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# Research on sexual & reproductive violence in Australia: Implications for clinical practice

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**Safer  
Families**



**restore**

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# Background & definitions

## Sexual violence (adulthood)

Any non-consensual sexual act by any perpetrator

## Reproductive violence = an umbrella term

Conflict related reproductive violence

Obstetric violence / Mistreatment during labour

Reproductive coercion and abuse (RCA)

→ Pregnancy promoting  
Pregnancy preventing



# Sexual violence – Chronically under-reported



**In Australia:** 1 in 6 women / 1 in 25 men

**BUT**

- Sexual violence under-reported
- Inconsistent measurement overly focused on “force”



# Sexual violence – Chronically under-reported



*I couldn't deal with the sulking because I just - I've got this people pleaser type of personality at the best of times, and it would just - it just made me very, very anxious if he was in one of those moods.*  
(Tarzia & Hegarty, 2022)



Frequency of IPSV behaviours in last 5 years and 12 months in a sample of women experiencing abuse (N=1,026)

	Last 5 years	12 months (once or more) <i>n (%)</i>
<b>Factor 1: Dominance &amp; humiliation (n=181)</b>		
Made me perform a sex act with an animal	46 (4.5)	39 (3.8)
Made me have sex in front of my child/ren or other people (including online)	70 (6.8)	53 (5.2)
Threatened to share my sexual orientation or gender identity publicly if I would not have sex with them	77 (7.5)	60 (5.8)
Made me have sex with other people (including for money) when I did not want to	71 (6.9)	53 (5.2)
Made me have sex or perform a sex act by threatening to physically hurt me, my children, someone close to me or a pet	85 (8.3)	68 (6.6)
Made me watch them having sex with someone else	71 (6.9)	55 (5.4)
Used a weapon to make me have sex or perform a sex act when I did not consent to it	60 (5.8)	48 (4.7)
Distributed sexual images of me without my consent	101 (9.8)	70 (6.8)
Touched me in a sexual way or performed a sex act on me without my consent when they were my caregiver for a disability or illness	93 (9.1)	75 (7.3)
Made me have sex when I was medically advised not to (e.g. after surgery or childbirth)	107 (10.4)	73 (7.1)
Choked or strangled me during sex without consent	122 (11.9)	92 (9.0)
<b>Factor 2: Emotional Coercion (n=364)</b>		
Accused me of cheating or not loving them when I said 'No' to sex	318 (31.0)	211 (20.6)
Verbally abused me when I refused to have sex	282 (27.5)	189 (18.4)
Threatened or implied they would go elsewhere for sex if I did not have sex with them	268 (26.1)	177 (17.2)
Told me it was my duty or obligation to have sex with them	282 (27.5)	195 (19.0)
Made negative comments to other people about my sexual performance	218 (21.2)	156 (15.2)
<b>Factor 3: Aggressive indifference (n=333)</b>		
Made me participate in sex acts or sexual positions that they knew I did not like	257 (25.0)	176 (17.1)
Made me participate in sex acts or sexual positions that made me feel degraded	279 (27.2)	187 (18.2)
Forced me to continue having sex or performing sex acts even though I was in discomfort or distress or asked to stop	232 (22.6)	163 (15.9)
Insisted that I have sex even after I said 'No' or demonstrated disinterest	356 (34.7)	242 (23.6)
<b>Total <sup>a</sup></b>	<b>609 (59.4)</b>	<b>445 (43.4)</b>

**Notes**

Factors are not mutually exclusive; participants could experience behaviours in more than one dimension; <sup>a</sup> Participants who have experienced 1+ IPSV dimension

# Reproductive coercion & abuse – a hidden epidemic

COMMENTARY

Open Access

## A conceptual re-evaluation of reproductive coercion: centring intent, fear and control

Laura Tarzia<sup>1,2\*</sup> and Kelsey Hegarty<sup>1,2</sup>



### Abstract

**Background:** Reproductive coercion and abuse (RCA) is a hidden form of violence against women. It includes behaviours intended to control or dictate a woman's reproductive autonomy, for the purpose of either preventing or promoting pregnancy.

