RESEARCH SYNTHESIS

Intimate partner sexual violence

2nd Ed.

ANROWS

AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY

to Reduce Violence against Women & their Children

We acknowledge the lives and experiences of the women and children affected by domestic, family, sexual violence and neglect who are represented in this report. We recognise the individual stories of courage, hope and resilience that form the basis of ANROWS research.

Caution: Some people may find parts of this content confronting or distressing.
Recommended support services include: 1800 RESPECT – 1800 737 732 and Lifeline – 13 11 14.

Background

Intimate partner sexual violence (IPSV) is a tactic of domestic violence (DV). IPSV is the intentional perpetration of sexual acts without consent in intimate relationships (including cohabiting and non-cohabiting partners, as well as boyfriends, girlfriends and dates). It includes vaginal, oral or anal sex obtained by physical force or psychological/emotional coercion (rape) or any unwanted, painful or humiliating sexual acts. IPSV also includes tactics used to control decisions around reproduction (Bagwell-Gray, Messing, & Balwin-White, cited in Toivonen & Backhouse, 2018), and can include image-based abuse or forced watching of pornography.

Providing freely given consent for sexual activity within the context of the perpetration of DV, is, arguably, not possible. This is because the perpetration of DV creates a climate of ongoing fear or control (Logan & Cole; McOrmond-Plummer, both cited in Cox, 2015). Research suggests that people experiencing DV cannot safely negotiate contraception or sex, and may submit to sex to prevent the escalation of physical violence (Kerr, 2018).

Like other tactics of DV, IPSV is driven by gender inequality embedded in institutional, social and economic structures; social and cultural norms; and organisational, community, family and relationship practices (Our Watch, ANROWS, & VicHealth, 2015).

Purpose

This paper provides a synthesis of the evidence on IPSV, examining its characteristics, current service responses and prevention activities. It includes recommendations for policy and practice. A case study is included at the end to draw together and highlight the key issues in a single example.

This paper is not intended to be a comprehensive literature review — it focuses on existing ANROWS research, while also drawing on recent grey literature for further supporting evidence. The specific focus on IPSV is intended to complement, not detract from, the importance of attention to the wide range of sexual violence perpetration and experiences that occur outside of the intimate partner context.

Audience

This synthesis is designed for policy-makers and practitioners engaging with people affected by domestic and sexual violence, and/or who are developing policy frameworks responsive to and inclusive of sexual assault in the context of domestic and family violence.

Wording

This paper centres on IPSV, and therefore makes reference to DV as the broader context within which IPSV is perpetrated. However, some studies compare IPSV perpetration and experience to the perpetration and experience of domestic and family violence (DFV) more broadly, and these references to DV or DFV have been maintained in the text.

FAST FACTS

Since the age of 15, approximately

1 in 4 women

(23% or 2.2 million)

have experienced violence by an intimate partner, including sexual violence

(Australian Bureau of Statistics, 2017).

Women are most likely to experience sexual violence from

a previous cohabiting partner
(4.5% of women)

or

a boyfriend/ girlfriend or date
(4.3% of women)

(Australian Bureau of Statistics, cited in Australian Institute of Health and Welfare, 2018).

Australian DFV workers believe that

90 - 100% of their female clients have **experienced IPSV**

(Heenan, cited in Backhouse & Toivonen, 2018).

KEY ISSUES: SUMMARY

- IPSV is a high-risk indicator.
- IPSV has serious and long-lasting effects.
- IPSV usually co-occurs alongside other tactics of DV.
- Community attitudes toward issues of sexual activity and consent show that sexual violence, and in particular IPSV, is not understood well, or taken seriously.
- IPSV is difficult to name and recognise.
- There are many barriers to reporting IPSV.
- Incidents are underreported and hard to prosecute.
- Responses to and services for IPSV need further resourcing and development.
- Education and prevention programs do not sufficiently address IPSV.
- Current research on IPSV faces limitations with small population groups and definitional issues.

KEY ISSUES

IPSV is a high-risk indicator

IPSV is a significant indicator of escalating frequency and severity of DV (Campbell et al., cited in Toivonen & Backhouse, 2018). Studies of IPSV show higher incidences of threats to kill an intimate partner than in other abusive relationships (Messing, Thaller, & Bagwell, cited in Cox, 2015). IPSV also puts someone at a much higher risk of being killed, particularly if they are also being physically assaulted (Campbell et al., cited in Toivonen & Backhouse, 2018).

