ANROWS

AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY
to Reduce Violence against Women & their Children

Domestic Violence in Australia

ANROWS's response to the *One in Three Campaign's* Supplementary Submission to the Senate's Finance and Public Administration References Committee

Australia's National Research Organisation for Women's Safety (ANROWS) appreciates the opportunity to respond to the supplementary submission by the *One in Three Campaign* (*One in Three*) and in particular their comments about the verbal evidence I gave to the Committee.

Before responding to the detailed comments, ANROWS would like to express concern about the supplementary submission and general approach taken by *One in Three*. In this submission and on their website *One in Three* have consistently used legitimate research such as the *Personal Safety Survey (PSS*) and *National Community Attitudes Survey* in a way that is false, misleading, incomplete or to make points the research was not designed to address. Whether this is intentionally misleading or the product of poor analysis, it creates confusion by implying legitimacy for many of *One in Three's* claims that are not supported by evidence. An example on their website is about the claim there is "no credible research that supports the assertion that women are routinely falsifying claims of abuse to gain a tactical advantage" which they refute without reference to a single credibly study exploring the actual incidence of false allegations. Rather, they only cite research on the *opinions* of lawyers, magistrates and family law applicants, including one study that found only a small minority believe this to be the case. Further, *One in Three's* fact sheet (p.23 of their submission) contains inappropriate use of the images, styling, graphics, font, colours and words from the *Violence against women: key statistics* infographics produced by ANROWS and Our Watch.[1] It could be considered that this is an attempt by *One in Three* to associate ANROWS and Our Watch with messages that neither organisation have authorised or are likely to support. Of greater concern, however, is the potential to confuse what are serious issues and undermine messages opposing violence against women. This would be an outcome contrary to *One in Three's* professed support for this issue and it is disappointing that they appear willing to undermine organisations working to increase women's safety.

The consistency of these approaches to research by *One in Three*, and their potential to create confusion, necessitate a detailed response to their supplementary submission. To not respond in detail would risk undermining the substantial gains made in responding to violence against women reflected in the combined Australian governments' commitment to the *National Plan to Reduce Violence against Women and their Children 2010-2022*. Nevertheless, ANROWS is concerned that this response has required a substantial diversion of resources that would have been better directed toward endeavours to reduce the incidence and impact of violence against women and their children. While the focus of the detailed response below is therefore on aspects of the submission specifically about ANROWS, we would appreciate the Committee noting our concerns about *One in Three's* submission, overall.

[1] Formerly the Foundation to Prevent Violence against Women and their Children.

1. The burden of disease caused by intimate partner violence

One in Three's submission takes issue with citation of the study *The health costs of violence: Measuring the burden of disease caused by intimate partner violence* undertaken by VicHealth in Victoria in 2004 (the VicHealth Report), a copy of which is at Attachment 1. When I paraphrased the study I did not use the exact wording contained in the report and made an error in referring to "cause" rather than the words "responsible for", "contributor to", and "attributed to" as used by the researchers. Although the difference is a subtle one, it is nevertheless important in the context of burden of disease methodologies as these words have quite different meanings in that context than they do in every day usage. I do note, however, that this is a common mistake which was also made by *One in Three* themselves when they refer to the potential for "violence against men to be one of the leading causes of illness and ill-health" (p.12). Nevertheless, their point does not invalidate the key finding of the report which is that intimate partner violence is a significant contributor to the burden of disease for women, and indeed the highest contributor for women under the age of 45.

Although not noted by *One in Three*, I would like to draw to the Committee's attention to the possibility that my verbal evidence could be seen to imply that the VicHealth report refers to violence against women (i.e. sexual assault and domestic violence). The Report only refers to intimate partner violence in the form of physical and sexual violence. ANROWS understands that currently there are insufficiently robust data sources to measure the burden of disease for sexual assault and for other forms of intimate partner violence, such as emotional abuse. Were the necessary data sources on these forms of violence against women to exist, the burden of disease of violence against women would logically be even higher than that identified in the VicHealth Report.