**Main text:** In this commentary, we argue that there is a lack of conceptual clarity around RCA that is a barrier to developing a robust evidence base. Furthermore, we suggest that there is a poor understanding of the way that RCA intersects with other types of violence (intimate partner violence; sexual violence) and—as a result—inconsistent definition and measurement in research and healthcare practice. To address this, we propose a new way of understanding RCA that centres perpetrator intent and the presence of fear and/or control. Recommendations for future research are also discussed.

**Conclusion:** We suggest that IPV and SV are the *mechanisms* through which RCA is perpetrated. In other words, RCA cannot exist without some other form of co-occurring violence in a relationship. This has important implications for research, policy and healthcare practice including for screening and identification of women in reproductive healthcare settings.

**Keywords:** Reproductive coercion, Intimate partner violence, Sexual violence, Reproductive autonomy, Women, Family violence

- Studies often measure forced pregnancy alone
- Intent of perpetrator not accounted for (e.g. stealthing) which can over-inflate prevalence.
- Including any behaviour with reproductive impact.

(Tarzia & Hegarty 2021)



# Reproductive coercion & abuse – a hidden epidemic

Original Research

## Prevalence and Predictors of Reproductive Coercion and Abuse by a Partner Among a National Population Sample in Australia

Laura Tarzia<sup>1,2</sup> , Nicholas Egan<sup>3</sup> ,  
Melissa L. Harris<sup>3</sup>, and Deborah Loxton<sup>3</sup> 

### Abstract

Reproductive coercion and abuse (RCA) involves the use of violence, deception, or threats to undermine another person's reproductive autonomy. Largely perpetrated against women by their male intimate partners or other close family members, RCA is harmful to health and well-being. Despite this, it is under-researched, with conceptually sound, robust data lacking globally. The present study addresses this gap within the

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- Recent work in Australia provides a more accurate estimate of partner-perpetrated RCA.
- Using data from >6000 women aged 43-48 drawn from the ALSWH
  - 4.5% lifetime RCA
  - 2.4% pregnancy promoting
  - 2.6% pregnancy preventing



# Health impacts of sexual violence

Anxiety 2.6 x 

Depressive symptoms 3.4 x 

PTSD 7.6 x 

Eating disorders 1.9 x 

Other chronic health conditions

Risky health behaviours (e.g. alcohol, substance misuse)

Self-harm, suicide

Gynaecological conditions, STIs, pelvic pain

Unwanted pregnancies

(Dworkin et al. 2020)



# Health impacts of reproductive coercion

**\*\*\* Evidence base is shaky due to poor measurement\*\*\*\*\***

Unwanted pregnancies


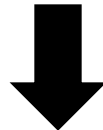
Rapid, repeated pregnancies (Cha et al. 2016)

Unwanted abortions

Poor birth outcomes (Grace et al. 2025)

Gynaecological issues

STIs (Capasso et al 2019)

Anxiety, depressive symptoms, stress, PTSD  life satisfaction   
(Sheeran et al. 2024; Munoz et al. 2023)



# Key research on sexual & reproductive violence in Australia



# Sexual violence in general practice: PROSPER study (2017)

- Study conducted in Australian general practice clinics
- Recruited women aged 18+ waiting to see doctor
- Women asked to fill out survey on iPad
- Two waves of recruitment
- Broad definition of SV using 21-item scale from NIPSVS



# KEY FINDINGS – WAVE ONE

- n=230 women completed the survey from 4 clinics
- **Nearly half (45%) had experienced at least 1 incident of SV as an adult**
  - Flashing/public masturbating (27%)
  - Harassment in public (22%)
  - Fondled or grabbed (20%)
  - Pressured into sex by partner (15%)

## **Women who had experienced SV:**

- experienced higher mean anxiety over past 2 weeks **even after adjusting for age & child abuse**
- were more likely to feel down, depressed or hopeless (but association disappeared after adjusting for child abuse)

This suggested that even more “subtle” SV can impact women’s mental health.



