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Intimate Partner Violence and Sexual Communication

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Intimate partner violence and sexual communication are two areas of research that have been extensively studied, but only few findings connect these areas. This literature review will examine the research that has been done on intimate partner violence, sexual communication and the connections between these two variables. In the light of the discoveries in this field of research, a U shape model is proposed to explain the connection between sexual communication and intimate partner violence. With this information, preventive interventions could be created to stop intimate partner violence before it happens.

Keywords: intimate partner violence, sexual communication, power imbalance, sexual satisfaction, sexual assertiveness, contraceptive

La violence conjugale et la communication sexuelle sont deux domaines de recherche qui ont été étudiés de façon approfondie, mais il n'y a que peu de résultats qui relient ces domaines. Cette revue de littérature examinera la recherche qui a été menée sur la violence conjugale et sur la communication sexuelle ainsi que les liens entre ces deux variables. Un modèle en U est proposé pour expliquer le lien entre la communication sexuelle et la violence conjugale. Grâce à cette information, des interventions préventives pourraient être créées pour arrêter la violence conjugale avant qu'elle ne se produise.

Mots-clés : violence conjugale, communication sexuelle, déséquilibre de pouvoir, satisfaction sexuelle, affirmation sexuelle, contraceptif

Violence is "the intentional use of physical force or power [...] which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (World Health Organization). From intimidation to homicides, there is just as large a range of negative outcomes when violent actions are perpetrated. Therefore, studying the various expressions of violence appears to be necessary, in order to allow society to better prevent these negative outcomes. One type of violence that is important to study because of its alarming prevalence is intimate partner violence. Statistics show that one in three women, and one in four men will experience violence during the course of a relationship. Such happenings usually result in psychological distress and physical harm (National Coalition Against Domestic Violence, 2016). With so many people experiencing the negative side effects of violence within an intimate relationship, it is crucial to find ways to prevent violence from occurring. Sexual communication may be an important component in preventing violence within relationships due to its possible correlation with intimate partner violence. Although both of these areas of research have been extensively studied, findings connecting these two variables are still scarce. A model to explain the relationship between intimate partner violence and sexual communication will be proposed in the hopes that it will assist the creation of preventive interventions and further investigations.

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Intimate Partner Violence

Intimate partner violence (IPV) is "violence committed within an intimate relationship" (Statistics Canada, 2015, p. 22). This can include psychological and physical violence as well as sexual abuse. For example, a women's partner may either continuously tell her that she is worthless or hit her (or both) if dinner is not ready when he gets home. IPV can be perpetrated by a spouse, dating partner or ex-partner. Abuse is often part of a cycle (Adolescents Working for Awesome Relationship Experiences, n.d.). Tensions start to build and the victim then tends to be careful not to set off the abuser. Then there is an incident of verbal, emotional, or physical abuse. Next there is a reconciliation stage, in which the abuser apologizes: he or she may buy gifts to make things better. Then it remains relatively calm before tension starts to build up again and the cycle starts again (Adolescents Working for Awesome Relationship Experiences, n.d.).

IPV is often symptomatic of an imbalance of power in the relationship (Domestic Abuse Intervention Project, 1984). The abuser has more power than the victim in some area of their

relationship, which allows him or her to be able to perpetrate violent behaviours. IPV can cause an enormous amount of distress for its victims, their families and society as a whole. It is seen as a public health issue by the World Health Organization (Statistics Canada, 2015).

There are six main areas of research on IPV: prevalence, consequences, effects on children, risk factors, condom use, and interventions. IPV occurs across different ages and genders. Research in this area has focused on subjects between 15-90 years of age. Although IPV is prevalent at all ages, rates are lower in older populations. No matter the age bracket, women are on average at least two to three times more likely to experience IPV in comparison to men. It seems like IPV reaches summits between the ages of 20 and 24 years old, where women are six times more likely to experience IPV than men (1,127.7 per 100,000 women, versus 197.3 per 100,000 men) (Statistics Canada, 2015). Considering this, it is no surprise that IPV is prevalent at post-secondary institutions. DeKeserdy and Kelly (1993) studied abuse in dating relationships of post-secondary students and found that 35% of women had experienced physical IPV and 86% of women had experienced psychological IPV. They also found that 17% of men had experienced physical IPV and 81% of men had experienced psychological IPV. Even though DeKeserdy and Kelly (1993) did not measure sexual IPV, they measured sexual abuse since leaving high school, which is related to IPV. They found 45% of women and 20% of men had been sexually abused since leaving high school. These statistics show that IPV is an important issue across genders and throughout the lifespan.

