Sexual and reproductive abuse

Australian and international studies demonstrate the prevalence of sexual and reproductive abuse as a form of domestic and family violence that may be part of a broader and complex pattern of abusive behaviours experienced by a victim.

Sexual abuse as a form of domestic and family violence includes rape, sexual assault, or sexual victimisation perpetrated predominantly by men against women. Behaviours may include: forced, attempted forced or unwanted sexual penetration; forced penetration by a third party, object or an animal; forced prostitution; forced or unwanted sexual touching; or forced partial or total removal of the victim's external genitalia, or other mutilation or injury to the victim's genital organs for reasons that are not medically warranted (sometimes referred to as female genital mutilation or FGM [The Royal Australian and New Zealand College of Obstetricians and Gynaecologists 2017]). Any of these behaviours may be facilitated or aggravated by alcohol or drugs, and may also be associated with physical and other forms of domestic and family violence [Mouzos & Makkai 2004]. Most at risk are young women who have separated from their intimate partner and have experienced prior abuse as adults or sexual abuse as children [Lievore 2003]. The Australian Bureau of Statistics reported that in 2015 domestic and family violence-related sexual assault accounted for over a third of the total number, that it is most likely to occur in the age range 10-19 years, and there are five times as many female victims as male victims [ABS FDV-related offences 2017].

Proof of the victim's lack of consent in judicial processes is central to establishing sexually abusive behaviours and their criminality. The issue of consent is profoundly complicated by the nature and circumstances of the relationship between victim and perpetrator. Sexual abuse may be part of a broader pattern of domestic and family violence, and a victim may only comply due to coercion by the perpetrator. Coercion may not necessarily involve physical force; rather, psychological means may be used. For example: demeaning the victim's physical appearance, intelligence and dignity; dictating that the victim meet the perpetrator's sexual demands; or threatening to severely or fatally injure or abandon the victim if those demands are not met.

Australian research indicates that sexual abuse in this context is the least likely form of domestic and family violence to be reported by victims. Unique contributing factors may include a victim's lack of awareness of the criminality of sexually abusive behaviours, especially where the perpetrator is a current for former partner; cultural or religious beliefs and traditions; a fear of reprisal by the perpetrator against the victim or other family members; a sense of betrayal of trust and violation of intimate personal and psychological boundaries by the perpetrator; debilitating feelings of shame and self-blame; anxiety associated with health and reproductive risks; and an apprehension of re-victimisation through the reporting and judicial processes [Heenan 2004].

Domestic and family violence may commence or escalate, or its patterns may change, during a victim's pregnancy. In some reported cases, the violence lessened and victims came to view pregnancy as a means of self-protection. More often however, the perpetrator is likely to regard the pregnancy and change in family circumstances as a threat to previously held dominance and may intensify abusive behaviours in an effort to reassert control over the victim.

A pregnant woman in an abusive relationship is less likely to want or to have planned her pregnancy. She may seek a termination to avoid further risk of harm to herself or the child; to avoid having to parent with the perpetrator; or to better enable her escape from the abusive relationship. However, if the pregnant woman is experiencing heightened levels of monitoring and manipulation by the perpetrator, she may be prevented from accessing the funds, transport and other means necessary to terminate the pregnancy. Physical and other forms of violence experienced during pregnancy may result in maternal or foetal death, pre-term birth, low birth weight, or extreme stress in the mother manifested, for example, in eating and sleep disorders, poor weight gain, inadequate access to antenatal care, misuse of alcohol or drugs, sexually transmitted diseases, and mental illness [Miller et al 2010].

Domestic and family violence during pregnancy can be characterised as reproductive abuse, which also extends to earlier perpetrator behaviours specifically intended to coerce pregnancy. For example: rape, insisting on unprotected sex, sabotaging the woman's birth control measures (destroying pills, pulling out vaginal rings or contraceptive implants), exercising financial control so as to restrict the woman's access to contraception, or threatening to leave her if she fails to conceive. Where a woman is also experiencing other forms of violence there is an increased risk of unintended pregnancy as she is more likely to fear the consequences of resisting the perpetrator's coercion, and she may be significantly vulnerable to poor reproductive and general health [Moore et al 2010].