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#MeToo on the Canadian Prairies: Raising Awareness of Sexual Assaults and Mental Health in Women Abused by Intimate Partners

Leslie M. Tutty[1] and Kendra L. Nixon[2]

Abstract

Studies of intimate partner sexual assault (IPSA) and its effects on mental health are limited. This secondary data analysis examines IPSA, a history of child sexual abuse, depression, trauma, mental distress and quality of life in 665 Canadian women, 41% of whom had been sexually assaulted by intimate partners; 53% were sexually abused as children. Women who had experienced any IPSA had significantly higher scores on all Composite Abuse subscales (IPV), mental distress (SCL-10), and depression (CES-D-10). PTSD (PCL) was higher for women with both IPSA and CSA histories. Implications for advocates, clinicians, and researchers are presented.

Keywords

intimate partner sexual violence, sexual assault, child sexual abuse, violence against women, mental health

Introduction

While the seriousness of intimate partner violence (IPV) has been acknowledged worldwide (García-Moreno et al., 2013), the extent to which the violence includes sexual assaults, sexual coercion, and other degrading sexual victimization, defined here as intimate partner sexual violence (IPSV), has not been sufficiently highlighted (Bagwell-Gray et al., 2015; Logan et al., 2007). The current research focuses on one

[1]University of Calgary, AB, Canada
[2]University of Manitoba, Winnipeg, Manitoba, Canada

Corresponding Author:
Leslie M. Tutty, Faculty of Social Work, University of Calgary, MT 301, 2500 University Drive NW, Calgary, AB T2N1N4, Canada.
Email: tutty@ucalgary.ca

aspect of IPSV, intimate partner sexual assaults (IPSA), which occur relatively frequently. In the 2010 U.S. National Intimate Partner and Sexual Violence Survey, "More than half (51.1%) of female victims of rape reported being raped by an intimate partner" (Black et al., 2011, p. 1), with the lifetime prevalence for rape by an intimate partner estimated as 9.4% or more than 11 million – almost one in 10 American women.

The nature of the physical partner abuse is more severe for women whose partners also sexually assault them (Black et al., 2001; Campbell, 1989; Marshall & Holtzworth-Monroe, 2002; Symes et al., 2014) and women often experience multiple forms of violence (Basile, 2008; Krebs et al., 2011). "Among all women who experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime, 63.8% experienced one form of violence by an intimate partner; 56.8% experienced physical violence alone, 4.4% experienced rape alone, and 2.6% experienced stalking alone" (Black et al., 2011, p. 41). Sexual assaults by intimate partners also commonly occur after separation (DeKeseredy & Joseph, 2006).

The #MeToo movement has raised awareness of sexual assaults and sexual harassment of women in the workplace. Started by American activist Tamara Burke in 2006, the movement initially focused on women of color in low-income communities, encouraging them to speak up in order to hold perpetrators accountable and allow for the provision of support (Murphy, 2019). Discussions and research have expanded the reach of #MeToo beyond sexual harassment and abuse in the workplace to sexual assaults generally (Alaggia & Wang, 2020). Agathis et al. (2018) argue for an extension of #MeToo to address the sexual abuse of children. Hegarty and Tarzia (2019) see sexual and domestic violence as central issues for primary care physicians, also framing their discussion from a #MeToo perspective.

Recently, researchers including Logan et al. (2015) and Van Deinse et al. (2019) have argued for more research on intimate partner sexual violence. Sexual assaults within intimate partner relationships are likely to be serial events (Russell, 1990) and, as mentioned, are associated with more severe physical violence (Boucher et al., 2009). As such, it is important to continue studying IPSA, especially given the context of the #MeToo movement. The current study is a secondary analysis of data on intimate partner sexual assault in a large sample of Canadian women from the prairie provinces, examining mental health and histories of child sexual abuse.

Intimate Partner Sexual Assaults

While considerable research has focused on sexual assaults as one factor of partner violence but not treated as a separate variable (i.e., Lacey et al., 2013) and also on acquaintance sexual assaults, particularly in college women (i.e., Macy et al., 2006), few studies focus exclusively on intimate partner sexual assaults. Early seminal studies of marital rape, as it was called then (Campbell & Alford, 1989), were conducted in the 1980s and 1990s, including quantitative research by Campbell (1989), Riggs et al. (1992) and Shields and Hanneke (1992) and qualitative studies by Bergen (1995), Basile (1999), and Russell (1990). The quantitative studies had small sample sizes, which is

understandable given the reluctance of many women to report sexual assaults by strangers, but even more so by intimate partners (Campbell & Soeken, 1999).

The consequences of IPSA have been documented, often in comparison to other forms of IPV, including more pronounced effects on physical health (Bonomi et al., 2007). Campbell and Soeken (1999) found significant negative health effects and more risk factors associated with homicide in women whose partners had forced sex on them compared to women with no partner sexual assaults. It is important to note that, as well as mental health difficulties developing as a result of IPSA and other sexual assaults/abuse (Chen et al., 2010), women with significant mental health diagnoses are more vulnerable to physical and/or sexual victimization by intimate partners (Van Deinse et al., 2019).