One in Three's key concern appears not to be the citation of the report, but rather with the VicHealth Report itself. The concerns they express are incorrect on a number of grounds. First, *One in Three's* claim that VicHealth has conflated all forms of sexual and physical violence against women with intimate partner violence is incorrect. The VicHealth Report clearly identifies their focus is 'intimate partner violence' as defined on page 5 of their report and identifies that the prevalence statistics used from the *PSS* solely include physical and sexual violence by an intimate partner (pp.17-19). This is consistent with their statement "Nearly one in five Australian women identified at least one experience of physical or sexual violence by a current or former partner since the age of 15" (p.17). If the VicHealth Report had made the error claimed by *One in Three*, they would be quoting a figure of at least one in three, and not one in five.

Second, it is important to note the qualifier made in the VicHealth Report that "intimate partner violence is responsible for more ill-health and premature death for Victorian women **under the age of 45** [emphasis added] than any other well-known risk factors" (p.8). The VicHealth Report does not claim that this is the case for all women. The *One in Three* submission is confusing and misleading because it does not identify what population group the burden of disease figures they cite refer to, nor do they state whether the cited study included intimate partner violence in figures used for their calculations. Burden of disease methodology has historically been critiqued for ignoring risk factors that have a significant influence in shaping women's health, disability and mortality, such as sexual and reproductive activities and violence against women. In this context, the VicHealth research was ground-breaking in including physical and sexual violence by an intimate partner as a known risk factor for ill-health and mortality. To do this, the researchers drew on the most reputable sources available to establish links between intimate partner violence and health

outcomes including the well-respected Australian Longitudinal Study on Women's Health (ALSWH) (pp. 20-23). They also used an internationally accepted burden of disease methodological approach (p. 25).

Third, in emphasising that 2.3% of the burden of disease is from homicide and physical injury, *One in Three* erroneously infer that the only legitimate health impact of violence against women is death or physical injury. The impacts, outcomes and consequences of violence against women, including intimate partner violence, have been well-established in research as being wide-ranging and often substantially debilitating across a number of aspects of women's physical, sexual, mental and behavioural health. In addition to the research identified in the VicHealth Report (pp. 20-23), a more recent World Health Organisation (2012) publication[2] on the health consequences of violence against women clearly identifies the wide-ranging impacts of this violence beyond simply death and physical injury (see Attachment 2). Further, *One in Three* actually contradict their own inference here by outlining the substantial range of consequences of this violence on women's health in their submission (p.8).

ANROWS acknowledges there are various limitations of the VicHealth Report including: those identified by the researchers themselves (p.29); the fact that the study is over 10 years old and there has been advances in burden of disease methodology in the last 10 years; and the limitation of the study to Victorian women only. In recognition of this, and as part of the *ANROWS Research Program 2014-16*, ANROWS has commissioned the Australian Institute of Health and Welfare to undertake a national study exploring the burden of disease impact of violence against women. Working within Australia's national burden of disease framework, the researchers for the ANROWS study will also include members of the research team from the Australian Burden of Disease Study 2011. Further, with ever more accurate information on violence against women becoming available, it is likely that this study will provide us with an even more complete picture of the contribution of violence against women to the total burden of disease for Australian women.

2. Gender symmetry, the Conflict Tactics Scale and quantitative studies of violence against women

In the domestic and family violence field the term "gender symmetry" is used to refer to arguments that the rates of domestic violence perpetrated by men and women are approximately equal. ANROWS stands by the statement in my verbal evidence that *One in Three* claim gender symmetry and will not retract this as requested in their supplementary submission. *One in Three* assert they have "never claimed gender symmetry", that the name of their campaign suggests asymmetry, and that *PSS* statistics support their position that "one in three victims of **family violence** [emphasis added] are male" (p.12). Yet simultaneously within the same submission *One in Three* state "most family violence is mutual" (p.5) and make a range of assertions about gender symmetry in family violence (pp.5-9). *One in Three* also argue gender asymmetry, with women being more violent than men, in their submission , citing Straus and Gelles (the original authors of the Conflict Tactics Scale) in their discussion on violence in response to provocation (p.4). This is consistent with a statement on the bottom of *One in Three's* website homepage that "Much international research demonstrates that women are as physically aggressive, or more aggressive, than men in their relationships with their spouses or male partners".[3]

[2] World Health Organisation 2012 *Understanding and addressing violence against women: Health consequences* http://apps.who.int/iris/bitstream/10665/77431/1/WHO_RHR_12.43_eng.pdf?ua=1, accessed 15/1/2015.
[3] http://www.oneinthree.com.au/, accessed 16/1/2015.