There is a variety of physical and psychological consequences to being an IPV victim (Plitcha, 2004; Statistics Canada, 2015). Being beaten on a regular basis has both short and long term physical consequences. Short-term physical consequences include scratches, bruises, and broken bones. Long-term physical consequences include chronic pain, disability, and brain injury (Plichta, 2004). Being a victim or perpetrator of IPV also puts you at a higher risk of depression and suicide ideation (Larris, Leenaars, Jahn, & Lester, 2013). Victims may also feel hopeless and turn to substance abuse (Larris et al., 2013).

A large area of IPV research looks at its impact on children. Children's exposure to IPV can have a range of short and long-term consequences. Children who witness violence tend to feel like it's their fault and blame themselves (Groves, 1999; Holt, Buckley, & Whelan, 2008; Stern, 2014). Furthermore, witnessing violence can have a negative effect on a child's mental health, such as triggering PTSD and depression (Groves, 1999; Holt et al., 2008; Overbeek, Clasien de Schipper, & Lamers-Winkelman, 2013; van Heugten, & Wilson, 2008). Additionally, witnessing violence often indicates that future relationships will involve violence, whether the witness is the primary victim or is the perpetrator of the said violence (van Heugten, & Wilson, 2008). Moreover, a child may not only be a witness, but also a victim of violence from one or both parents. The problems that children experience often manifest themselves in behavioural problems (Holt et al., 2008; Overbeek et al., 2013; van Heugten, & Wilson, 2008). Overall, exposure to IPV negatively affects a child's emotional well-being, mental health, and behaviour.

Research has identified a number of risk factors of being a victim of IPV. Sexual coercion, sexual assault, IPV, and anticipated negative partner response are all highly positively correlated with each other (Quina, Harlow, Morokoff, Burkholder, & Deiter, 2000). Furthermore, people who experience IPV are also more likely to be victims of reproductive coercion, birth control sabotage, and pregnancy coercion (Bergmann, & Stockman, 2015). Additionally, having previously been in a relationship with IPV or having witnessed IPV as a child are indicators of experiencing violence in the future (Green & Navarro, 1998; Van Heughten, & Wilson, 2008). Revictimization has a wealth of research that consistently finds that being a victim of one type of sexual abuse seems to increase the likelihood of being a victim of other types of sexual abuse. Many theories have been put forward. For instance, there may be certain vulnerability factors shared by these victims, or a power influence that is silencing women. Risky behaviours such as a high amount of lifetime partners, excessive alcohol use, and young age at first intercourse are also a risk factor for IPV (Green & Navarro, 1998; Quina et al., 2000). Besides, women who do not believe they have power in their relationship are more likely to experience IPV (Green & Navarro, 1998; Quina et al., 2000). It’s important to be aware of the risk factors of IPV since they can help in creating effective interventions.

Condom use has been studied in relation to IPV as well. It seems that if a woman chooses to ask for a condom, her partner may get violent. Studies show that asking for a condom may lead to being threatened (Bergmann, & Stockman, 2015). This may be because the man feels that trust has been broken. In other words, if she is asking for a condom, either she must have been unfaithful, or she thinks he has been. Additionally, it has been found that these requests are disapproved of by perpetrators (Bergmann, & Stockman, 2015). Knowing there is a possibility of a negative partner response may create fear. This fear may discourage women from asking for a condom in

the first place (East, Jackson, O'Brien, & Peters, 2011). This fear also limits women's confidence in their ability to negotiate condom use (Bergmann & Stockman, 2015). The serious repercussions of trying to negotiate condom use are related to the power imbalance present in relationships involving violence (Bergmann & Stockman, 2015; Peasant, Parra, & Okwumabua, 2015). This imbalance makes women feel disempowered, and as though they are unable to speak up about their preference for the use of protection (East et al., 2011). The consensus in these studies is that people in a relationship with IPV are less likely to use contraceptives than people whose relationship does not involve violence (Bergmann & Stockman, 2015; Swan & O'Connell, 2012).

Interventions for both the victims of IPV and the children exposed to it have also been studied. The research tends to focus on protecting children, with the goal of reducing their exposure to IPV (MacMillian, Wathen, & Varcoe, 2013). Because of the complexity of IPV, many different interventions have been proposed. However, researchers have found minor or unclear results (MacMillian, Wathen, Barrlow, Fergussion, Leventhal, & Taussig, 2009). Additionally, the interventions are actually treatments, meaning that they deal with the problem after it has happened. Therefore, violence has already occurred, and these interventions are trying to stop it, but it would be beneficial to find ways to prevent violence in the first place. The link between sexual communication and IPV may help to create interventions that prevent violence rather than treat it.