Regarding mental health sequelae, PTSD has been commonly associated with partner sexual assaults (Bennice et al., 2003; McFarlane et al., 2005; Temple et al., 2007). Other research examining mental health issues in addition to PTSD, found that women whose partners sexually assaulted them also reported significant depression, anxiety, and other difficulties such as suicidality (Cole et al., 2005; Honda et al., 2018; Nakyazze et al., 2020; Pico-Alfonso et al., 2006; Tarzia et al., 2018; Wong et al., 2019). In a cross-national study of 11 developing countries conducted by the WHO, women whose IPV included sexual violence reported the poorest health, thoughts of suicide, and memory loss (Potter et al., 2021).

Regarding racial/ethnic diversity, both McFarlane et al. (2005) and Temple et al. (2007) sampled with ethnic diversity in mind with the inclusion of African American and Hispanic women in their studies. The sample in Bennice et al. (2003) was 47.5% White and 47.5% African American. Campbell and Soeken's (1999) sample was primarily African American women (77%). Recent international studies that support IPSA as associated with significant mental health difficulties have been conducted with different racial groups of women in China (Wong et al., 2019), Japan (Honda et al., 2018), Uganda (Nakyazze et al., 2020), as well as Potter et al.'s (2020) cross-national WHO study with women in such diverse countries as Tanzania, Bangladesh, Brazil, and Cambodia.

Several studies documented childhood sexual abuse as a demographic characteristic in their samples (Bonomi et al., 2007; Campbell & Soeken, 1999; Cole et al., 2005; Wong et al., 2019), generally finding more CSA histories in women who had experienced intimate partner sexual assaults. When studying the mental health consequences of intimate partner sexual assaults, we argue that it is important to examine other sexual traumas such as child sexual abuse and/or sexual assaults by non-partners or strangers. The consequences of child sexual abuse to the mental health of adults are well-documented and include PTSD and depression (Hillberg et al., 2011), and sexual abuse victims in childhood may be vulnerable to other forms of sexual victimization later in life (Barnes et al., 2009; Campbell et al., 2008).

Although the studies reviewed provide a solid base of information about intimate partner sexual assaults and mental health, more need to be conducted, especially with respect to racial/ethnic diversity. No investigations of IPSA have yet been conducted with Canadian Indigenous women who are an important subpopulation and

report the highest rates of IPV in the country (Statistics Canada, 2011). Indigenous people in the prairie provinces constitute 39.2% of the First Nations population and 50.4% of the Métis population in Canada.

With unique access to a large study of Canadian women who were abused by intimate partners, over half of whom are Indigenous, the goal of the current secondary data analysis was to explore the demographics, severity of the intimate partner violence, and mental health characteristics of women who were sexually assaulted by their intimate partners taking child abuse history into consideration. The current research is exploratory and, consistent with much secondary data analysis, since it is with respect to variables that were not central in the original research, we did not create hypotheses (Radey, 2010). Nevertheless, based on the literature review, one could expect those with IPSA histories to report more serious mental health symptoms.

Methodology

This article reports on a secondary data analysis undertaken on participants in the "The Healing Journey." The primary aim of the original longitudinal study was to assess a number of characteristics of women abused by intimate partners including mental health and health, and to follow these over 2.5 years. This study had a convenience sample of 665 abused women who had sought shelter and/or counseling in the three Canadian prairie provinces of Alberta, Saskatchewan, and Manitoba. Both academics and community agency members of the research team assisted in designing the research, recruiting participants, and interpreting the results. Data for the study were collected in seven waves between 2005 and 2009. The primary outcomes from the study have been previously published (Tutty et al., 2020a, 2021).

The research protocols were approved by the Ethical Review Boards of the six associated universities (Universities of Calgary, Manitoba, Regina, Brandon, Lethbridge, Winnipeg). Each province conducted an environmental scan of agencies (i.e., women's shelters and counselling agencies) to cover urban, rural, and northern sites from which to recruit. Potential participants attended information sessions at agencies or were provided with sealed envelopes containing information about the study by agency staff. The criteria for inclusion were: a minimum 18 years of age; the most recent incident of IPV no sooner than three months and no longer than five years prior; commitment to stay in the study for the full four years; and no significant mental health issues that would impede answering the measures accurately such as hallucinations or delusions (to our knowledge no women were excluded for this reason). Honoraria of CAN$50 were provided to participants at each wave. The first wave of The Healing Journey data collection commenced in 2005, with six additional waves collected every six months over four years.

Research Measures

Data were collected in four major areas: demographics and history of abuse; general functioning and service utilization; health and mental health (Tutty et al., 2021); and

mothering (Ateah et al., 2019; Nixon et al., 2017) over four years. The surveys included standardized measures as well as open- and closed-ended questions developed specifically for the study (all administered verbally by trained female research assistants). The current analysis used data from the first two waves of The Healing Journey study. The core demographics, CAS, and QoL were administered in Wave 1; and the mental distress, depression, PTSD, and protective strategies in Wave 2. These two waves constituted the baseline data for the study.

