV only during the past year, 8% sexual IPV only (defined as forced sexual things such as kissing, touching, or being physically forced to have sexual intercourse), and 6% both physical and sexual IPV (Vagi et al., 2015). Finally, within a diverse sample of young women with a history of partner violence, the co-occurrence of sexual and physical IPV plus coercive control was the most common pattern across adolescence (19–29% of abusive relationships) (Kennedy et al., 2018a).

Among a sample of female college students (80% White, 12% African American, 6% Asian, 2% Latina), 79% had experienced some type of IPV (physical, sexual, or psychological abuse), with 25% of survivors enduring sexual IPV, either in combination with physical IPV (8%) or with both physical and psychological IPV (17%) (Eshelman & Levendosky, 2012). In one of the few longitudinal studies of co-occurring IPV among young women (71% White, 25% Black, with sexual IPV defined to include unwanted or coerced sex, attempted rape, and rape), 64% reported lifetime experience with both physical and sexual IPV, vs. 14% sexual IPV only and 11% physical IPV only (Smith, White, & Holland, 2003). Using NISVS data on adult women’s lifetime experiences with physical, sexual, and psychological IPV, as well as stalking, Krebs and colleagues (2011) found that sexual IPV was associated with an average of three types of IPV; in a random sample of insured women, 28% of those who experienced IPV reported both physical and sexual IPV, vs. 62% physical IPV only and 11% sexual IPV only (Bonomi, Anderson, Rivara, & Thompson, 2007).

In samples of IPV survivors in shelters or seeking formal help from LE, the rate of sexual IPV in combination with physical IPV ranges from 20–58% (Cole, Logan, & Shannon, 2005; Weaver et al., 2007). In a longitudinal study of IPV cluster patterns among survivors in shelter or seeking a personal protection order, African American and employed women were more likely to be in the first cluster (moderate physical and psychological abuse and stalking, low sexual IPV) vs. the second (high physical and psychological abuse, high stalking, low sexual IPV) or third cluster (high across all four types) (Dutton, Kaltman, Goodman, Weinfurt, & Vankos, 2005). Notably, co-occurring sexual and physical IPV has been associated with greater violence severity and lethality threat appraisal (Cole et al., 2005; Dutton et al., 2005). Sexual IPV in combination with both physical IPV and coercive control may be especially brutal, as Molly describes:

I think that’s how he got off. You know I think he got hard from beating me and physical fighting, you know what I mean? And it was a way for him to overpower and
Sexual violence in intimate relationships

I would just hush sometimes and – the control. It was the control thing. . . . And it seemed like the harder I rebelled the harder he controlled and it always led into sex and I think sex became a way of controlling me.

(Logan et al., 2007, p. 79)

Global studies

There have been a handful of studies that have examined co-occurring IPV among adult women who were married or cohabiting. In Norway, within a sample of female IPV survivors seeking help, 36% had experienced sexual IPV, almost exclusively in combination with physical and psychological IPV (Vatnar & Bjørkly, 2008). In Bangladesh, 35% of urban women and 46% of rural women reported ever being raped by an intimate partner; for the majority of participants (60–63%), sexual IPV co-occurred with either physical IPV or both physical and emotional IPV, rather than alone (17–31%) (Naved, 2013). In two studies with Pakistani women, recruited at either a hospital or in a large city, lifetime prevalence of sexual IPV ranged from 21–34%, with sexual IPV co-occurring with both physical and psychological/emotional IPV the most common pattern, reported by 50–58% of survivors (Ali et al., 2011; Kapadia, Saleem, & Karim, 2009). Lastly, within a randomly selected sample of pregnant women in Ethiopia, 30% had been raped during their pregnancy by their husband or cohabiting partner, with 56% reporting co-occurring sexual, physical, and psychological IPV (Abate et al., 2016).

What predicts sexual IPV?