Contradictions and inaccuracies in *One in Three's* submission and position on intimate partner violence arise from the following separate but interrelated key errors, which I will address in more detail below:

- over-reliance on arguments of gender symmetry based on research using the Conflict Tactics Scale;
- misunderstanding of widely accepted definitions of domestic violence;
- misunderstanding of the limitations of quantitative research, such as the *Personal Safety Survey*, for measuring domestic violence; and
- misrepresentation of the findings of quantitative research such as the *Personal Safety Survey*.

Professor Michael Kimmel, a world renowned sociologist specializing in gender, men and masculinities wrote an article which, although dated, is helpful in exploring and convincingly refuting claims of gender symmetry through a comprehensive critique of the literature[4] (see Attachment 3). Kimmel identifies that proponents of gender symmetry in domestic violence tend to rely heavily, indeed almost exclusively, on research studies that utilise the Conflict Tactics Scale (CTS). The limitations of the CTS identified by Kimmel and others[5] include:

- its framing assumption that physical violence is a one-off result of an argument, difference or 'conflict' rather than a pattern of a range of behaviours intended to assert power or control;
- its tendency to limit findings to the previous year which both exclude ongoing systematic patterns of abuse and violence or equate them to a single violent incident and also rely on retrospection and accurate recall by participants;
- its exclusion, particularly in the original CTS, of many types of violence such as burning, suffocating, squeezing, spanking, scratching, sexual assault, and many forms of psychological, social and economic abuse;
- it's failure to measure the severity of the violence;
- its failure to consider context such as who initiates the violence, relative size and strength of the person being violent, intention behind the violence (for example to control or in defence of oneself or children), and what acts of violence preceded the violence recorded; and
- the impact and consequences of the violence.

One in Three's claims of either gender symmetry or that a significant minority of victims of domestic violence are male rely on a definition and understandings of domestic violence not commonly accepted in policy or research. Domestic violence may be described in many ways, and each Australian jurisdiction has different definitions in their laws and policies, most of which are notably gender-neutral. Although varied, these definitions all identify common elements of domestic violence as including acts of physical, sexual,

[4] Kimmel, M. (2002) '"Gender Symmetry" in Domestic Violence: A Substantive and Methodological Research Review' in *Women Against Violence* Volume 8, Number 11, pp.1332-1363.
[5] DeKeseredy, W. and Dragiewicz, M. (2007) 'Understanding the Complexities of Feminist Perspectives on Woman Abuse: A commentary on Donald G. Dutton's Rethinking Domestic Violence', in *Violence Against Women,* Volume 13, No 8; and Bagshaw, D. and Chung, D. (2000) 'Gender Politics and research: male and female violence in intimate relationships', in *Women Against Violence*, Volume 8.

emotional and psychological violence in current or past intimate relationships and as an ongoing pattern of behaviour aimed at exercising power and controlling a partner through fear.[6]

Given such definitions of domestic violence, *One in Three's* assertion that the *PSS* supports their claim that "one in three victims of **family violence**[7] [emphasis added] are men" (p.12) is false. Such a claim relies on domestic violence being defined as a single incident of physical or sexual violence by a current partner only. It does not include the range of types of violence, or the intent and impact of the violence, that are included in common definitions of domestic violence. The statistics cited are misleading in excluding previous partners (this figure is closer to 1 in 4)[8] and lifetime prevalence. An accurate statement using the statistics cited by *One in Three* is "one in three people who reported experiencing an incident of physical or sexual violence from a current partner in the 12 months preceding the survey are male".[9] Contrary to their claims, *One in Three's* assertions about the prevalence of domestic violence as commonly defined in policy and research are therefore not supported by *PSS* data.