The questionnaires were administered face-to-face, with female interviewers reading the questions and recording answers to ameliorate any literacy problems. The women chose where the interviews took place: their homes, the agency/shelter from which they were recruited, or the university campus. The more than 50 interviewers were upper-level undergraduate/graduate university students and professionals from the communities surveyed. The interviews lasted from one to two hours.

Intimate Partner Violence. The nature of the IPV was assessed by the Composite Abuse Scale (CAS) (Hegarty et al., 2005). This screening measure consists of 30 items rated for frequency in the past 12 months on a six-point scale from "never" to "daily", with a possible total of 150. The four subscales are: Severe Combined Abuse (8 items; possible score 0–40; suggested cut-off of 1), Physical Abuse (7 items; possible score 0–35; cut-off of 1), Emotional Abuse (11 items; possible score 0–55; cut-off of 3), and Harassment (4 items; possible score 0–20; cut-off of 2). The suggested clinical cut-off for the total score is 3 or 7 to minimize false positives. The scale has demonstrated convergent and discriminant validity (Hegarty et al., 2005). Cronbach's alpha for the CAS in the current study is .93.

Intimate Partner Sexual Assault. IPSA was determined by answers to item 7 from the Composite Abuse Scale, "My Partner: Raped me." In scoring the CAS, this item is included in the Severe Abuse subscale. A second general question, "Were you ever physically forced to have sex?" (yes/no), was not specific to child sex abuse or IPSA but provided additional information although, since the question did not specify the abuser and some women were sexually abused in several ways, interpreting the answers to this is limited.

Child Abuse. Child abuse history was collected via structured questions with "yes/no" answers: "Were you abused as a child or adolescent? (a) physical, (b) sexual, (c) emotional/psychological, (d) witnessing abuse among family members (consistent with Elias, et al., 2012).

Disability Status. An open-ended question asked the women to self-report physical and mental health conditions. To assess disability, the women were asked whether these conditions affected their employability or the kind or amount of daily activities in which they could engage (Du Mont & Forte, 2014). The women were then asked their opinions about whether they attributed any of the disabilities to their child abuse or intimate partner violence.

Mental Health and Well-Being. The Symptom Checklist Short Form (SCL-10) (Nguyen, et al., 1983) is a screening tool to assess global mental health functioning and psychological distress in the previous week. Items (e.g., "In the past week, how much were you distressed by feeling lonely?") are endorsed with a 0 to 4 Likert scale (0 = "not at all;" 4 = "extremely"). Higher scores indicate more distress. Published clinical cut-offs for the 10-item version were not found. However, since clinical cut-off scores are one standard deviation above the mean (Jacobson et al., 1984), we used Müller's data (2010) reporting a mean score of 7.8 (*SD* of 6.3), resulting in a clinical cut-off score of 14.2. Cronbach's alpha in the current study is .89.

The CES-D-10 (Centre for Epidemiological Studies – Depression) is a short form of the CES-D-20 (Radloff, 1977) used to document depression symptoms in the previous week (Andresen et al., 1994). Ten items (e.g., "In the past week I was bothered by things that usually don't bother me") are rated on a 0 to 3 Likert scale, with zero as "rarely or none of the time (less than 1 day)", and three as "all of the time (5–7 days)." Internal consistency and test-retest reliability are good (Björgvinsson, et al., 2013). Cronbach's alpha in the current study is .84. Björgvinsson et al. (2013) suggest that a cut-off of 15 has the best "sensitivity" and "specificity."

The PTSD Checklist (PCL) (Blanchard et al., 1996) is a 17-item self-report questionnaire that measures symptoms of PTSD in the past month. Items (e.g., "In the past month how much have you been bothered by repeated, disturbing memories, thoughts or images of abuse or violence?") are endorsed with a 0 to 4 Likert scale with 0 meaning "not at all" and 4 meaning "extremely." Blanchard et al. (1996) recommend a clinical cut-off of 44. The scale has good psychometric properties (Cronbach's alpha = .94; Blanchard et al., 1996). Cronbach's alpha in the current study is .92.

The original 25-item Quality of Life Questionnaire (Andrews & Withey, 1976) was shortened by Sullivan and Bybee (1999) to nine items (QoL-9) measuring satisfaction with overall quality of life (e.g., "How do you feel about life as a whole") and satisfaction with particular areas (e.g., "How do you feel about yourself; your personal safety; the amount of fun and enjoyment you have"). Items are rated on a 7-point scale (1 = extremely pleased, 7 = terrible). Higher scale scores indicate poorer QoL. Cronbach's alpha for QoL in the current study is .84.

Data Analysis

Categorical descriptive data were analyzed using Pearson's chi-square analysis with effect sizes calculated with Phi or Cramer's *V*. Standardized residuals were calculated to identify the category differences responsible for the statistically significant chi-square (Field, 2009). Effect sizes were interpreted using Rea and Parker's (1992) suggested benchmarks of under .10 as a "negligible" association; between .10 and under .20 as "weak"; between .20 and under .40 as "moderate"; and between .40 and under .60 as relatively "strong" (p. 203). In cases where the cell count is less than five, the Fisher exact test was used (Field, 2009).