IPSV has serious and long-lasting effects

Research shows that IPSV, when it is perpetrated alone or in concurrence with other non-sexual tactics of violence, has a greater burden of disease than physical DV only (Bonomi et al.; Monson & Langhinrichsen-Rohling, both cited in Cox, 2015). IPSV victims/survivors frequently experience repeat abuse, which is associated with higher levels of physical injury (Fredericton Sexual Assault Crisis Centre, cited in Backhouse & Toivonen, 2018; Tellis, cited in Cox, 2015), and the physical health impacts of IPSV often continue after abuse has stopped (Andersen et al.; Bonomi et al.; Parekh & Williams, all cited in Cox, 2015). IPSV is associated with increased severity of PTSD symptoms, and compared to women who experience non-sexual tactics of DV only, women who experience IPSV have:

- higher likelihood of clinically significant distress;
- higher likelihood of experiencing depression; and
- higher rate of suicide attempt and threat (Spiller et al.; Bonomi et al.; Pico-Alfonso et al.; McFarlane, Malecha, & Gist et al., all cited in Cox, 2015).

Sexual health is also particularly negatively impacted by IPSV (Cox, 2015). A key intersecting harm is forced activity that puts someone at risk of HIV transmission (Stockman et al., cited in Cox, 2015) or other sexually transmitted infections (Herman, cited in Cox, 2015). A further key intersecting harm is reproductive coercion (see Bagwell-Gray et al., cited in Toivonen & Backhouse, 2018). Reproductive coercion refers to interference with reproductive autonomy. It may take the form of, for example, preventing effective use of contraception; use of threats, coercion or force to promote pregnancy; or control over the outcome of pregnancy (for example, decisions around abortion or birth) (Kerr, 2018).

IPSV usually co-occurs alongside other tactics of DV

IPSV should be considered a tactic of DV, not a separate phenomenon: it generally forms part of a larger pattern of coercive control and is perpetrated alongside other tactics of violence (Cox, 2015). This is supported by an ANROWS study of experiences of violence amongst immigrant and refugee women in Australia (Vaughan et al., 2016). None of the women involved in the study reported any one form of violence occurring in isolation. Multiple forms of violence were used against women at the same time; for example, physical and sexual violence was accompanied by verbal abuse, often in a context of extreme social isolation (Vaughan et al., 2016).

Community attitudes toward issues of sexual activity and consent show that sexual violence, and in particular IPSV, is not understood well, or taken seriously

The 2017 NCAS results (see box on right) are not surprising given previous ANROWS research into attitudes toward IPSV. This research found that heteronormative beliefs and conservative gender norms are associated with the acceptance and experience of sexual coercion for both men and women, and can normalise IPSV as part of an accepted masculinity or characteristic of seduction (Eaton & Matamala; Heenan; Flood & Kendrick; Noonan & Charles, all cited in Cox, 2015). Research has found that IPSV is viewed by the community as both less serious and more justifiable than sexual assault by a stranger or acquaintance (Christopher & Pflieger, cited in Cox, 2015). Indeed, the greater the familiarity between the victim/survivor and perpetrator, the greater likelihood that reports will be considered a lie or misinterpretation (McLean & Goodman-Delahunty; Orchowski et al., both cited in Cox, 2015). Social norms also may increase the negative impacts of IPSV on the wellbeing of women who experience it (McOrmond-Plummer, cited in Cox, 2015).

IPSV is difficult to name and recognise

As indicated above, there is still a lack of understanding about what causes sexual violence, and myths about sexual violence are still prevalent. As such, IPSV victims/survivors often face difficulty in recognising sexual violence as violence, assault or rape (see Orchowski, Untied, & Gidycz; Littleton, Breitkopf, & Berenson; Logan et al., all cited in Cox, 2015; Backhouse & Toivonen, 2018). In particular, a key reason for this is that women are socialised to understand rape as occurring between two strangers, and women may have difficulty thinking of a partner they love as a "rapist" (Backhouse & Toivonen, 2018).

Normative understandings of "real rape" affect how IPSV is viewed and contributes to its minimisation. In ANROWS-funded research on seeking help in remote, regional and rural areas, one participant, "Angela", talked about her experience of sexual violence at the hands of her husband and the difficulty she had in recognising it as such. Family members told her that she was "overreacting" when she talked about his abuse, which led to her losing "confidence of misjudging a scenario", and particularly because her husband was not using overt physical force, "Angela" felt complicit (Wendt, Chung, Elder, Hendrick, & Hartwig, 2017, p. 29).