In his critique of research based on the CTS, Kimmel also identifies that claims such as those made in *One in Three's* submission (p.8) that men are less likely than women to report either the occurrence or effects of domestic violence, are speculative rather than evidence-based and are empirically groundless. Kimmel argues the empirical research demonstrates the opposite to be true with women tending to over-estimate their own use of violence and under-estimate their victimization, while men under-estimate their own use of violence and over-estimate their victimization. He cites research showing men who are assaulted by intimates are more likely than women to call the police, to press charges and not drop those charges. Research with male perpetrators of domestic violence has also shown that in the initial stages of disclosure of the abuse, the man is likely to exaggerate the extent of the female partner's violent acts against himself in an attempt to establish a self-defence argument as a means of avoiding both prosecution and shame.[10] Such research highlights the importance of establishing the 'primary aggressor' and 'primary victim' in domestic violence police and court responses as failure to do so has resulted in female victims being wrongly charged with family-violence related offences and inappropriately having protection orders taken out against them.[11]

The data cited in *One in Three's* fact sheet (p.25) demonstrates their use of *PSS* statistics in a way that, although appearing to refute the research on disclosure cited by Kimmel and others, actually misrepresents the statistics. First, they incorrectly state the *PSS* data cited refers to "male victims of family violence". As discussed above (and further below) this is false since the *PSS* uses an incident-based concept of violence and

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[6] *National Plan to Reduce Violence against Women and their Children 2010-2022*, https://www.dss.gov.au/our-responsibilities/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children-2010-2022, accessed 15/1/2015, p.2.

[7] *One in Three* appear to use the terms domestic violence and family violence interchangeably.

[8] The rate if former partners are included is 1 in 3.56 compared to 1 in 3.00 if only current partners are included (see Table 3 of the *Personal Safety Survey*, http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4906.02012?OpenDocument).

[9] See Table 3 of the *Personal Safety Survey* http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4906.02012?OpenDocument.

[10] Miller, S. (2001), 'The paradox of women arrested for domestic violence: Criminal justice professionals and service providers respond' in *Violence Against Women*, Volume 7, pp.1339-1376; and 'Scott, K., and Straus, M. (2007). Denial, minimization, partner blaming, and intimate aggression in dating partners' in *Journal of Interpersonal Violence*, Volume 22, Number 7, pp.851-871.

[11] NSW Ombudsman, *Domestic Violence Community Stakeholders Forum*, 9 December 2009. See also Day, A., O'Leary, P., Chung, D., & Justo, D. (2009) 'Integrated responses to domestic violence: research and practice experiences in working with men' in Journal of Family, Violence 24, pp. 203-212; and Australian Law Reform Commission (2010) 'Police and Family Violence Identifying the 'primary aggressor'' http://www.alrc.gov.au/publications/9.%20Police%20and%20Family%20Violence/identifying-%E2%80%98primary-aggressor%E2%80%99, accessed 16/1/15.

does not make claims about family or domestic violence, but rather reported incidents of violence experienced from a current or former partner. Second, although the percentage figures provided by *One in Three* are technically correct, the Australian Bureau of Statistics has advised that the representation is misleading as it doesn't make it clear that women are substantially more likely to experience violence by a partner than men. Since the percentages provided are of men and women respectively, a more accurate representation of this data would be to also include the population count estimates so that the reader can understand the proportions within the relevant context of the size of the contributing male and female sub-populations. So, for example, the first statistic on page 25 of *One in Three's* fact sheet would more accurately be cited as "54.1% of males (64,700 males) compared to 25.6% of females (60,800 females) who reported experiencing violence by a previous partner since the age of 15 had never sought advice or support".

Although *One in Three's* submission suggests that men are less likely to disclose their experiences of domestic violence due to "stigma" (p.8), there may be alternative explanations for the *PSS* data they cite on reporting. For example, it may be that men's reporting is lower because the violence they have reported in the *PSS* is less severe, less likely to result in injury or other harms, less likely to be part of an ongoing pattern of violence and abuse that characterises domestic violence, or the violence may have been used in response to domestic violence including in self-defence. Unfortunately the limitations of the *PSS* data as outlined below mean that these are not definitive explanations as we cannot be conclusive about such hypotheses either way. It is therefore inappropriate and a misrepresentation of the *PSS* data for *One in Three* to represent their claims about family violence and non-disclosure by men as being supported by the *PSS*.