# KEY FINDINGS – WAVE TWO

- Association between type of SV & mental health
  - rape/sexual assault (with/without any other experiences)
  - coercive behaviour and/or reproductive control (with/without unwanted sexual contact)
  - unwanted sexual contact only (e.g. flashing, groping, kissing)
- Effect of perpetrator type on mental health
  - intimate partner / other known person / stranger
- n=325 women from 4 clinics
- 41% had experienced at least 1 form of SV since age 15



# KEY FINDINGS – WAVE TWO

## Type of SV and relationship to MH

Compared to women with no experiences of SV:

- Women who had experienced rape/sexual assault had significantly higher mean PTSD, depression & anxiety scores
- Women who had experienced coercive behaviours and/or reproductive control had significantly higher mean PTSD and anxiety scores
- No statistically significant relationship between unwanted sexual contact → mental health



# KEY FINDINGS – WAVE TWO

## Impact of perpetrator type

Women who experienced SV perpetrated by an intimate partner:

- Had significantly higher mean PTSD scores than women assaulted by a stranger;
- Had higher mean depression scores than women assaulted by another known person
- Little differences in anxiety between perpetrator types



# Implications for GPs and other primary healthcare providers

- **SV is very prevalent in this setting!**
- Even historical SV can impact current mental health in women (**unexplained MH symptoms = red flag!**)
- Coercion/reproductive control similar levels of PTSD to rape/sexual assault, and above screening cut-off score in primary care
- GPs could enquire about more than rape/sexual assault
- Identity of perpetrator important



# Understanding IPSV and risk (forthcoming)

- IPSV is frequently cited as a risk factor for serious harm & homicide
- Measurement has largely focused on “force” but IPSV is multidimensional
- Relationship with risk poorly understood
  - How do different types of IPSV co-occur?
  - How do patterns of IPSV relate to risk?
  - What does this mean for practice?