WHAT ARE THE CURRENT COMMUNITY ATTITUDES?

The 2017 National Community Attitudes towards Violence against Women Survey (NCAS) led by ANROWS found that community attitudes and understanding are improving regarding the complexities of DFV and intersections with sexual violence. However, there are still concerning trends of violence-supportive attitudes that contribute to the perpetration, non-recognition (or acceptance), non-reporting and non-conviction of IPSV offences. For example:

- 25% of respondents believed that women prefer a man to be in charge of a relationship.
- 23% said that women find it flattering to be persistently pursued, even if they are not interested.
- 12% still believe that women often say no when they mean yes.
- 31% agreed that in many instances, women who say that they were raped had led the man on and then had regrets.
- 42% agreed that it is common for women to use sexual assault accusations as a way to get back at a man.
- 28% agreed that when a man is very sexually aroused, he may not realise that the woman doesn't want to have sex.
- 33% agreed that rape results from men not being able to control their need for sex.
- 19% are not clear that rape in marriage is a crime.
- Approximately one in seven believe that a man would be justified to force sex if the woman first initiated intimacy, and there was slightly greater support for justification if the couple was married (15%) than if the couple had just met (13%) (Webster et al., 2018).

Similarly, research shows that younger women rarely identify sexually coercive behaviours by boyfriends as sexual assault, and tend to excuse sexually violent behaviour by saying that their own behaviour justified the assault or by pointing to extenuating circumstances (Christopher & Pfleiger; Lloyd & Emery, both cited in Cox, 2015), which again points to the strength of commonly held perceptions of what "counts" as sexual violence. This is supported by figures that show that women in Australia are significantly more likely to perceive a sexual assault as a crime if it was perpetrated by a stranger (Cox, 2016).

There are many barriers to reporting IPSV

There are many barriers to reporting any form of domestic, family or sexual violence to the police. However, there are both specific and compounded barriers for IPSV. As identified above, the very first barrier to reporting is recognising the behaviour as sexual violence or as a crime. Shame (see Messing et al.; Palmer & Parekh; Temple et al.; Wall, all cited in Cox, 2015) and fear (see Cox, 2016) have also been shown to be more significant barriers to reporting for women who experience IPSV as compared to women who experience sexual violence perpetrated by a stranger, or women who experience non-sexual tactics of DV. Shame can also be exacerbated by perceptions that discussing sex or sexual assault within relationships is "taboo" or private (Backhouse & Toivonen, 2018).

Experiences of police response can heavily influence whether women will report repeat incidences — in particular:

- lack of action by the police;
- feelings of not being listened to;
- abuser manipulation of the police;
- language barriers; or
- police stereotyping. (see, for example, Wolf et al., cited in Day, Casey, Gerace, Oster, & O'Kane, 2018)

Research points to a particular underreporting of IPSV in Aboriginal and Torres Strait Islander communities (Aboriginal Family Violence and Legal Service Victoria, cited in Cox, 2015) and immigrant and refugee communities in Australia (see Vaughan et al., 2016). Research also shows the existence of additional personal, structural and service level barriers for women in same-sex relationships (National Coalition of Anti-violence Programs; Potter et al., both cited in Cox, 2015; Ristock; Ball & Hayes; Tayton et al.; McNair; Potter, Fountain, & Stapleton, all cited in Mitra-Kahn, Newbigin, & Haderfeldt, 2016). This is also true for women with disability, even though there is evidence that women with disability are at greater risk of sexual assault or abuse (Murray & Powell; Tarczon & Quadara; Victorian Health Promotion Foundation, all cited in Maher et al., 2018). Similarly, despite evidence that transgender individuals face extremely high rates of IPSV, transgender individuals experience significant barriers to reporting, including transphobia or violence from police (National Coalition of Anti-violence Programs, cited in Cox, 2015).

Incidents are underreported and hard to prosecute

Given the community attitudes, issues of recognition and barriers to reporting outlined above, women who experience IPSV are less likely to seek help or report than victims/survivors of other tactics of DFV or of sexual assaults by non-intimate partners (Heenan; Wall, both cited in Cox, 2015; Toivonen & Backhouse, 2018). Women tend to only report severe IPSV to the police, with studies finding a zero percent report rate for sexual coercion (which is unsurprising given that most women do not believe that sexual coercion is a crime) (Sabina & Ho, cited in Cox, 2015). When reported, appropriate and sensitive police response is vital.