Continuous data were compared with independent t-tests and repeated analysis of variance, with Bonferroni procedures as post hoc tests when findings were statistically significant and effect sizes calculated as *r*-values (Field, 2009). According to Cohen (1988), *r*'s of .2, .5 and .8 are the small, medium, and large reference values, respectively.

Results

Of the 665 women who participated in our study on intimate partner violence, 140 (21.1%) reported neither child sexual abuse nor intimate partner sexual assaults, 189 (28.4%) reported child abuse only, 108 (16.2%) reported IPSA only, and 165 (24.8%) reported both CSA and IPSA. Across categories, 53.2% of the women had been sexually abused as children and 41% had been sexually assaulted by intimate partners. In response to the CAS Item 7 regarding the frequency with which her partner "raped her," of the 660 women who answered this question, 387 (58.6%) indicated "never"; 69 (10.5%) as "only once"; 129 (19.5%) as "several times"; 24 (3.6%) as "once a month"; 29 (4.4%) as "once a week"; and 22 (3.3%) as "daily."

A smaller number (63 or 9.5%) reported having been physically forced to have sex (i.e., from a different non-intimate partner) but no child sexual abuse or IPSA. Unfortunately, because the women were not asked to specify the perpetrator of the forced sex, we could not identify women in the sample who been physically forced to have sex but also had either child or IPSA, which likely occurred.

With regards to demographic characteristics (see Table 1), only a small difference in racial/ethnic background was found such that women from visible minorities reported more IPSA-only than White or Indigenous women ($\chi^2 = 13.7$, Cramer's $V = .10$, a weak effect). Although the majority of the women were no longer living with their abusive partners (81.6%), women with a CSA-only history were more likely to remain together, while women with CSA and IPSA were less likely to still cohabit ($\chi^2 = 17.5$; Cramer's $V = .16$; a weak effect). There were no significant differences across education levels based on the type of sexual assault experienced. Similarly, whether or not the women had children (90.7% did) did not vary significantly across type of sexual assault.

Forty-four percent of the women had a disability; however, those with both CSA and IPSA reported having significantly more disabilities than women with no CSA or IPSA abuse history ($\chi^2 = 28$; Cramer's $V = .21$, a moderate effect). With respect to the type of disability, women with both CSA and IPSA histories reported both physical and mental disabilities significantly more than women with no CSA or IPSA histories ($\chi^2 = 33.5$; Cramer's $V = .13$, a weak effect). The women were asked their opinion about whether their disability was a result of the childhood or partner abuse (not necessarily of a sexual nature) that they had experienced. Of the subsample of women who answered this question ($N = 425$), significantly more women who had experienced IPSA-only attributed their disability to their partner's general abusive behaviors. Fewer of the women with no sexual abuse history linked their disability to any general childhood or partner abuse. Finally, a higher proportion of women

Table 1. Comparison of Women's Demographics by Sexual Assault Status ($N = 665$).

Variable		No CSA or IPSA ($N = 203$)	CSA only ($N = 189$)	IPSA only ($N = 105$)	CSA & ISPV ($N = 164$)	Sign.	Cramer's V
Racial/Ethnic background	White ($n = 283$)	94 (33.2.%)	75 (26.5%)	46 (16.3%)	68 (24%)	$\chi^2 = 13.7$; $p = .033$*	.10
	Indigenous ($n = 336$)	92 (27.4%)	107 (31.8%)	47 (14%)	90 (27.8%)		
	Visible Minority ($n = 40$)	15 (37.5%)	7 (17.5%)	12 (30%)*	6 (15%)		
Current partner relationship	Not together ($n = 543$)	164 (30.2%)	138 (25.4%)	95 (17.5%)	146 (26.9%)	$\chi^2 = 17.5$; $p = .001$	.16
	Together ($n = 122$)	39 (32%)	51 (41.8%)**	13 (10.7%)	19 (15.6%)*		
Children	Yes ($n = 603$)	181 (30%)	175 (29%)	100 (16.6%)	147 (24.4%)	$\chi^2 = 2.3$; $p = .51$ n.s.	
	No ($n = 62$)	22 (35.5%)	14 (22.6%)	8 (12.9%)	18 (29%)		
Highest Education	No complete HS ($n = 283$)	70 (24.7%)	92 (32.5%)	42 (14.8%)	79 (27.9%	$\chi^2 = 13.9$ $p = .13$ n.s.	
	HS or GED ($n = 139$)	49 (35.3%)	31 (22.3%)	24 (17.3%)	35 (25.2%)		
	Post sec-tech ($n = 114$)	40 (35.1%)	32 (28.1%)	22 (19.3%)	20 (17.5%)		
	Post sec-univ ($n = 128$)	44 (34.3%)	34 (26.6%)	20 (15.6%)	30 (23.4%)		
Disability	Yes ($n = 291$)	65 (22.3%)*	93 (32%)	39 (13.4%)	94 (32.3%)**	$\chi^2 = 28$; $p < .000$.	.21
	No ($n = 370$)	136 (36.8%)*	95 (25.7%)	69 (18.6%)	70 (18.9%)*		
Type of Disability	No disability ($n = 379$)	136 (36.8%)*	95 (25.7%)	68 (18.4%)	71 (19.2%)*	$\chi^2 = 33.5$; $p =$ .000***	.13
	Physical ($n = 89$)	26 (29.2.%)	26 (29.2%)	15 (16.9%)	22 (24.7%)		
	Mental health ($n = 73$)	13 (17.8%)*	26 (35.6%)	11 (15.1%)	23 (31.5%)		
	Physical & MH ($n = 129$)	26 (20.2%)*	41 (31.8%)	14 (10.9%)	48 (37.2%)**		
Disability from Abuse?	No/Not sure ($n = 137$)	52 (38%)**	35 (25.5%)	19 (13.9%)	31 (22.6%)	$\chi^2 = 64.3$; $p =$ .000***.	.23
	Childhood Abuse[1] ($n = 26$)	6 (23.1%)	11 (42.3%)	0 (0%)*	9 (34.6%)		
	IPV ($n = 122$)	36 (29.5%)	24 (19.7)*	32 (26.2%) ***	30 (24.6%)		
	CA & IPV ($n = 140$)	13 (9.3%)***	55 (39.3%)*	12 (8.6%)	60 (42.9%)**		