United States studies

In a mixed methods study of sexual victimization (including sexual IPV) during adolescence, lack of parental supervision or guardianship, inexperience with sex and dating, substance use, social and relationship concerns (e.g., peer pressure), and powerlessness were all noted as contributors to heightened risk of sexual IPV within the sample of young women (76% White, 16% Black, 3% Latina) (Livingston, Hequembourg, Testa, & VanZile-Tamsen, 2007). Kennedy and colleagues (2018b) used multilevel modeling to examine risk factors for sexual IPV across young women’s relationships, beginning with their first. The sample was recruited from a university, a two-year community college, and community sites serving low-income young women, and was diverse: 39% Black, 39% White, 10% Latina, 7% biracial, 5% Asian, and 1% Native American. During participants’ first relationships, begun when they were just under 15 years old on average, socioeconomic status (SES) and age were inversely related to sexual IPV, physical IPV plus coercive control was positively related, and two-year college and community participants had significantly lower sexual IPV than university participants (after controlling for covariates). Two-year college participants’ trajectory of sexual IPV increased significantly over the course of relationships, in comparison to university participants’ sexual IPV trajectory, which declined significantly. Across relationships, age difference (between participants and their partners) and physical IPV plus coercive control both positively co-varied with sexual IPV. Shondra, a poor African American woman who was HIV+ as a result of sexual IPV, illustrates this age difference dynamic:

He forced me to have sex. If I didn’t want it, he’d say I was giving it to someone else. He was real jealous because he was 20 years older and thought I’d go off with someone younger. He’d lock me up and take the keys.

(Lichtenstein, 2005, p. 709)
In contrast, results from a longitudinal study with high school students revealed being depressed or having a friend who had been a victim of IPV – but not SES – as significant predictors of sexual IPV among female participants. (Foshee, Benefield, Ennett, Bauman, & Suchindran, 2004).

Among adult women, data from the National Crime Victimization Survey indicate that older age (age 50+) and household income are inversely related to the odds of sexual IPV, while living alone, rural residency (vs. urban), household crime, and being never married, separated, or divorced (vs. married) are all positively related to sexual IPV (Siddique, 2016). Graham-Bermann and colleagues (2011) found that sexual IPV was significantly associated with physical IPV in conjunction with other adversity (e.g., childhood victimization, serious illness), in comparison to physical IPV alone, within their diverse sample of female community residents (48% White, 37% African American). In a related vein, co-occurring sexual and physical IPV (vs. physical IPV only or no IPV) was associated with childhood sexual abuse, physical victimization, and witnessing IPV in two samples of women (Bonomi et al., 2007; Cole et al., 2005). Finally, in a two-year longitudinal study with a community sample of women aged 18–30 (78% White, 17% African American, 33% in college), being married or cohabiting (vs. being single), Time 1 sexual IPV, additional sexual victimization, and drug use all predicted increased odds of sexual IPV at Time 3, while Time 1 sexual refusal assertiveness predicted decreased odds of sexual IPV at Time 3 (Testa, VanZile-Tamsen, & Livingston, 2007).

Global studies

Risk factors for sexual IPV have been studied extensively across the globe. In the lone study involving high school students, being bullied, being female, having an older partner, and witnessing IPV in the family were all predictors of sexual IPV within a sample of Norwegian adolescents (Hellevik & Øverlien, 2016). After controlling for a variety of SES factors, Kidman (2017) found that child marriage (i.e., a girl marrying before she turned 18) was associated with heightened risk of sexual IPV across 34 low- and middle-income countries. Across multiple countries in Africa (Democratic Republic of Congo, Ethiopia, Ghana, Malawi, Nigeria, Rwanda, and Uganda), Asia (Bangladesh, India, Nepal, and Pakistan), and Eastern Europe (Azerbaijan, Moldova, and Ukraine), as well as the West Bank/Gaza Strip region and Haiti, risk factors for sexual IPV are quite consistent, with a few exceptions. Overall, lower SES, his and her lower education level, his and her reduced employment and income level, his and her history of witnessing IPV in their family of origin, a higher number of children, her lower age and decision-making, his use of coercive control, and his drinking are associated with increased odds of sexual IPV in Africa (Adebowale, 2018; Bazargan-Hejazi et al., 2013; Deribe et al., 2012; Ebrahim & Atteraya, 2019; Issahaku, 2017; Onigbogi et al., 2015; Tlapek, 2015; Umubeyi et al., 2014; Wandera et al., 2015), in Asia (Ali et al., 2011; Dalal & Lindqvist, 2012; Hadi, 2000; Naved, 2013; Kapadia et al., 2009; Pandey, 2016), in Moldova and Ukraine (Barrett et al., 2012; Ismayilova & El-Bassel, 2013), in the West Bank/Gaza Strip (Haj-Yahia & Clark, 2013), and in Haiti (Gage & Hutchinson, 2006). On a positive note, Hadi (2000) found that women’s participation in a micro-credit program reduced the odds of sexual IPV, indicating that anti-poverty approaches aimed at women might be an effective prevention strategy.