Further, IPSV offences are difficult to prosecute. This could be partly due to delays in reporting because of the barriers outlined above, and also partly due to the current lack of legal recognition of affirmative consent models in many jurisdictions. Without an affirmative model, demonstrating lack of consent is complicated because sexual violence may have been perpetrated in a context where consensual relations may have taken place before and/or after the assault, and in the context of established patterns of sexual behaviours that do not include verbalised consent (Easteal; Heenan; Logan et al.; Martin et al., all cited in Cox, 2015).

Responses to and services for IPSV need further resourcing and development

Attitudes of legal practitioners shape the results of court cases — both in women's experience of feeling supported and believed, as well as how the abuse against them is understood and taken into consideration. For example, in ANROWS research on barriers to justice for women with disabilities, "Simone" described her experience:

> [I]t was the family violence as well as sexual assault through the whole ten years of our relationship ….I don't think the gravity of sexual assault within a marriage….the impact of that is just not taken into account in a court hearing. The sentencing was incredibly light. (Maher et al., 2018, p. 53)

DFV and sexual assault services and responses are often separate and underpinned by different funding models, mandates, goals and practice frameworks. As IPSV victims/survivors present with intersecting issues and diverse needs, both types of services report IPSV as a particularly challenging issue which increases the complexity of providing appropriate service responses (Macy et al.; Zweig & Burt, both cited in Cox, 2015). Studies have shown a lack of attention to IPSV in both DFV and sexual assault services, with some workers in DFV and sexual assault services feeling that IPSV is more compatible with the work of those in the other field (Bennice & Resick; Heenan; Levy-Peck, all cited in Cox, 2015). This was reflected in an ANROWS study of trauma-informed care in healthcare settings, with some women reporting a lack of holistic help when trying to access assistance for sexual violence that intersected with other forms of DFV (Hegarty et al., 2017). Though it differs across states and territories, there is increasing government support for combined services; however, studies have shown mixed outcomes for victims/survivors (Fotheringham & Tomlinson; Macy, Giattina, Parish & Crosby, both cited in Cox, 2015).

Although efforts vary across the states and territories, in health settings there is limited training on IPSV for health professionals, who are fundamental access points to services. In mental health settings, despite the increased risk of adverse mental health effects, some research has shown that IPSV victims/survivors less commonly access mental health services than women who experience non-sexual forms of DFV (Prospero & Vohra-Gupta, cited in Cox, 2015).

In relation to risk assessments used by DFV services, a major limitation is that the tools and frameworks for assessing risk tend to only address heterosexual violence (McCulloch et al., cited in Backhouse & Toivonen, 2018), reflecting the inadequacy of initial responses to non-heterosexual violence.

Education and prevention programs do not sufficiently address IPSV

Public education on DFV does not tend to focus on IPSV specifically as a tactic, despite its prevalence (Cox, 2015). Other preventative measures, such as programs addressing community attitudes, have been under-researched, with most research focusing on changes to *individual* behaviour (Sabina & Ho, cited in Cox, 2015). As indicated above, however, community attitudes are fundamental to addressing perpetration, non-recognition, non-reporting and non-conviction of IPSV. Prevention activities are most effective when they involve mutually reinforcing strategies across multiple levels and aim to achieve changes in attitudes, behaviours and systems and structures (Fulu, Kerr-Wilson, & Lang; Warner, Kerr-Wilson et al.; Our Watch et al.; WHO, all cited in Webster et al., 2018). As

the 2017 NCAS reported, "[a]ction to achieve changes in knowledge and attitudes needs to be integrated into wider strategies at community and organisational levels rather than attempting to change attitudes in isolation" (Webster et al., 2018, p. 15). Additionally, programs should be ongoing and not offered as a "once-off" (Our Watch et al., 2015).