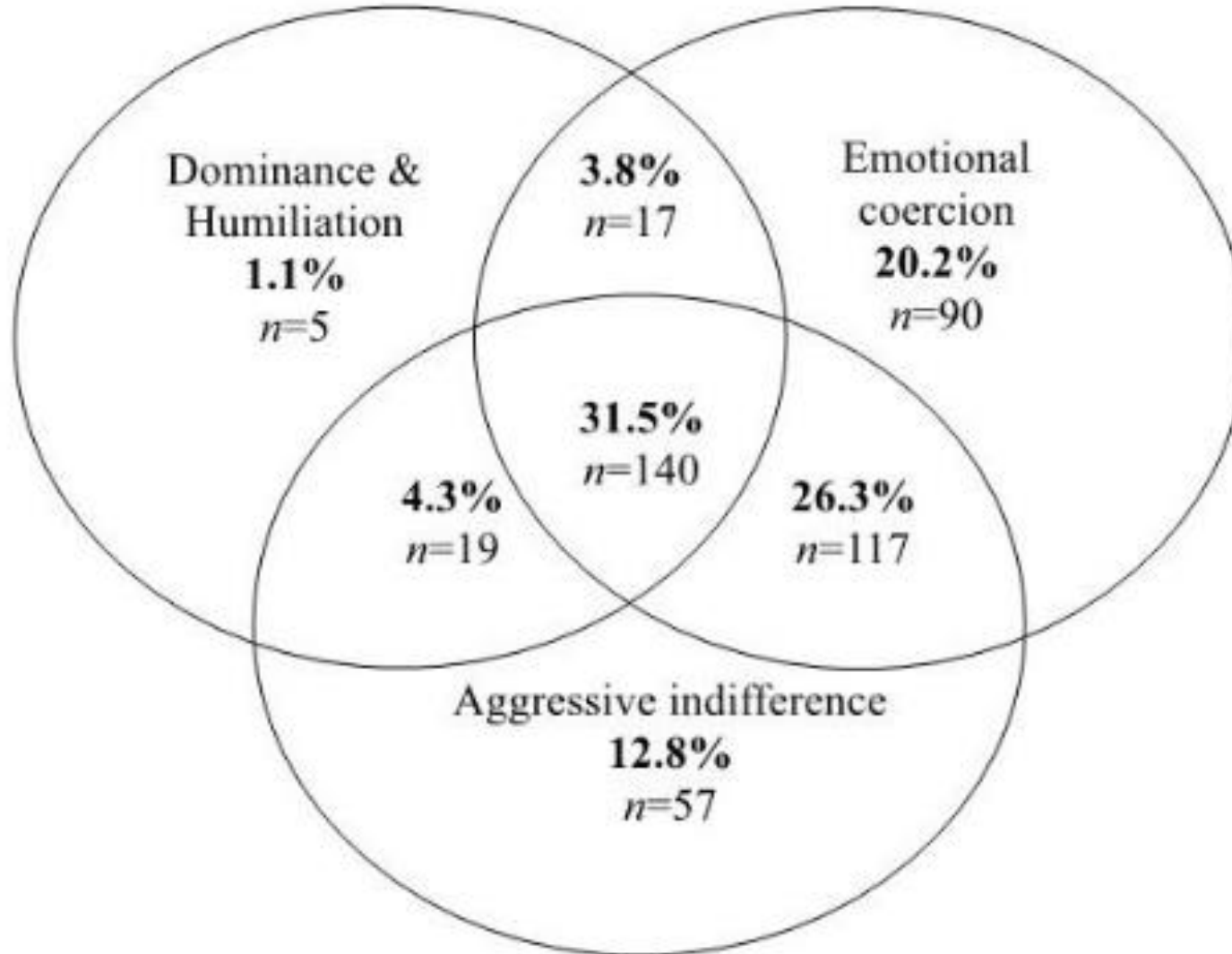


# Understanding IPSV and risk (forthcoming)

- Study with national community sample of 445 women in Australia who experienced IPSV in past 12 months.
- IPSV measured using IPSV Scale (Tarzia et al. 2024) which categorises 20 behaviours into 3 domains:
  - Dominance & humiliation
  - Emotional coercion
  - Aggressive indifference
- Focus was on patterns of co-occurrence of domains & relationship to indicators for homicide/severe physical violence (stalking, weapons, threats to kill etc)



# Understanding IPSV and risk (forthcoming)



# Understanding IPSV and risk (forthcoming)



## Combined IPSV pattern most associated with all homicide risk factors & severe physical violence:

- 85.6% (155/181) of participants had been stalked in the past 12-months
- 79.5% (144/181) had felt afraid of their partner
- More than half had experienced severe physical violence in the last 12 months (58.6%, 106/181)
- Around two out of five had been threatened that they and/or their children would be killed by the perpetrator (43.1%, 78/181).
- One in four (26.0%, 47/181) participants who had experienced Combined IPSV reported that a knife, gun or other weapon had been used against them



# Understanding IPSV and risk (forthcoming)



## Aggressive indifference + Emotional coercion behaviours

- Over half also reported:
  - being stalked (57.3%, 67/117)
  - feeling afraid of their partner or ex-partner (59.0%, 69/117)
  - having a partner or ex-partner be extremely possessive (58.1%, 68/117).
- One in five reported that their partner or ex-partner had threatened to kill themselves (20.5%, 24/117).



## Emotional coercion alone

- 40% also reported extreme possessiveness from a partner or ex-partner.

# Understanding IPSV and risk (forthcoming)

- Combined IPSV pattern most strongly associated with all risk factors
- Dominance & humiliation behaviours (most extreme) may occur as part of escalating pattern of IPSV
- Implications for risk assessment in health & other settings
- Current practice is to ask: “Has a partner ever forced you to have sex?” but may be more useful to ask about *escalation*.
- Practitioners could explore types of behaviours, patterns of co-occurrence, and if there are escalating tactics of sexual degradation, humiliation, and physical injury.



# Reproductive coercion & abuse: Longitudinal predictors


## AIMS

1. Identify prevalence of RCA perpetrated by current or former partners amongst women aged 43 to 48 in a national Australian sample.
2. Examine sociodemographic and health factors from childhood and early adulthood associated with partner-perpetrated RCA by mid-life.
3. Explore associations between partner-perpetrated RCA and types of IPV.