who reported both CSA and IPSA linked their disabilities to both general child and partner abuse ($\chi^2 = 64.3$; Cramer's $V = .23$, a moderate effect).

In examining mean scores on the IPSA and mental health measures (see Table 2), a consistent pattern was revealed on the CAS subscales and Total scores, such that women who reported IPSA-only or IPSA in addition to childhood sexual abuse reported significantly more severe partner violence than either women who had experienced CSA-only, or women with no CSA or IPSA history. Scores on the SCL-10 (mental distress) were in the clinical range for women who had experienced both IPSA and CSA. These women and those who had endured IPSA-only had significantly mental distress symptoms than women who had no IPSA or CSA.

None of the women were in the clinical range on the CES-D-10 (depression). Women with both IPSA and CSA has statistically significantly more dysfunctional scores on depression than women with no IPSA or CSA. With regard to the PTSD checklist (PCL), none of the groups scored in the clinical range, although those with histories of both IPSA and CSA reported significantly more PTSD symptoms than women with no CSA or IPSA histories or women with a CSA history. The significant scores on the SCL-10 but not on the CES-D-10 or the PCL may be attributable to the fact that the CES-D-10 and the PCL are each specific to one symptom, depression and PTSD, respectively. The SCL-10 assesses a broader range of issues (some but not all of clinical concern) such as distress because of loneliness, feeling afraid to go out of your house, and feeling no interest in things.

Finally, with respect to scores on the Quality of Life Questionnaire (QoL-9), significantly poorer scores were obtained from both the women with CSA and IPSA histories and CSA-only, in comparison to women with no CSA or no IPSA histories.

Discussion

That 41% of the women reported a history of IPSA is similar to Campbell and Soeken (1999), who found 45.9% in their study. The rate reported by McFarlane et al. (2005) among a group of women with protective orders was 68%; however, the fact that the women had sought legal support likely indicates the serious nature of their partner's violence. Cole et al. (2005) also sampled women with protective orders, finding that a much smaller proportion (19.5%) reported threatened or forced sex. Clearly, different samples and definitions of IPSA make comparisons across studies challenging.

Over half of the women in the current study (53.2%) had been sexually abused as children. Bonomi et al. (2007) found a similar rate of child sexual abuse (51%) in the group of women who had endured both intimate partner violence and intimate partner sexual assaults. Cole et al. (2005) reported that 33% of women had experienced forced IPSA had CSA histories, significantly more than the no-IPSA (19.8%) and the sexual insistence group (26.3%).

Demographically, there were no differences between the groups on education levels or whether they had children. One small difference was found regarding racial/ethnic background, such that women from visible minorities reported more IPSA-only than

Table 2. Scores on Standardized Measures by Sexual Assault Status[2].