Current research on IPSV faces limitations with small population groups and definitional issues

Limits within current research coincide with limits to research on DFV more generally, such as limitations in quantitative evidence on the prevalence and perpetration of violence (Mitra-Kahn et. al., 2016). Because of limited sample sizes and mechanisms for reporting, these limitations are exacerbated within diverse communities for both DFV and IPSV specifically, such as:

- women from culturally and linguistically diverse (CALD) communities (Trijbit, cited in Mitra-Kahn et al., 2016; Mitchell; Tapia, both cited in Cox, 2015);
- women with disabilities (Attard & Price-Kelly; Healey et al.; Frohmader & Sands, all cited in Mitra-Kahn et al., 2016; Plummer & Findlay, cited in Cox, 2015);
- LGBTIQ experience (Murray & Mobley, cited in Mitra-Kahn et al., 2016; Messinger, cited in Cox, 2015);
- women in prison (Lievore, cited in Mitra-Kahn et al., 2016);
- Aboriginal and Torres Strait Islander women (Aboriginal Family Violence Prevention and Legal Service Victoria, cited in Cox, 2015; Lum On, Ayre, Webster, & Moon, 2016); and
- sex workers (Cox, 2015).

Additionally, much of the research that exists is unable to be extrapolated to the general population, as it tends to focus on non-representative groups (for example, participants recruited from a particular service) (Friesen et al., cited in Cox, 2015). Crime statistics, too, are a limited resource because they only capture reported incidents, and don't capture a full range of sexual violence (ABS, cited in Mitra-Kahn et al., 2016).

Another issue is definitional inconsistencies that may result in varied reporting — for example, estimates of IPSV vary significantly depending on the definition of IPSV that was used in the research (Cox, 2015). Importantly, paired with the above issue that many victims/survivors of IPSV may not recognise or name the abuse toward them as sexual violence, lived experience and understanding does not always align with the research definitions being used (Cox, 2015), which can lead to significant underreporting and incomplete data. Data on IPSV is also often captured within — and becomes inseparable from — other data on DFV or sexual assault (Lum On et al., 2016; Wangmann, cited in Cox, 2015), making it difficult to address the issue of IPSV specifically.

ANROWS RECOMMENDATIONS FOR POLICY AND PRACTICE

- Support augmentation and enhancement of existing surveys and administrative data in order to better capture experiences and rates of different tactics of DFV, including IPSV (see Mitra-Kahn et. al., 2016).
- Aim for definitional consistency (Mitra-Kahn et al., 2016; Cox, 2015).
- Support promotion of longitudinal research, because this is critical to understanding the complex pathways that result in IPSV (and intersections of disadvantage), and enables differentiation between risk factors, consequences and correlates (Poister, Tusher, & Cook; Classen et al., both cited in Cox, 2015).
- Support future research focused on relevant target groups with dedicated surveys, and prioritise quantitative research (Cox, 2015).
- DFV and sexual assault services should continue to work to raise awareness of the effects of stigma around IPSV (including within their own organisations) (Cox, 2015). Professional development for staff could include learning on:
    - myths and dynamics of sexual violence within relationships;
    - guidance on "how to ask" sensitively and building trust;
    - specific effects and health consequences of IPSV;
    - how best to manage victims'/survivors' safety;
    - cultural considerations; and
    - legal options and evidence requirements (Braaf, cited in Toivonen & Backhouse, 2018).
- Consider IPSV specifically in all risk assessment and safety management processes and practices as part of DFV risk assessment, and ask separately about IPSV (as distinct from physical abuse); while maintaining sensitivity to diverse communities (Toivonen & Backhouse, 2018).
- Promote existing IPSV screening tools to a wide range of mainstream frontline providers (Cox, 2015), and consider specialised services such as antenatal care.
- Provide specialist training for judiciary, police and providers of mainstream health services to enhance support and reporting, particularly for diverse communities (Cox, 2015).
- Support trauma-informed care in mainstream service provision (Cox, 2015; see also Hegarty et al., 2017).
- Resource DFV and sexual assault services to facilitate cross-sector co-ordination (from referral pathways to fully integrated care) in ways that support specialist responses to the specific contexts of IPSV (Cox, 2015).
- Ensure prevention activities address consent, ethical sexual practice and the relationship between normative gender roles and dating sexual violence (Cox, 2015; Our Watch et al., 2015).

Case study

TRANSFORMING LEGAL UNDERSTANDINGS OF INTIMATE PARTNER VIOLENCE

CONTENT NOTE
This case study contains descriptions of physical and sexual violence, and child abuse.

A recent report released by ANROWS, *Transforming legal understandings of intimate partner violence*, led by Associate Professor Stella Tarrant at the University of Western Australia, illustrates the cumulative effect of the key issues highlighted here, namely: that IPSV occurs alongside other DV tactics; that it is difficult to name; that there are barriers to disclosure; that widely-held attitudes have an impact; and that IPSV is underreported and hard to prosecute.