Outcomes associated with sexual IPV

Most of the research in this area has been conducted in the United States, with a few exceptions, so our review is organized by outcome: acknowledgment and labeling; self-blame, shame,
and anticipatory stigma; and mental health and health. When global studies are available, we have included them and noted the country or region.

**Acknowledgment and labeling**

When a girl or woman has been raped (based on the behavioral definition of being forced to have sexual intercourse), she may or may not acknowledge the experience and label it as a rape or sexual assault. Indeed, a recent meta-analysis found that 60% of rapes among adolescent and adult women were unacknowledged, with college students more likely to resist labeling in comparison to non-college students (Wilson & Miller, 2016). There are many reasons why a survivor would not acknowledge her experience as rape. One key factor is the extent to which her experience conforms to societal notions about “real rape,” understood as a violent, one-time traumatic incident perpetrated by a stranger, during which she fought back (Harned, 2005; Johnstone, 2016; Kahn, Jackson, Kully, Badger, & Halvorsen, 2003; Littleton, Axsom, Breitkopf, & Berenson, 2006; Littleton, Breitkopf, & Berenson, 2008; Logan et al., 2015). Sexual IPV does not conform to this standard, and thus, girls and women who have been raped by their intimate partners may have greater difficulty labeling their experience as rape or assault: in a recent study on sexual assault with young women from community settings (73% White, 27% African American, 7% Latina), participants who had been raped by their spouses or partners were significantly less likely to label their experience as rape, compared to women who had been raped by a non-partner (Jaffe, Steel, DiLillo, Messman-Moore, & Gratz, 2017). Several studies have similarly found that partner-perpetrated rapes are less likely to be acknowledged and labeled (Kahn et al., 2003; Littleton, Axsom, & Grills-Taquechel, 2009; Littleton et al., 2008), though others have revealed no differences in women’s acknowledgment by perpetrator type (Fisher, Daigle, Cullen, & Turner, 2003; Littleton et al., 2006).

Girls and women in an ongoing relationship with a partner who is raping them may minimize or deny what is happening because they want to avoid upsetting him, they do not want to acknowledge it to themselves, they see it as part of their role as a girlfriend or wife, or because they are committed to enduring it in order to maintain the relationship. Sarah, an 18-year-old European Canadian who was forced to have sex by her boyfriend, states: “Well, I said, I don’t think I used the word ‘rape’ ’cause I think it would have . . . like sounded harsh to him” (Johnstone, 2016, p. 281). Cultural values such as machismo and marianismo may also play a role, as illustrated by this Mexican American survivor describing forced sex by her husband as an important sacrifice she made as a wife:

> I think a woman needs to take care of her husband’s needs so he can be happy in the relationship so he will not go find other women that are around. As husband and wife, we sometimes need to sacrifice certain things in the relationship for it to function. If not, we can’t live together.

(Valdovinos & Mechanic, 2017, p. 336)

Similarly, an IPV survivor named Judith understood sexual IPV as part of her role as a Christian wife: “Lot of times I felt like I had to because I keep going back to that Scripture in the Bible, where it says the wife is supposed to be submissive to her husband”. (Logan et al., 2007, p. 78)

Acknowledging and labeling sexual IPV experiences may best be understood as a process that unfolds over time, as women grapple with what happened (rather than avoiding or denying it), disclose to others, leave the relationship, and enter into new relationships (Harned, 2005;
Johnstone, 2016). A college student describes how her previous experience with sexual IPV was unexpectedly influencing her new relationships:

[A]s I entered into other relationships, it almost haunted me . . . it is hard to even be able to realize that something wrong has happened, until it starts to affect other relationships and parts of life. It can be very difficult and scary.

(Harned, 2005, p. 292)

A Mexican American woman reflects on her new, critical understanding of what she – and others she knew – had experienced:

As women being with them, we do not call it sexual abuse because we feel we need to satisfy them because we are the wives and we have to satisfy them regardless if we want to or not, so we don’t call it sexual abuse. Now that I look back I realize that it was sexual abuse what they would do to us because it was not an intimate relationship that we wanted to have.