Sexual Communication

Sexual communication is the "process of discussing aspects of one's sex life with one's partner" (Holmberg & Blair, 2009, p. 59). Research on sexual communication has mainly focused on two objectives: to improve safe sex practices and to improve sexual satisfaction. Sexual communication is a broad subject and there are many subcategories. For the purpose of this review, sexual communication will be discussed as a whole, in addition to two main subcategories: protective sexual communication, which refers to discussing the use of contraceptives and sexual history, and preference sexual communication, which in turn refers to partners discussing what they like and do not like under the bed sheets. Although these categories are split up in this paper and in most of the research, it is important to note that protective and preference sexual communication are highly correlated with each other, so discussing one often means discussing the other (Quina et al., 2000). Meaning people who discuss protective sexual communication are likely to also discuss preference sexual communication and vice versa.

Sexual communication has a number of benefits, including increased use of protection, increased relationship and sexual satisfaction, increased self-esteem, and increased sexual well-being. Although self-esteem and satisfaction are also positively correlated to each other, Babin (2012) found that communication, specifically non-verbal, mediates this relationship. Preference sexual communication increases sexual well-being, including satisfaction (Byers, 2011). Byers (2011), notes two reasons for this connection: an instrumental one and an expressive one. The instrumental path states that communicating about preferences allows for partners to better understand each other's wants and desires which leads to the creation of mutually satisfying sexual scripts. The expressive path states that sexual communication enhances intimacy, which increases sexual well-being.

While communicating about sexual aspects of a relationship has its benefits, limited communication can lead to several negative consequences. Not discussing protection decreases its overall use, which can lead to unwanted pregnancy or Sexually Transmitted Infections (STIs; Byers, 2011). Furthermore, some researchers argue that a lack of sexual communication can contribute to sexual coercion. In fact, a lot of sexual coercion is verbal, which suggests that a difficulty to communicate plays a role in this phenomenon (Byers, 2011). Overall, the benefits of sexual communication and the adverse effects of not doing so show how important it is for couples to discuss the sexual aspects of their relationship. When the benefits of sexual communication and the harms of avoiding it now appear to be so clear, why is it that couples do not talk about their sexuality?

Research on the barriers to sexual communication indicates there are a variety of reasons that couples do not discuss sexuality. Sexual communication apprehension (SCA) is one of these reasons. SCA is a fear or anxiety of discussing sexual topics with a partner (Babin, 2012). Babin (2012) found that men are more likely to experience SCA. There are a few characteristics that impact one's ability to communicate about sexual topics. Individuals who are avoidant are less likely to discuss sexual aspects of their relationship (Khoury & Findlay, 2014). Anxious individuals had poorer communication once they had been in a relationship for more than nine months (Khoury & Findlay, 2014). Moreover, having sexual problems, such as dyspareunia or vulvovaginal disorders, can contribute to avoidance of sexual communication because of fear or discomfort caused by discussing aspects of their abnormal sex life (Pazmany, Bergeron, Verhaeghe, Van Oudenhove, & Enzlin, 2014).

There are many factors that influence protective sexual communication based on people's own insight such as people's perceptions of its importance, their own confidence, and aspects of their relationships. Protective sexual communication is related to the belief that it is important to discuss this issue, if someone feels it is important to discuss protection, they are more likely to do so (Dilorio, Dudley, Lehr, & Seot, 2000). Secondly, sexual communication is more likely to be discussed if the person is confident in their ability to communicate about sexual topics. The quality of communication with parents and discussing aspects of sexuality with parents positively correlates with protective sexual communication with a partner (Dilorio et al., 2000). Additionally, the perception that their partner desires to discuss aspects of their sexual life is associated with actually discussing protection (Dilorio et al., 2000).

Up until now, researchers have debated the ways in which sexual communication influences couples' sexual lives. Dilorio and colleagues (2000) and Quina and colleagues (2000) found that communication is positively correlated to condom use, meaning that the more partners discuss, the more they are likely to engage in protected sexual intercourse. Alternatively, Greene and Faulkner (2005) found them to be negatively correlated, suggesting that the more partners communicate, the less likely they are to use condoms. When looking further into this, Wildman, Moar, Choukas-Bradley, and Francis (2014) and Johnson, Sieving, Pettingell, and McRee (2014) found that the relationship is moderated by topic. Specifically, contraceptive communication was found to increase the use of hormonal contraceptives (Johnson et al., 2014). Wildman et al. (2014) found that contraceptive communication increases condom use, while Johnson et al. (2014) found no significant increase. The two studies did agree that discussing sexual history or general sexual topics have little to no effect on contraceptive use. It was also found that if they were in a relationship, hormonal contraceptive was consistently used, even when only general sexual topics were discussed (Johnson, 2014). More research with larger sample sizes would help to clarify such mixed results. Additionally, researchers should investigate how different types of sexual discussion influence various aspects of couple's sexual lives.