Original Research

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**Prevalence and Predictors of Reproductive Coercion and Abuse by a Partner Among a National Population Sample in Australia**

Laura Tarzia<sup>1,2</sup>, Nicholas Egan<sup>3</sup>,  
Melissa L. Harris<sup>3</sup>, and Deborah Loxton<sup>3</sup>

**Abstract**  
Reproductive coercion and abuse (RCA) involves the use of violence, deception, or threats to undermine another person's reproductive autonomy. Largely perpetrated against women by their male intimate partners or other close family members, RCA is harmful to health and well-being. Despite this, it is under-researched, with conceptually sound, robust data lacking globally. The present study addresses this gap within the



# Associations with other types of violence



## Women who had ever....

- Experienced physical abuse by a partner were **1.6 times** more likely to report RCA
- Experienced harassment or sexual abuse by a partner were **3 times** more likely to report RCA



## Women who had ever...

- Experienced psychological abuse as a child were **1.6 times** more likely to report RCA
- Experienced sexual abuse as a child were **1.5 times** more likely to report RCA

# Sociodemographic predictors

Sociodemographic variables (reported at 18-23 years)	Predicts RCA at age 43-48?
Age	NO
Country of birth	NO
Area of residence	NO
Qualifications	NO
Relationship status	YES (Non-partnered women at age 18-23 were 28% less likely to report RCA in mid-life)
Ability to manage on income	YES (Women who found it difficult or impossible = 2x more likely to report RCA in mid-life)
Alcohol consumption	NO
Smoker	YES (smokers 68% more likely to report RCA in mid-life)



# Implications for health & specialist practice

- Consider asking about RCA if other violence is disclosed (including history of child abuse) and vice versa
  - In particular, IPSV and harassment were associated
- Sensitive inquiry about sense of autonomy around reproductive decisions may encourage disclosure
  - Screening tool for clinical practice currently being developed
- Early engagement with women partnered young or in financial difficulty to prevent later RCA



# Responding to sexual & reproductive violence in health settings

## LIVES Model



**Listen**



**Inquire about needs**



**Validate experience**



**Enhance safety**



**Support**

## CARE Model

**Choice & control**



**Action & advocacy**

**Recognition & understanding**

**Emotional connection**

# Responding to RCA in healthcare settings

## Women's expectations of healthcare providers in the context of reproductive abuse in Australia

Sonia Srinivasan<sup>a</sup>, Jennifer Marino<sup>b</sup>, Kelsey Hegarty<sup>a,c</sup>  and Laura Tarzia<sup>a,c</sup> 

<sup>a</sup>Department of General Practice, The University of Melbourne, Carlton, VIC, Australia; <sup>b</sup>Department of Obstetrics & Gynaecology, The University of Melbourne and The Royal Women's Hospital, Parkville, VIC, Australia; <sup>c</sup>Centre for Family Violence Prevention, The Royal Women's Hospital, Parkville, VIC, Australia

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**Reinforce that behaviour is wrong / take RCA seriously**




**Ask about other forms of violence**

**Help women with contraceptive needs (e.g. less detectable)**



# Responding to RCA in healthcare settings

## Women's Experiences Seeking Health Care in the Context of Reproductive Coercion and Abuse

Molly Wellington<sup>a</sup> , Kelsey Hegarty<sup>a,b</sup>  and Laura Tarzia<sup>a,b</sup> 

<sup>a</sup>Department of General Practice and Primary Care, University of Melbourne, Melbourne, Australia; <sup>b</sup>The Royal Women's Hospital, Melbourne, Australia

### ABSTRACT

Reproductive coercion and abuse (RCA) is a form of violence against women where physical, psychological, sexual, or coercive behaviors are used to control women's reproductive choices. This study aimed to understand women's experiences and expectations with health professionals after experiencing RCA. Using qualitative methodology, 20 women who had experiences of RCA were interviewed. Three themes were developed that captured women's experiences: Everyone was looking at me with "those" eyes; Recognize that something is not right; and Empower me to make my own choices. This study highlights how women's perceptions of judgment from health professionals deeply impacts their experience of RCA.