One in Three's emphasis on 'uni-directional' or 'unilateral' violence (p.5 and 7) demonstrate a belief in the myth that victims of domestic violence must be passive and not engage in violent acts to qualify as victims. This assertion is not empirically grounded. Empirically supported definitions of domestic violence do not require that the victim is passive and both Kimmel and a number of other authors cite research showing sizeable numbers of women, including victims of domestic violence, may indeed commit violent acts against their partner. [12] These authors also demonstrate, however, that there are substantial qualitative differences between men's and women's violence. They show that men are more likely to use violence *instrumentally* to dominate, control, injure, terrorise, and instil fear in their partner and that this violence often escalates if their partner uses violence in self-defence or they experience some other loss of control of their partner such as separation. [13] In contrast, women are more likely to use violence *expressively* as a reflection of their dependence on their male partner and in response to frustration, stress or in self-defence. In this context, the presence of 'bi-directional' violence does not in itself suggest that domestic violence has not occurred as *One in Three* implies. In fact, the demonstrated qualitative difference between men's and women's violence illustrates that men are much more likely to be the perpetrators of domestic violence as it is commonly understood.

[12] See for example James, K. (1999) 'Truth or fiction: men as victims of domestic violence' in Breckenridge, J. and Laing, L. (eds) *Challenging Silence: Innovative responses to sexual and domestic violence*, Allen and Unwin, Sydney, pp. 153-162; Swan, S. and Snow, D. (2002). 'A typology of women's use of violence in intimate relationships' *Violence Against Women*, Volume 8; and Muftic, L. and Bouffard, J. (2007) 'An Evaluation of Gender Differences in the Implementation and Impact of a Comprehensive Approach to Domestic Violence', in *Violence Against Women*, Volume 13, Number 1.

[13] This is one reason why the exclusion of violence by a previous partner in many of the statistics quoted by *One in Three* is particularly problematic.

ANROWS acknowledges there are substantial limitations of crime victimisation surveys such as the *PSS* and that they share some of the limitations of research based on the *CTS*. As identified again by Kimmel,[14] and also by respected Australian academic Dr Michael Flood,[15] the limitations of such surveys include that they:

- do not consider the context in which the violence occurs and rely on single act-based or incident-based reports of violence;
- do not adequately record certain characteristics of domestic violence including
    - the multiple experiences of different types of violence,
    - the frequency of violence that is perpetrated by the same perpetrator, or
    - the coercion and intimidation used to maintain power and control without resorting to violence;
- tend only to include those acts that are defined as crimes and thus exclude forms of domestic violence such as spiritual or emotional abuse; and
- rely on retrospection, accurate recall of events, and willingness to report by participants.

Despite these limitations, crime victimization surveys also have substantial benefits in that they tend to have large population sizes, are systematic and statistically rigorous, include a wide range of assaults in their samples, include both current and former partners, and may explore severity and frequency of violence to some extent. To their credit, the Australian Bureau of Statistics have attempted to include components in each successive *PSS* to address some of the limitations of crime victimization surveys. This includes questions about emotional abuse, frequency of violence, the context of violent incidents (e.g. location), and impact or outcome (e.g. involvement of support services and time off work).

In this context, the *PSS* is the best available evidence we have in Australia to give us insights into the prevalence of violence by current and previous partners, and thus, from a policy perspective the extent and urgency of the problem. *One in Three's* criticism of my use of the *PSS* data on prevalence since the age of 15 (instead of the 12 months prior to the survey) is neither valid nor relevant. The Australian Bureau of Statistics have advised that the best data set to use depends on what purpose it is being used for. Prevalence data (since the age of 15) is the best data to use when the purpose is to understand the extent of the problem as it provides information about lifetime prevalence (i.e. the number of people in the population who have experienced a particular form of violence). It is of particular use for policy, research, and service planning for responding to the impact and longer term effects of violence and should be relied on for broader claims about reported experiences of violence. Data from the 12 months prior to the survey is of particular value for service planning for crisis services such as hospitals and police agencies as it gives a better indication of the likely presentation to those services in any given period. Contrary to *One in Three's* claims, it is therefore best to use prevalence data (since the age of 15), as I did, for making claims about broad findings on violence. In contrast, *One in Three* tend to focus on data from the 12 months prior to the survey to make claims about the prevalence and the nature of violence in general which is inaccurate in providing a limited and incomplete understanding of the violence reportedly experienced by the Australia population.