Scale	No CSA or IPSA ($N = 198$)	CSA only ($N = 183$)	IPSA only ($N = 107$)	CSA & IPSA ($N = 163$)	Total ($N = 651$)	*F*-test	*r-value*
CAS Severe Combined[3]	3.2 ($SD = 3.4$)[a]	4.2 ($SD = 4.3$)[b]	11.4 ($SD = 6.6$)[ab]	12.9 ($SD = 7.2$)[ab]	7.2 ($SD = 6.9$)	137; $p < .000$***	.63
CAS Emotional Abuse	24.3 ($SD = 13.7$)[a]	23 ($SD = 12.6$)[b]	34.3 ($SD = 12.3$)[ab]	34 ($SD = 13.6$)[ab]	28 ($SD = 14.1$)	33; $p < .000$***	.37
CAS Physical Abuse	9.5 ($SD = 7.4$)[a]	10.6 ($SD = 7.0$)[b]	15.5 ($SD = 8.9$)[ab]	16.8 ($SD = 8.5$)[ab]	12.6 ($SD = 8.4$)	34.7; $p < .000$***	.37
CAS Harassment	6.4 ($SD = 4.8$)[a]	6.6 ($SD = 4.7$)[a]	9.5 ($SD = 5.6$)[ab]	9.9 ($SD = 5.3$)[ab]	7.8 ($SD = 5.3$)	21.8; $p < .000$***	.31
CAS Total Score[1]	42.9 ($SD = 23.4$)[a]	43.4 ($SD = 22.7$)[b]	70.70 ($SD = 25.5$)[ab]	72.6 ($SD = 27.6$)[ab]	54.8 ($SD = 28.3$)	63.1; $p < .000$***	.49
SCL-10 Total Score	11.6 ($SD = 8.7$)[a]	12.2 ($SD = 7.9$)	12.9 ($SD = 9.5$)[a]	15.2 ($SD = 9.0$)[a]	12.9 ($SD = 8.8$)	5.3; $p < .001$***	.16
CES-D-10 Total score	11.0 ($SD = 6.4$)[a]	12.0 ($SD = 6.0$)	12.0 (SD = 6.4)	13.6 ($SD = 6.3$)[a]	12.1 ($SD = 6.3$)	4.6; $p < .004$**	.17
PTSD Checklist	23.5 ($SD = 13.6$)[a]	26.1 ($SD = 14$)[b]	27.5 ($SD = 14.5$)	31.6 ($SD = 14.7$)[ab]	26.9 ($SD = 14.4$)	8.9; $p = .000$***	.21
QoL	30.0 ($SD = 10.1$)[a]	32.8 ($SD = 9.3$)[a]	32.2 ($SD = 10.5$)	33 ($SD = 9.5$)[a]	32 ($SD = 9.8$)	3.6; $p = .014$*	.12

White or Indigenous women. This small group ($N = 40$) reported little child sexual abuse, which increased the proportions in the IPSA-only category.

Considering the common histories of violence perpetrated in residential schools, colonization, and child sexual abuse among Canadian Indigenous women (Libesman & McGlade, 2016), we had expected significantly more CSA in this group. In Tutty et al. (2020b), Indigenous women reported significantly more CSA. However, in the current analysis that, importantly, also considers intimate partner sexual assaults, this difference is no longer apparent.

In studies that compared women from diverse racial/backgrounds with respect to differences in IPSA rates, Campbell and Soeken (1999) reported significant differences between African American and non-African American women such that the former reported significantly more sexual assaults from partners (50.4% compared to 30.6%). McFarlane et al. (2005) found no differences in IPSA rates across White, African American, and Hispanic women. Temple et al. (2007) documented that African American women experienced sexual assaults from a current partner significantly more than Hispanic women, but White women did not differ from either group. Given the relative paucity of studies on IPSA and mental health, further research that includes race/ethnicity as a variable and includes additional ethnicities, such as the Indigenous women in the current study, is warranted.

The current study reported differences with respect to whether or not the women still resided with their abusive partners such that women with a CSA-only history were more likely to remain together compared to women with both IPSA and CSA (a small effect size). This makes sense, as women in the CSA-only group were not currently being sexually assaulted by partners and the partner violence was significantly less severe, as indicated by the lowest CSA Total score. None of the other studies with IPSA and non-IPSA samples compared cohabitation across study groups.

Moderate effect sizes were found for whether or not women had a disability (women with both CSA and IPSA reported significantly more disabilities than women with no CSA or IPSA) and what type of disability the women attributed to their abuse history (a higher proportion of women who reported both CSA and IPSA linked their disabilities to both general child and partner abuse). The type of disability also differed but with a small effect size: Women with CSA and IPSA histories reported both physical and mental disabilities significantly more than women with no CSA or IPSA histories. Aside from studies that identify women with mental health difficulties as more vulnerable to IPSA, none of the reviewed studies examined disability and intimate partner sexual assaults. The original studies with this data set also identified the importance of disability as linked to difficult mental health symptomology both at baseline (Tutty et al., 2021) and longitudinally (Tutty et al., 2020).

Congruent with previous studies (i.e., Black et al., 2001; Campbell, 1989; Campbell & Soeken, 1999), women who had experienced IPSA and a combination of CSA and IPSA experienced significantly more serious violence from their intimate partners, characterized by higher scores on all CAS subscales and the Total Composite Abuse Scale in the current study.

When comparing the groups on their mental health symptoms, the strongest difference was with respect to PTSD (a small effect size). PTSD was higher (but not in the clinical range) for women with histories of both IPSA and child sexual abuse (congruent with Bennice et al., 2003; McFarlane et al., 2005; Temple et al., 2007). Bennice et al. (2003) did not examine CSA but found higher PTSD symptomatology for women with IPSA beyond the effects of physical IPV. While depression scores were not in the clinical range for any of the groups in the current study, the higher depression symptomatology is consistent with Campbell and Soeken (1999).