(Valdovinos & Mechanic, 2017, p. 337)

Self-blame, shame, and anticipatory stigma

Adolescent and adult women who experience sexual IPV may blame themselves, feel ashamed, and anticipate that others will judge them harshly or disbelieve them if they share what happened (Kennedy & Prock, 2018). Though these sequelae have been studied extensively by SA researchers and IPV researchers focused on physical IPV, they have received limited attention by those examining sexual IPV specifically. In a quantitative study with IPV survivors seeking formal help from LE (45% White, 33% African American, 13% Native American, 7% Latina), women who had experienced sexual IPV along with physical IPV reported significantly higher levels of shame, compared to those with physical IPV only (Messing et al., 2014). Additionally, Vatnar and Bjørkly’s (2008) study with Norwegian IPV survivors seeking help revealed that sexual IPV was associated with significantly more shame than psychological IPV. However, Jaffe and colleagues (2017) found that women who had been raped by a partner were less likely to blame themselves in comparison to women who were raped by a non-partner, in part because they were less likely to acknowledge their experience as rape. Qualitative findings reveal that women raped by their partners may blame themselves for their “poor judgment” and failure to protect themselves (Weiss, 2010). Amanda, a young woman attending college, stated: “I often have flashbacks and find myself crying. I feel unsafe and scared. I feel weird and guilty about being raped, therefore, I don’t really like telling people about it (i.e., counselors)” (Amar & Alexy, 2005, p. 166). An African American woman who was HIV+ as a result of sexual IPV characterizes herself as weak:

The guy I was going out with introduced me to drugs. He had me out there selling my body to get all the drugs and stuff for us, you know? He got to beating on me because I didn’t want to get out there no more in the streets doing it, and that’s when he broke my cheekbone and everything. That’s when I got infected by him because he kept forcing me to have sex. I felt bad about myself, weak-minded, you know? Because I got into drugs and prostitution and then I got myself infected.

(Lichtenstein, 2005, p. 707)
Finally, a Mexican American woman describes her self-blame and shame:

You feel like you are the worst, very bad because you feel abused. It is no longer a relationship; it is not pleasing to be with him if you have to satisfy him forcefully because you get beaten and you have to comply because of the fear you have. Then you feel bad within yourself because you have to take it.

(Valdovinos & Mechanic, 2017, p. 336)

Blaming yourself, feeling ashamed, or anticipating that others will judge, blame, or disbelieve you can be a powerful barrier to disclosure and attaining help, as well as exacerbate mental health and health outcomes (Kennedy & Prock, 2018; Weiss, 2010).

**Mental health and health**

Among female adolescents in high school in the US, sexual IPV has been linked to mental health issues such as sadness, hopelessness, suicidality, and suicide attempts, and poor health outcomes including unhealthy weight control, heavy alcohol use, drug use, fighting, and pregnancy (Kim-Godwin et al., 2009; Silverman et al., 2001; Vagi et al., 2015). One study with female college students demonstrated an association between sexual IPV and depression, anxiety, and posttraumatic stress (PTSD) symptoms, as well as body shape concerns, substance use, and school withdrawal (Harned, 2004). A second found that sexual IPV, in combination with physical and psychological IPV, predicted depression and PTSD symptoms, as well as injuries (Eshelman & Levendosky, 2012). Among adult IPV survivors, researchers have examined co-occurring sexual and physical IPV, vs. physical IPV only, as a predictor of mental health and health outcomes: compared to physical IPV only, sexual and physical IPV are linked to depression, anxiety, PTSD symptoms, suicidal ideation (as mediated by PTSD and depression), and suicide attempts (Bonomi et al., 2007; Cole et al., 2005; Dutton et al., 2005; McFarlane et al., 2005b; Weaver et al., 2007). Negative health outcomes include poor health symptoms, increased daily health limitations, lower quality of life and social functioning, injury, sexually transmitted infections (STIs), and substance use (Bonomi et al., 2007; Cole et al., 2005; McFarlane et al., 2005a; McFarlane et al., 2005b). Dana, an IPV survivor in recovery, illustrates one connection between sexual IPV and substance use:

He knew a little bit about my past. I explained to him that I do have an addiction to alcohol and drugs and that I black out easily and I pretty much do anything and everything in those blackouts. And I guess that’s what really [encouraged] him to try to [get] me to go there. So that he could get me to do just what I didn’t want to do.

(Logan et al., 2007, p. 82)

Women who are raped repeatedly by partners (who are themselves having unprotected sex with multiple partners) are at heightened risk of contracting HIV, given that the vaginal tears and abrasions that women experience during forced sex appear to heighten the risk of infection (Lichtenstein, 2005). Ilene, a Black woman who was pregnant and HIV+ as a result of sexual IPV, describes her depression and isolation:

I became so depressed that I asked him to come back and look after me. That’s how desperate I was. I took to my bed and cried for three months. It just made me more
dependent on him, you know? And I guess him coming back was just an open door to say, “I’ll treat you any way I want to.”