One variable that may have an impact on the connection between communication and condom use is condom self-efficacy. Condom self-efficacy is how confident people are in their ability to deal with condoms, which includes purchasing them, suggesting their use and using them persistently (Sterk, Klein, & Elifson, 2003). Quina et al. (2000) found that condom self-efficacy predicted discussions about protection. Condom self-efficacy was found to be higher in people who have higher self-esteem and better communication with their partner (Sterk et al., 2003). Quina et al. (2000) also found that women who believed that their partner would have a negative response to protective communication were less likely to discuss protection. Therefore, sexual communication seems to lead to self-efficacy, which in turn, leads to contraceptive use. Overall, these studies indicate that protective sexual communication increases the use of contraceptives, while preference sexual communication does not affect its use.

In addition, sexual assertiveness predicts sexual communication (Greene & Faulkner, 2005). The former is split into three areas: initiation, refusal and sexual talk (Greene & Faulkner, 2005; Quina et al., 2000). Initiation assertiveness is how much someone initiates intimate physical contact. Refusal assertiveness is being able to refuse of "unwanted, nonforced sexual contact" (Quina et al., 2000, p. 531). Lastly, sexual talk assertiveness is the capacity to initiate sexual discussions. Although Greene and Faulkner (2005) found that each area of sexual assertiveness, and therefore sexual assertiveness as a whole, impacted sexual communication, Quina et al. (2000) noticed that it was specifically initiation and refusal assertiveness that led to both protective and preference sexual communication. Overall, research indicates that people who are sexually assertive communicate more about their sexual lives.

Even though sexual communication research has focused on two main objectives, which are to improve safe sex practices and sexual satisfaction, sexual communication may also be influential in other areas. One of them that still has few findings is the connection between sexual communication and IPV.

Impact of Sexual Communication on Intimate Partner Violence

Although research in the area of sexual communication and IPV has been scarce, many connections can be made. As discussed earlier, it has been argued that deficient communication can lead to sexual coercion (Byers, 2011). Since sexual coercion and IPV are also correlated, poor communication may also increase IPV. Additionally, sexual coercion in the context of a relationship can be considered as IPV. Negative partner reaction has also been found to limit sexual communication. For instance, people with higher condom self-efficacy are more likely to discuss protection, but having experienced violence can decrease condom self-efficacy, indicating that people in a relationship with violence are less likely to communicate about sexual aspects of their life to their partner. These connections indicate that there may be a relationship between sexual communication and IPV.

It has also been noted that sexual assertiveness may predict sexual communication, suggesting that its increase could result in a greater amount of sexual communication, which would, in turn, decrease IPV. In fact, research has shown that there is a reciprocal relationship between sexual assertiveness and IPV (Stoner et al., 2008). It is therefore possible that sexual communication is a mediator in this relationship. Sexual assertiveness has also been proposed as a protective factor of various types of sexual victimization which suggests that it may also be a protective factor for IPV, considering it's correlation with sexual communication (Green & Navarro, 1998).

When looking at these studies, it seems that sexual communication has an effect on IPV through many different angles. Although in many instances more sexual communication indicates a decrease in IPV, too much sexual communication may, on the contrary, create a fertile environment for violence. As discussed earlier, the simple act of asking for a condom can sometimes lead to violence, whether verbal or physical (Bergmann & Stockman, 2015). A partner might also get annoyed with excessive information or not approve of a sexual fantasy. In these instances, communication may actually increase IPV.

Therefore, the relationship between sexual communication and IPV can be explained using a U shape (see Figure 1). The proposed model indicates that there is an ideal amount of sexual communication under which or over which IPV may occur. If our model on the relationship between sexual communication and IPV is true, relationships with the ideal amount of sexual communication will see less instances of IPV. Additionally, relationships with too much or too little sexual communication will see more instances of IPV.

Theoretical and Social Implications

This model shows that relationships that lack sexual communication or have too much sexual communication are at risk of IPV. Therefore, increasing women's abilities to discuss sexual aspects of their relationship with their partner may prevent IPV. Moreover, there are a number of other positive outcomes related to sexual communication, such as sexual satisfaction and increased use of protection. It seems like those who are in relationships involving violence tend to communicate too little or too much about sexual aspects of their life to their partner, which makes them unable to reap the benefits of a healthy sexual discussion. A connection between sexual communication and IPV has yet to be solidified. This model offers a better understanding of the relation between these two variables. The variables that have an impact on sexual communication can therefore open up new possibilities of variables that also affect IPV. This will enable the creation of better and more varied interventions. For example, research indicates that sexual assertiveness positively impacts sexual communication. If sexual communication helps to decrease instances of IPV, then interventions targeting sexual assertiveness would be beneficial.