### ARTICLE HISTORY

Received 24 August 2025  
Revised 3 December 2025  
Accepted 4 December 2025

### KEYWORDS

Reproductive coercion and abuse; pregnancy coercion; abortion coercion



**Avoid allowing any judgement to cloud response**


**Read between the lines (ambivalence, increased distress, fear, uncertainty)**

**Empower women to make autonomous choices**

# Responding to SV in healthcare settings

Research Article

## Women's Experiences Accessing Mental Health Care in Australia After Sexual Violence in Adulthood

Sandra Isaac<sup>1</sup>, Elizabeth McLindon<sup>1,2</sup>, Kelsey Hegarty<sup>1,2</sup>, and Laura Tarzia<sup>1,2</sup> 

### Abstract

In Australia, at least one in every five women has experienced sexual violence since age 15. Research consistently links sexual violence with poor mental health, persisting long after the crisis period. Trauma-informed mental health support is therefore critical. This article draws on interviews with 29 women who had experienced sexual violence to understand their experiences accessing mental health services in Australia. Our findings suggest that, constrained by a biomedical model of care, mental health practitioners' understanding of trauma generally, and sexual violence particularly, may be lacking. Further, women struggle to navigate a "maze" of services.

Violence Against Women  
1–23

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- Recognise & validate ongoing impacts of past trauma
- Recognise specific nature of SV-related trauma (especially if not physical violent assault) & avoid victim-blaming
- Let go of reliance on biomedical model & pathologizing approach
- Support service navigation, not just 'washing hands'



# Responding to SV in healthcare settings

RESEARCH

Open Access



“Counteract the gaslighting” – a thematic analysis of open-ended responses about what women survivors of intimate partner sexual violence need from service providers

Siofra Peeren<sup>1,2\*</sup>, Elizabeth McLindon<sup>3,4</sup> and Laura Tarzia<sup>3,4</sup>

## Abstract

**Background** Intimate partner sexual violence (IPSV) is a prevalent but misunderstood form of gender-based violence with significant impacts women's health and well-being. Research suggests that IPSV has a specific context and unique impacts, but little is known about how to tailor service responses. To address this gap, we explored help-seeking experiences and needs among IPSV survivors after disclosure.

**Methods** This study draws on qualitative data from a subsample of women who participated in a cross-sectional survey about the service needs of intimate partner violence survivors. Women who reported IPSV and provided information about IPSV-specific help-seeking needs after disclosure were included in the analysis. Open-ended text responses of 37 IPSV survivors were analysed using thematic analysis.

**Results** IPSV was invisible and silenced in service responses. Three themes suggest potential ways forward. In the first theme, 'Don't dismiss it', women needed providers to take their disclosures seriously and listen to the significant impacts of IPSV on their well-being and safety. In the second theme, 'See the bigger picture', women needed service providers to understand that IPSV fits into broader patterns of abuse, and that psychological abuse and coercive control impacts women's ability to consent. In the third theme, 'counteract the gaslighting', women needed providers to educate them about the continuum of IPSV and help them label IPSV as a form of violence.

**Conclusions** Our exploratory findings extend the limited evidence base on IPSV and highlight a need for further in-depth research to explore a tailored approach to supporting IPSV survivors. To avoid contributing to the silencing of IPSV survivors, service responses should recognise the harmful and sexualised nature of IPSV, challenge cultural stereotypes that minimise IPSV, and understand that co-occurring psychological abuse may exacerbate shame and prevent women from articulating the source of their distress.

**Keywords** Intimate partner violence, Sexual violence, Intimate partner sexual violence, Thematic analysis, Qualitative, Disclosure, Help-seeking

- ‘Don’t dismiss it’
- ‘See the bigger picture’
- ‘Counteract the gaslighting’



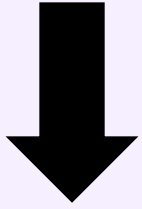
# The RESTORE Centre of Research Excellence



- Funded 2024-2029 by the National Health & Medical Research Council
- Our vision: Transform health services so that they restore the health and wellbeing of survivors of sexual violence in adulthood through new interventions, services and supports that are trauma-and-violence informed and responsive to individual needs
- Main focus is Australian context but also international – collaborators in US, UK, NZ

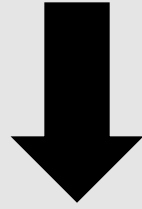


# WHERE?



Interrogating under-utilised datasets to drive health system enhancement

# WHAT?



Testing emerging therapeutic approaches to increase pathways to healing

# HOW/WHEN?



Scaling pathways & implementation strategies to embed TVIC in the health system





Thank-you!

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