(Lichtenstein, 2005, p. 710)

A handful of studies on sexual IPV and related outcomes have been conducted around the world. Beginning with mental health issues, Tiwari and colleagues (2014) used a mixed methods approach and found that sexual IPV predicted depression and PTSD symptoms, after controlling for physical IPV, in a sample of Chinese women residing in Hong Kong. A graduate student in her 30s described her experiences with sexual and physical IPV during her five years of marriage: “Whenever my husband wanted sex, I had to let him have it. Otherwise he would hurt me . . . just like that time when he bit my nipple so badly that I had to go to the hospital” (Tiwari et al., 2014, p. 7). Research in Bangladesh, India, Nepal, and Ethiopia has demonstrated a link between sexual IPV and health outcomes among married or cohabiting women (aged 15–49), including unintended or unwanted pregnancy and childbirth, STIs, and injuries (Acharya, Paudel, & Silwal, 2019; Anand, Unisa, & Singh, 2017; Deribe et al., 2012; Shabnam, 2017; Tiwari et al., 2014). Lastly, in a Canadian study involving women who had been raped and were seeking care from a hospital, sexual IPV was associated with greater violence severity and injury, in comparison to women who were raped by an acquaintance (Stermac, Del Bove, & Addison, 2001).

**Disclosure, help-seeking, and help attainment**

Adolescent and adult women who have experienced IPV may disclose what they have experienced, most often to friends and family members, and seek out the attainment of formal help in meeting their needs, including mental health and health services, LE involvement, housing, and legal advice (Bundock, Chan, & Hewitt, 2018; Kennedy et al., 2012; Sabina & Ho, 2014; Sylaska & Edwards, 2014). Unfortunately, empirical research on disclosure and seeking and attaining help related specifically to sexual IPV is very limited: researchers have almost exclusively focused on sexual assault (with sexual IPV obscured) or IPV in general (again, with sexual IPV obscured), predominantly with college or adult samples of women. Kennedy and colleagues examined disclosure of sexual or physical IPV across adolescent abusive relationships within a diverse sample of young women. They found that disclosure of sexual IPV was much less common than disclosure of physical IPV across relationships, and relationships characterized by sexual IPV only (vs. those characterized by physical IPV alone or in combination with sexual IPV) predicted reduced disclosure (Kennedy, Bybee, Adams, Moylan, & Prock, under review).

In a study with New Zealand high school students, girls were most likely to disclose emotional abuse (90%), followed by unwanted sexual activity (defined as unwanted kissing, hugging, genital contact, and sex; 54%), and then physical IPV victimization (45%, Jackson et al., 2000).

Among US college students, being more acquainted with the perpetrator was associated with significantly reduced disclosure of sexual assault over time, in comparison to being less acquainted (Orchowski & Gidycz, 2012). Results from the National College Women Sexual Victimization Study revealed that only 2% of female college students who had been raped by a partner reported it to LE (Fisher et al., 2010). Melissa, a 23 year old from Montreal who experienced sexual IPV, illustrates the desire to avoid disclosing, so as not to risk being exposed and potentially blamed: “I would not want to talk about things where the person could judge me or the situations. How could I? It’s because I know I’ll see the person often, if they judge me” (Fernet, Hébert, Couture, & Brodeur, 2019, p. 46).
Among adult women, rape acknowledgment (which was less likely among those who experienced partner rape vs. other perpetrators) was linked to increased disclosure within a sample of low-income women (51% Latina, 33% White, 12% African American) (Littleton et al., 2008). Results from the National Violence Against Women Survey indicate that sexual IPV in combination with physical IPV, vs. physical IPV alone, predicted reduced odds of seeking help (Flicker et al., 2011). In contrast, Cattaneo and colleagues (2008) drew on data from eight states to examine sexual and physical IPV within a sample of women seeking formal help from various providers (86% White); they found that women who had experienced both forms of IPV (vs. those experiencing only physical IPV) were simultaneously more likely to seek help and more likely to state that they had not sought help in the past even though they needed it. In a community sample with women from New England (66% Black, 20% White, 10% Latina), sexual IPV was associated with social support coping as well as negative social reactions upon disclosure (Sullivan, Schroeder, Dudley, & Dixon, 2010). Finally, female IPV survivors in Norway seeking formal help disclosed sexual IPV significantly less than physical or psychological IPV (Vatnar & Bjørkly, 2008).