Women with both IPSA and child sexual abuse histories had significantly higher mental distress on the SCL-10 (in the clinical range; congruent with Cole et al., 2005) than women with no CSA or IPSA history or than women with IPSA-only but the effect size was negligible. This contrasts with an analysis of the data for the original study (Tutty et al., 2021) in which mental distress was not in the clinical range when considering intimate partner violence, suggesting the impact of sexual assaults from partners on this more global measure of mental health functioning and psychological distress in the previous week.

Quality of Life was significantly more problematic for women with any child sexual abuse history. This may be a result of the initial consequences of CSA, many of which occur in childhood such as child protection intervention, foster care, and less education, and often have long-term consequences including poor employment prospects (Letourneau et al., 2018). One of the few studies on IPSA that examined QoL found poorer quality of life in three domains: psychological, social relationships, and environment in IPSA victims compared to women with no IPSA history (Wong et al., 2019), but given the different QoL measures, the results cannot be directly compared to the current study. Other IPV researchers have used QoL measures in longitudinal studies (Bell et al., 2007) or as outcomes in evaluations of interventions such as screening (Hegarty et al., 2013) as it provides a quick snapshot of how the women are faring from a larger ecological perspective, including, for example, how they feel about their lives in general. The current study supports research with respect to the long-term negative effects of child sexual abuse on mental health (Hillberg et al., 2011). Notably, though, we could find no studies of child sexual abuse that used QoL as an outcome variable.

Implications for Advocates, Clinicians, and Researchers

Intimate partner sexual assaults are somewhat unique in that not only do women not necessarily voluntarily disclose (Huff & Rappleyea, 2020), but they also may not perceive the sexual assaults perpetrated against them by a partner as "rape" (Howard et al., 2003). The stigma associated with sexual victimization across the lifespan is significant (Kennedy & Prock, 2018) and can be an obstacle to women disclosing. National studies on spousal and sexual assaults suggest that marital rape is largely underreported to police in Canada (Koshan, 2017).

One should not be surprised by women's reluctance to disclose sexual assaults perpetrated by their intimate partners given that it was not illegal for a husband to do so prior to 1983, when it was legally permissible for a man to rape his wife without criminal sanction in Canada (Koshan, 2017). In the United States, it was not until the early 1990s that marital rape was finally illegal in all 50 states (Bennice & Resick, 2003). Further, it is still not prosecuted as harshly as rape outside marriage, as Koshan (2017) reminds us that, "It continues to be rare for men to be charged with sexually assaulting their wives or partners" (p. 12). Indeed, advocates must demand stronger government action against sexual assaults by intimate partners.

It is the responsibility of those who work with survivors of intimate partner violence, whether in advocacy-based settings such as violence against women (VAW) shelters, justice-oriented organizations, and mental health centers, to enquire about possible sexual assaults, whether directly asking about these or using a screening or assessment instrument. While intimate partner violence measures such as the 19-item Danger Assessment (Campbell, Webster et al., 2009) and the 30-item Composite Abuse Scale both include one or two items with respect to forced sex, would counsellors pay attention to these specific items? The extent to which women-serving agencies such as VAW shelters or counselling programs use standardized measures in client assessments is also unknown.

Sexual assault-specific measures such as the 4-item Humiliation-Afraid-Rape-Kick (HARK) (Sohal et al., 2007) or the considerably longer and more detailed Revised Sexual Experiences Survey Short Form Victimization (SES-SFV) (Koss et al., 2007) could be useful once the sexual assaults are disclosed. Moreau et al. (2015) added additional items to the SES-SFV to capture issues such pornography and forced sex with others. Details about the extent and nature of the partner sexual assaults would be important to elicit in counselling sessions.

Given the scores on mental distress in the clinical range and the concerning levels of PTSD and depression, counselling for women whose partners have sexually assaulted them is recommended and has been found to be effective in one study (Howard et al., 2003), much as adult survivors of child sexual abuse often benefit from clinical intervention (Lundqvist et al., 2009). We concur with Maas-Despain and Todahl (2014) that clinicians need better training to assess and address sexual assaults in intimate relationships. Once partner sexual assault has been disclosed, counselling typically entails a trauma-focused approach, similar to clinical approaches for general partner violence, child sexual abuse, and victims of non-partner sexual assaults (Howard et al., 2003), so facilitating disclosure is key.

In addition, though, clinicians often have little training in addressing disabilities, a key factor in the current analysis. Disabilities include both mental health and physical conditions that result in serious limitations in employability or activity, key factors in quality of life. Disability has been significantly related to more dysfunctional mental health scores and severity of intimate partner violence in a number of studies (Barrett et al., 2009; Brownridge, 2006; Breiding and Armour, 2015; Hahn et al., 2014; Tutty et al., 2020) (none specific to sexual assaults) so perhaps it is not surpising that this is also the case with IPSA. As noted previously, women with disabilities are

more vulnerable to intimate partner violence (Du Mont & Forte, 2014), and partner violence often results in disabilities. Further, a history of child abuse, common in the current study, has also been correlated with mental health concerns (often among victims of child sexual abuse), or physical disabilities (often because of child physical abuse) (Ballan et al., 2014). As such, disability needs special attention from counsellors and advocates.

