Equally significant is how few women are ever asked by their GPs, and other service providers, about whether they are experiencing intimate partner violence, especially when women regularly present with the kinds of injuries or symptoms that are strongly suggestive of their being subjected to regular episodes of some form of violence. Heather Osland repeatedly visited her doctor with urinary infections, and vaginal and anal tearing as a result of her husband's violence and was never once asked about the injuries or about the chronic nature of her condition (Osland 1996: 967-968). Angela Taft (1999) chronicles the consistent failure of the medical profession to intervene appropriately to assist women like Heather and her children, and suggests it is symptomatic of a general reluctance by health professionals to adopt a more proactive role in supporting women who may be experiencing violence.

Impact on women's health and emotional wellbeing

The impact and consequences of male partner violence on women's health and wellbeing have been described by the World Health Organisation (WHO) as "profound" (Krug et al. 2002: 100). An emerging and compelling body of literature and research continues to suggest there are strong links between women's histories of intimate partner violence and the state of their reproductive health, their mental and emotional health (including levels of post-traumatic stress, depression, eating disorders, and misuse of substances such as alcohol and other drugs), their physical health, and their rates of suicide.[31] A comprehensive review of this literature is beyond the scope of this paper[32], but it is important to consider the implications of some of the more recent research that gives specific attention to the impact of sexual violence by male partners on women.

Emotionally, most women find it hard to heal. Contrary to popular belief, the effects are equivalent, if not more dramatic for women who may have been repeatedly raped by their partners than they are for those raped by strangers and acquaintances (Finkelhor and Yllö 1985; Riggs et al. 1992; Tjaden and Thoennes 2000; Bennice and Resick 2003). Alongside the constant fear and anxiety many women suffer at the thought of their violent partner returning, many of the women Bergen spoke to related their experiences of severe depression, of being hyper vigilant, of constant flashbacks and nightmares, and of feeling that their ability to trust, or to form new relationships and friendships had been irreparably damaged (1996: 59-60; see also Campbell and Soeken 1999).

Consistent with earlier research (Shields and Hanneke 1983; Finkelhor and Yllö 1985), Jacquelyn Campbell's (1989) study also revealed that women who were both raped and physically assaulted by their partner (51 per cent of her sample), experienced more severe forms of battering, were more severely injured, and were more likely to fit with profiles of women who were ultimately killed by their male partners, than women who experienced physical violence alone. The sexually and physically abused women were more likely to have been assaulted during pregnancy (1989: 341). Overall, Campbell notes the common "sequelae of marital rape can include sexually transmitted diseases, urinary tract infections, decreased sexual desire and pleasure, haemorrhoids, and other genito-urinary tract problems" (1989: 345).

A recent study by Bennice et al. (2003) has also distinguished the severity and higher levels of post-traumatic stress (PTSD) in women who have experienced both sexual and physical violence from women who have been traumatised by physical violence alone. They found that the severity of sexual violence that women who had been both raped and battered experienced resulted in more PTSD symptoms

being identified in self-reported surveys than for women who had been battered but not raped (2003). Even when the severity of physical violence was controlled, the results suggested that it was the severity of sexual violence that "accounted for the bulk of subsequent PTSD symptoms" (Bennice et al. 2003: 92).

Other studies have focused more closely on the relationship between women's experiences of intimate partner violence and their reproductive health (Campbell and Alford 1989). The report by WHO suggests that women living with violent male partners may be forced to deal with "unwanted pregnancy or sexually transmitted infections, including HIV infection, through coerced sex, or else indirectly by interfering with a woman's ability to use contraceptives, including condoms" (Krug et al. 2002: 101). The report also documents the findings from studies in Canada, Chile, Egypt and Nicaragua that reveal that anywhere between 6 per cent and 15 per cent of women who have ever been in a relationship have experienced physical or sexual violence during a pregnancy, usually by their male partners (2002: 101). In the United States, Goodwin et al. (2000) found that 12.6 per cent of women with "unwanted" or mistimed pregnancies reported violence from partners in the previous 12 months, while 15.3 per cent reported violence occurring some time throughout the pregnancy. However, the links between "unwanted" pregnancies and women's experience of male partner rape must be directly explored.