Regardless of which data sets are used, the insights into intimate partner and sexual violence offered by the *PSS* are indicative rather than definitive. This is why I cited in my verbal evidence the actual findings of the

[14] Kimmel 2002, *Op cit, p*p.1337-1338.
[15] Flood, M. (2006) 'Violence against women and men in Australia: What the *Personal Safety Survey* can and can't tell us' *DVIRC Quarterly*, Edition 4 2006 – Summer, pp.3-10.

Personal Safety Survey concerning rates of physical, sexual and emotional violence rather than making specific claims about domestic or family violence as *One in Three's* incorrectly does. Further, *One in Three* also tend to ignore additional information provided in the *PSS* that indicate women's experiences of violence by a current or former partner are more consistent with definitions of domestic violence than those of men. For example, when respondents were asked about frequency of violence from a current partner, women were substantially more likely than men to report the violence had occurred most of the time or some of the time compared to a little of the time.[16] While the *PSS* therefore provides some insights into the differences between men's and women's reported experiences of victimization, it is by no means definitive on what it can tell us about intimate partner violence or sexual violence. This is why ANROWS is undertaking an extensive and ambitious research program that is intended to offer more comprehensive insights into domestic, family and sexual violence against women than those gained from crime victimisation surveys like the *PSS* alone.

3. Allocation of resources

All public policy is concerned with debates and discussions about the best use of a finite set of available government resources to respond to social issues that are a priority to governments and communities. As an issue of increasing concern for communities and governments in recent years, investments in preventing the incidence and impact of domestic violence and sexual assault are important. This is particularly the case given the increasing recognition of the social, health, and financial costs of this violence to the Australian community as well as to individuals.[17] Such investments must, however, take into account that there are finite resources that need to be targeted to where they are of most need. The argument made by *One in Three* makes no sense in this context. It is indeed quite common for governments to direct resources to where they are of most need in terms of the extent or severity of the impact of the problem, even where this is based on gender. Breast cancer programs, for example, tend to focus on the needs and experiences of women despite the fact that a small minority of men may experience this form of cancer. Further, the suicide example provided by *One in Three* is a poor one since, not only is there, quite appropriately, a number of emerging programs and interventions specifically targeting men in this context, but women are also substantially more likely to *attempt* suicide than men,[18] necessitating interventions for both genders.

There is a significant disparity in the rates of domestic violence and sexual assault experienced by women and men, particularly where commonly accepted definitions of domestic violence are used.[19] Even more importantly, however, is that it has been widely demonstrated that the impact on women of this violence is substantially greater, even where the nature of the violent acts themselves are comparable. Compared to men, the domestic violence and sexual assault women experience is is more severe, frequent, and more often

[16] Of people who had experienced violence: a) 39.3% women and 59.1% of men reported a little of the time; b) 19.3% women and numbers too small to report for men reported violence some of the time; and 6.5% of women and numbers to small to report for men reported violence most of the time, Table 22 http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4906.02012?OpenDocument.
[17] National Council to Reduce Violence against Women and their Children (2009) *Background paper to Time for Action: The National Council's Plan to Reduce Violence against Women and their Children, 2009-2021* https://www.dss.gov.au/sites/default/files/documents/05_2012/background_paper_to_time_for_action.pdf, accessed 16/1/15, pp.36-47.
[18] Australian Institute of Health and Welfare (2014) *Suicide and hospitalized self-harm in Australia: trends and analysis* http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129549727, accessed 16/1/15.
[19] National Plan to Reduce Violence against Women and their Children 2012-2022, *Op cit*, p.1.

results in death, serious injury, and an extensive range of negative health and social consequences,[20] as even *One in Three* acknowledges in their submission (p.8). The differential rates and impact of domestic violence and sexual assault demonstrate the need for resources to be allocated and targeted accordingly to address violence against women. Even Straus, one of the key architects of the CTS and proponents of gender symmetry in domestic violence who is often cited by *One in Three*, concludes:

> … although women may assault their partners at approximately the same rate as men, because of the greater physical, financial, and emotional injury suffered by women, they are the predominant victims. Consequently, the first priority in services for victims and in prevention and control must continue to be directed toward assaults by husbands.[21]

One in Three's claims to services for men in relation to the numbers of men and women assaulted also seems to rely on the assumption that all women assaulted are provided with a safe, respectful pathways through the criminal justice system, are believed, receive adequate protection, experience an increase in their safety and/or are given access to the health, housing, financial assistance and/or counselling services they need, which is clearly not the case. This does not mean that male victims of domestic violence should not receive services or research on their experiences, but rather that the very small number of specialist and targeted responses for women, including ANROWS, are appropriate in reflecting the differential rate and impact of this violence on women.