More information in this area will help IPV survivors and perpetrators to get the assistance they need by creating efficient preventive interventions. For example sexual education could benefit those involved by including information on sexual communication. Teaching this in high school could create a preventive intervention for IPV, and allow the general public to take advantage of the many benefits of a healthy sexual communication. For instance, programs that increase predictors (e.g., confidence, knowledge of sexual health) and decrease deterrents

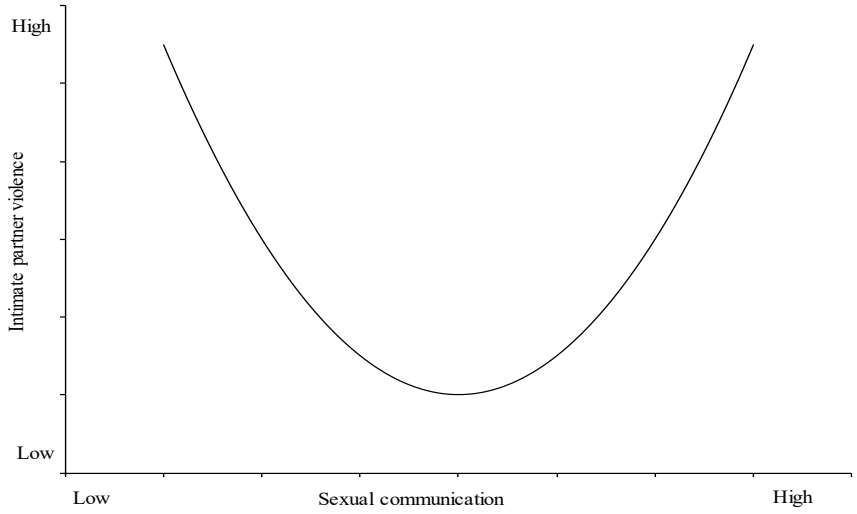

Figure 1. Proposed U-form model between sexual communication and intimate partner violence.

(e.g., SCA) to sexual communication would be beneficial. More research on the connection between sexual communication and IPV would also help create optimal treatments for those who have experienced IPV. Developing skills associated with sexual communication, such as sexual assertiveness, will assist in breaking the cycle of victimization. All in all, interventions that help to increase sexual communication will not only assist in preventing the occurrence of IPV, but also help IPV victims.

Future Research

Research should be done to look at the connection between sexual communication and IPV, specifically if increased sexual communication decreases IPV, and if decreased sexual communication increases IPV. In order to do this, researchers should look at both preference and protection communication, together and separately. Although this model indicates that all sexual communication has an impact on IPV, it is possible that one of them has more weight than the others. A longitudinal study following high school students up until their early 30s with periodic tests of sexual communication levels and rates of IPV could fill some gaps in sexual communication and IPV research.

It would also certainly be beneficial to look at possible mediators and moderators. Moderators could include socioeconomic status, education level, previous victimization or condom self-efficacy. Mediators could include self-esteem, confidence or feelings of power/worth. Additionally, looking at the quality of sexual communication versus the quantity of the sexual communication would indicate if amount or quality of the communication has more of an impact on IPV. This in turn leads to the importance of considering the limits to increasing sexual communication in avoiding IPV. For example, if one partner has a substance abuse problem, resolving this issue before increasing sexual communication is important. Research looking at the conditions needed to attain healthy sexual communication would be beneficial, as some situations may need the assistance of professionals.

Conclusion

Sexual communication has a number of benefits, such as increased satisfaction, and increased contraceptive use. Nonetheless, not everyone is able to take advantage of the benefits of sexual communication because of various barriers. While sexual communication research is valuable in its two main objectives of increasing satisfaction and contraceptive use, it has yet to realize its full potential. The connection between sexual communication and IPV can help to prevent future victimization. IPV is a serious problem that affects a large range of individuals and society as a whole. A U-form model was presented to better understand this connection so that those who have been victims of IPV and those that are at risk can take advantage of the benefits of sexual communication. This model as yet to be tested. Understanding the connection between sexual communication and IPV will allow researchers to know what aspects are important to target when preventing it and supporting its victims and perpetrators. Additionally, this understanding can be used to create interventions that can assist victims in improving their communication, which in turn can help increase relationship satisfaction.

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