**Conclusion**

Nearly one in ten women (9%) in the United States has experienced sexual IPV in their lifetime (Black et al., 2011); global lifetime estimates range from 3% in Azerbaijan and Ukraine (Ismayilova & El-Bassel, 2013), to 50% in rural Ethiopia (Deribe et al., 2012). Sexual IPV is likely to co-occur with other forms of IPV, including physical and psychological IPV, coercive control, and stalking (Krebs et al., 2011; Vagi et al., 2015; Vatnar & Bjørkly, 2008). Predictors of sexual IPV include lower socioeconomic status, her low age, and his drinking, physical IPV, or coercive control (Dalal & Lindqvist, 2012; Kennedy et al., 2018b). Associated outcomes among girls and women include lack of acknowledgment or labeling of the experience as rape; shame, self-blame, and anticipatory stigma; and mental and physical health problems such as depression and posttraumatic stress disorder symptoms, suicidality, unintended pregnancy and birth, and sexually transmitted infections, including HIV (Acharya et al., 2019; Dutton et al., 2005; Jaffe et al., 2017; Kennedy & Prock, 2018; Lichtenstein, 2005; McFarlane et al., 2005a). Disclosing sexual IPV and seeking and attaining help appears to be less common, in comparison to other forms of IPV, though research in this area is only beginning (Flicker et al., 2011; Kennedy et al., under review).

**Critical findings**

- Sexual IPV is relatively common among women, with one in ten US women and 3–50% of women around the globe reporting rape or attempted rape by an intimate partner, though there is great variability across nations.
- Sexual IPV is likely to co-occur with other forms of IPV, such as physical or psychological IPV, coercive control, and stalking.
- Key predictors include lower SES (including education level, income, and employment), her young age at the beginning of the relationship or marriage, and his drinking, physical abuse, and use of coercive control.
- Girls and women who have been raped by their partner may have difficulty acknowledging the experience or labeling it as rape or sexual assault; additionally, they may feel self-blame, shame, and anticipatory stigma.
• Sexual IPV has been linked to a host of negative mental health and health outcomes, such as depression and PTSD symptoms, unintended pregnancy and childbearing, and STIs, including HIV.
• Though research on sexual IPV disclosure, help-seeking, and help attainment is just beginning, it appears that sexual IPV may be associated with reduced levels of disclosure and seeking/attaining help, in comparison to other forms of IPV.

**Implications for policy, practice, and research**

• The high rate of co-occurrence of sexual IPV with other forms of IPV means that researchers must take this into account when examining the effects of sexual assault on outcomes: for example, in a study of PTSD among women who have experienced SA (which will automatically include a sizable percentage of women who have experienced sexual IPV, perhaps repeatedly), researchers must be able to disentangle the effects of the sexual assault(s) from the effects of other forms of co-occurring IPV.
• Given the gaps in our knowledge, researchers should qualitatively and quantitatively explore sexual IPV (including predictors, associated outcomes, acknowledgment, self-blame and shame, and disclosure/help attainment) during adolescence as well as among young adults who are not attending four-year universities and colleges.
• Globally, we know very little about acknowledgment and labeling of sexual IPV, or the disclosure and help attainment process; researchers should prioritize these areas.
• Practitioners must proactively assess for sexual IPV along with physical and psychological IPV, especially given that girls and women may be less likely to disclose sexual IPV in comparison to other forms of IPV.
• Prevention and intervention programming for SA and IPV needs to be integrated so sexual IPV – which may be less visible as both a form of SA and a form of IPV – can be addressed and prevented, especially among adolescents just beginning to form relationships or enter marriage.
• Health providers may be effective, non-stigmatizing screeners for sexual IPV, among girls and women both in the US and around the globe.
• Given that marriage before the age of 18 is common globally and predicts sexual IPV, and that marital rape is still legal in more than 100 countries, anti-violence activism should center on addressing these at the policy level.
• With lower SES such a strong predictor of sexual IPV, anti-poverty initiatives, especially aimed at women (e.g., micro-credit programs), may be an effective prevention approach.

**References**


Sexual violence in intimate relationships


Angie C. Kennedy et al.


Sexual violence in intimate relationships