Ballan and Freyer (2017) provide a model of trauma-informed counselling for women abused by intimate partners who have disabilities, with sexual assault considered one aspect that merits attention. The current study supports the need for such training with the high proportion of disability for women with both IPSA and child sexual abuse in addition to higher levels of PTSD symptoms.

With respect to researchers, like others (e.g., Lacey et al., 2013), the original publications of The Healing Journey did not identify partner sexual assaults separately from intimate partner violence (Tutty et al., 2020, 2021). The CAS does not have a separate subscale on sexual violence but only a few items. Had we looked beyond the subscale scores, the importance of partner sexual assaults would have been clarified sooner. Only with the current secondary data analysis did the link between IPSA and mental health symptomatology become apparent. In future research, using an intimate partner violence measure with a sexual assault subscale such as the Revised Conflict Tactics Scale (CTS2) (Straus et al., 1996), would be preferrable. Alternatively, one could add a short intimate partner sexual violence measure such as the Humiliation-Afraid-Rape-Kick (HARK) (Sohal et al., 2007) to the research protocol.

Study Limitations and Strengths

When conducting secondary analyses, one is limited by the nature of the original study, which, in this case, relied on convenience sample of women from VAW shelters or counselling agencies. Notably, though, most research on women and intimate partner violence does not randomly select cases. Nevertheless, the current results may not be generalizable to other women abused by intimate partners from Canada's prairie provinces, particularly those who have not sought assistance for partner violence.

Unfortunately, the women were not asked an explicit question about any sexual assaults as adults from non-intimate partners and the nature of these relationships. Generally, the mental health sequelae of sexual assaults by non-intimate partners are similar to victims of IPSA, including PTSD and depression (Campbell, Dworkin et al., 2009); however, we were not able to compare these as we could not identify women who had been sexually assaulted by non-intimate partners. A proportion of the respondents (9.4%) reported neither child nor intimate partner sexual abuse, but because the question did not subsequently ask who had perpetrated the sexual violence, it was impossible to ascertain if women who had been sexually abused as children and by intimate partners had also experienced sexual assaults from non-partners as adults. This would have been invaluable in interpreting the mental health scores, although it

could be argued that, as child and intimate partner sexual assaults are both often repeated since the victim often resides with the perpetrator, one-time sexual assaults by non-partners are categorically different (Boucher et al., 2009; Temple et al., 2007).

The current analysis uses only one CAS item to identify IPSA. As noted above, many women either do not perceive IPSA as wrong or illegal (Howard et al., 2003), or do not disclose IPSA (Huff & Rappleyea, 2020). Given this, the proportion of women who have been sexually assaulted by their intimate partners in this analysis may be an underestimate. Further, sexual violence often involves additional sexual acts that significantly impact women. Bagwell-Gray (2021) expands the definitions of partner sexual violence and sexual coercion to also include sexual abusive behaviors such as reproductive coercion and forced viewing of pornography. Unfortunately, questions specific to these issues were not asked in The Healing Journey study. Future research should include such expanded definitions of intimate partner sexual violence, and qualitative studies would add to our understanding of the importance of sexual violence beyond assaults.

A strength of the current study is that the women constitute a large sample of intimate partner violence survivors from the Canadian prairies with more than half of Indigenous background, a group whose well-being is particularly important in Canada but who are often not included in research. The women's candor with respect to such taboo topics as sexual assaults from their partners adds increased urgency to raising awareness of this seldom-discussed aspect of intimate partner violence.

Conclusions

The current study adds to our understanding of sexual assaults within intimate partner relationships, a topic that has received some attention but that merits considerably more, especially in the era of the #MeToo movement. We are hopeful that this movement will serve as a powerful vehicle that brings attention to sexual violence within intimate relationships to the public discourse. It behooves advocates, researchers, and clinicians alike to remind the general public of the prevalence and significant consequences of sexual violence in the lives of women abused by intimate partners.

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ORCID iD

Leslie M. Tutty https://orcid.org/0000-0003-3000-7601

Supplemental Material

Supplemental material for this article is available online.

Notes

1. Includes multiple forms of abuse beyond child sexual abuse such as physical abuse or neglect.
2. The superscripts "a" and 'b" indicate between which categories the significance lies.
3. The item "Partner; Raped me", used to categorize IPSA, is included in the Severe Abuse subscale and CAS Total score.

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Author Biographies

Leslie M. Tutty, PhD, is professor emerita with the Faculty of Social Work at the University of Calgary where she has taught courses in clinical social work methods and research. Over the past 30 years, her research has focused on policies, prevention programs, and services for intimate partner violence and child abuse including evaluations of shelters and support groups for abused women, treatment for adult and child victims of sexual abuse, and groups for men who abuse their partners.

Kendra L. Nixon, PhD, is an associate professor in the Faculty of Social Work, University of Manitoba. Her research interests include violence against women; mothering in the context of intimate partner violence; children's exposure to intimate partner violence; social and family policy, child protection; and feminist social work. She is currently the Director of the RESOLVE research network across the Canadian prairie provinces.