Mahoney and Williams (1998) note studies that suggest the timing of male intimate partner rape often correlates with women having been in hospital, most often because of childbirth. Women in Bergen's study (1996) described partners insisting on having intercourse soon after they have given birth in spite of doctor's advice to abstain. Other studies have found an increase of violence during pregnancy that can lead to miscarriage, still- or premature births, low birth weights, or women delaying their contact with prenatal care health workers (Campbell 1989; Campbell and Soeken 1999).

Women who are raped and battered have also been found to experience lower self-esteem (Shields and Hanneke 1983; Campbell 1998), and suffer more significant damage to body image than women who experience physical violence from their male partners but are not raped (Campbell 1989). Campbell (1989: 344) notes that these outcomes held true even when women identified a single instance of rape, or when it had occurred early in the life of the relationship.

In Australia, researchers have increasingly been targeting their studies at general practitioner and other health settings to better establish the relationships between the prevalence of male partner violence and its impact on both women's health and wellbeing, and their use of health services (Roberts et al. 1993; Bates et al. 1995; deVries Robbe et al. 1996). This follows overseas studies, such as that undertaken by Koss (1993) and Abbott et al. (1995). More recently, by Ann Coker and her colleagues (2000: 553) found that: "Women experiencing intimate partner violence use a disproportionate share of health care services, making more visits to emergency departments, primary care facilities, and mental health agencies than non-abused women."

The research team involved in the Australian Longitudinal Study on Women's Health, recognised the extent to which women's experiences of violence must be explored as part of measuring the psychological, emotional, biological and social situational factors that impact on women's physical health and well being and their perceptions of the treatment they received from health care services (Lee

2001). The study involves following three age cohorts or groupings of women (young, mid-age and older) over a 20-year period. The study is the first of its kind in Australia to be able to provide population based assessments of the impact of violence on women's health over time.[33]

The findings from the first series of surveys that addressed the issue of violence with the mid-age cohort have been reported by Parker (1999, 2001). As detailed earlier in this paper, approximately one-third of women in this age group identified having experienced intimate partner violence. Sixty percent of these women identified experiences of sexual abuse in particular, with 73 per cent of the total number of women identifying the perpetrator of the physical, sexual or emotional abuse as a current or former partner (Parker 2001: 188). While Parker (1999) does not distinguish the health consequences for women who were offended against by partners from other relationship types, the findings are consistent with studies that do. Women who were the subject of non-recent, but regular and ongoing abuse as adults, were likely to have poorer physical and mental health, be more prone to depression and have more negative self-perceptions.

There seems little doubt that as violence escalates, or as women are supported to re-define their experiences, they will increasingly look to health and other support services for assistance. Health care providers and general practitioners are therefore critical points of intervention in being able to initially screen, respond to, and possibly prevent women's revictimisation. At the local level the challenge remains for the health sector to develop best practice approaches, including professional training, that would facilitate sensitive and appropriate screening practices and responses to women who present with symptoms suggestive of intimate partner violence.

Encouragingly, women in Hegarty and Taft's study (2001) were twice as likely to disclose violence if they were *directly asked* about it by their GPs than if no enquiry was made (2001: 434). Hence, while women may feel uncertain about how to define their experiences, or question whether it may be just a "normal" consequence of relationship breakdown, researchers like Campbell (1989: 344-345) have concluded that "in whatever shelter or health care setting they are seen . . . women will not spontaneously discuss the violence in their sexual relationship and will need to be asked". And yet, commentators have consistently pointed to a reluctance by service providers, such as in the health care professions and women's counselling services, to respond to the specific issue of sexual violence by male partners, even though they are likely to be the first point of contact for women seeking support (Russell 1990; Bergen 1996; Yllö 1999).

The following section will examine these issues drawing on studies conducted with service providers and women survivors of male partner sexual violence in the United States. Their relevance in understanding service responses in the Australian context will also be considered.

A reluctance by service-providers to respond

> "I don't think battered women's shelters or rape crisis centres know how to deal with it [wife rape]. They've all been so segmented, and they can't deal with it as a whole. They say we'll deal with battering and then go there for rape. The women [the victims] who've been chopped up in so many pieces can't deal with being chopped up again." (Bergen 1996: 106)