The report examines homicide trials in which self-defence is raised by women who have killed an abusive intimate partner. It explores how legal professionals and experts understand intimate partner violence (IPV).

The project involved a close analysis of the case of *The State of Western Australia v. Liyanage*, a case that demonstrates the way in which women's claims to have acted in self-defence against an abusive partner have been systematically rejected. Dr Chamari Liyanage killed her husband, Dinendra, in June 2014 after he had subjected her to years of physical, sexual, emotional and financial abuse. She was charged with his murder in 2014 and convicted of his manslaughter in 2016 after a trial by jury, meaning that the jury rejected her self-defence case. The below provides a summary of the issues raised in this paper; a deeper account of Dinendra's abuse and Chamari's experience, which uses a social entrapment framework, is produced in the full report.

[Note: Chamari's name is used here, and in other ANROWS publications, with her permission.]

Sexual violence was perpetrated alongside other tactics of violence

Dinendra's abuse of Chamari involved tactics of control (isolation, deprivation and microregulation) and coercion (violence and intimidation). The sexual violence formed part of a web of abusive behaviours that cumulatively shut down Chamari's space for action.

Dinendra isolated Chamari over time, intensifying this behaviour after he invited her to move from Sri Lanka to Australia. Once in Australia, he began micro-regulating Chamari's life: her leisure time, career pathway, sleep, contraception, living arrangements, weight, finances and what she would cook. He monitored her whereabouts. Dinendra used physical violence to force Chamari to comply with his will and punish her for non-compliance. He hit Chamari, beat her using weapons and made her inflict violence on herself, such as hitting her head against a wall. Eventually, it was enough for Dinendra to give Chamari a "look" and she would do as he wanted. Dinendra also made repeated threats to kill or harm her family.

It was in this context that Dinendra was sexually abusive. He would force Chamari to masturbate and use sex toys, and would rape her on camera as a "swap" with others who had pornography, including images depicting children. Dinendra repeatedly raped Chamari, anally and vaginally, including while he had tied her up, and while forcing her to look at pictures or videos of children being raped or indecently assaulted. Chamari described Dinendra's behaviour as "sexual torture". Dinendra's violence was physically painful and caused injury, so that Chamari had to take pain relief to function.

Barriers to Chamari seeking help

Fear and shame played a large part in Chamari's ability to seek help. Crucially, Dinendra's violence did not occur in an independent "cycle", as imagined under theories such as Battered Woman Syndrome. It was instrumental—directed at getting Chamari to do what he wanted—and he would "punish" her for resisting or

asserting any independence. Chamari's options for responding were also completely bound by this violence, as it was specifically designed to close down those options. Dinendra's repetitive use of violence wore Chamari down over time: she became exhausted and terrified. Additionally, Chamari found the sexual abuse incredibly degrading and was too ashamed to disclose what was happening. When she did disclose it, tellingly, she was not able to disclose its full extent: "by that time I—I was so ashamed of the things Dinendra ask me to do, so I did not want to go into that much detail."

Although Chamari was isolated, and there were many barriers to disclosure, there were, in fact, people around her (at work and in her family) who knew about Dinendra's abusive behaviour. However, the responses from those in Sri Lanka, including Dinendra's family, validated his right to use violence to discipline her if her behaviour made this "necessary". Work colleagues in Australia noticed something was wrong and Chamari made disclosures to some. Nobody did anything in reponse, providing Chamari with no help. Chamari also testified that she did not report Dinendra's abuse to the police as this would have provided her with no help and, in fact, would have escalated the danger that he presented to her and her family.

The effect of attitudes minimising sexual violence

During trial, the court "invisibilised" the sexual violence against Chamari. The report's analysis reveals that despite the presence of sexual violence against Chamari in the trial as fact (through testimonial, image and video evidence), the sexually abusive behaviours played little or no part in the case as *violence*. This included the characterisation of sexually abusive behaviours as "sexual practices she did not like" or conduct that "may be regarded as unusual" and "unpleasant". This violence was also referred to as "sexual intercourse". This is a dangerous characterisation of rape and assault as "bad sex"—i.e. that it might be occurring with a lack of consent but is "sex" nonetheless—which ignores the violence and physical, emotional and psychological violation of rape or sexual assault that holds it completely apart from "sex".

As sexual violence was a core part of Chamari's claim of the harm she was defending herself from, this re-characterisation of sexual violence was a key contributor to the rejection of her self-defence case.

FURTHER RESOURCES

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