One in Three's verbal evidence and supplementary submission suggest a legitimate concern for the needs of genuine male victims of domestic violence is secondary to a preoccupation with opposing feminism and a sense of entitlement for men to access the small number of specialist services for women. Examples of this include *One in Three's* statements against feminism and feminist-run services referenced on page 9 of their submission and the statement on their website "Males make up a significant proportion of victims of family and sexual violence, yet are excluded from government anti-violence programs such as Our Watch and ANROWS".[22] As anyone who has worked with survivors of domestic violence in services, policy or research knows, the overwhelming majority of the service response to this issue is from mainstream, gender-neutral services including police, hospitals and other health services, courts, and welfare and child protection agencies. All of these are services that male victims of domestic and family violence quite appropriately have access to. If *One in Three* were genuinely concerned with the plight of male victims, their advocacy would focus on improving the service response to all victims of violence in these mainstream services as this would have a much greater positive impact on male victims than access to women's services. Given that men experience such higher rates and impacts of violence from other men rather than women, including from both strangers and known people as indicated in the *PSS,* it is also surprising that *One in Three* focuses so much of their attention on family violence perpetrated by women.

In a related point, *One in Three* is doing a substantial disservice to men who have experienced violence from other men in their misuse and misrepresentation of *PSS* data. *One in Three* commonly use statistics that relate to men's violence towards other men to make claims about women's violence towards men. In their fact sheet (pp.23-25), for example, they cite statistics such as the number of men killed in domestic homicides, the number of victims of physical and sexual abuse, and the number of all men who experienced

[20] World Health Organisation 2012 *Op cit*; Kimmel 2002, *Op cit,* p.1347-1348; Flood 2006, *Op cit*, p.9; and James 1999, *Op cit*, p.155-157.
[21] Straus 1997, p. 219 cited in Kimmel 2002, *Op cit*, p.1348.
[22] http://www.oneinthree.com.au/, accessed 16/1/2015.

violence, without clearly identifying that these refer predominantly to violence perpetrated by other men. Instead, these statistics are under headings about "family violence" and confusingly interspersed with statements and statistics about violence from female partners creating the false impression they refer to violence perpetrated by women. Such a strategy is harmful in negating the fact that violence by other men is the most prevalent experience of male victims and most likely to cause harm. Moreover, it has the potential to create confusion and, in a policy environment of finite resources, encourage resources for male victims to be redirected from interventions for male victims of male perpetrators where they are most needed.

ANROWS will continue our strong commitment to deliver relevant, accurate and translatable research evidence which drives policy and practice to reduce the incidence and impact of violence against women and their children and appreciates the Committee's ongoing interest in this important social issue.

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The health costs of violence

Measuring the burden of disease caused by intimate partner violence

A summary of findings

State Government Victoria Department of Human Services

VicHealth

Safety and security don't just happen: they are the result of collective consensus and public investment. We owe our children – the most vulnerable citizens in any society – a life free from violence and fear. In order to ensure this, we must become tireless in our efforts not only to attain peace, justice and prosperity for countries but also for communities and members of the same family. We must address the roots of violence. Only then will we transform the past century's legacy from a crushing burden into a cautionary lesson.

Nelson Mandela > World Report on Violence and Health 2002

The health costs of violence

Measuring the burden of disease caused by intimate partner violence

A summary of findings

Intimate partner violence:

prevalent, serious, preventable

Project contributors

Prevalence data review and expertise

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Health impact data review and expertise

Associate Professor Jill Astbury, Key Centre for Women's Health in Society, University of Melbourne

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Compilation and editing

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We have some of the tools and knowledge to make a difference – the same tools that have successfully been used to tackle other health problems. Violence is often predictable and preventable.

Gro Harlem Brundtland > Director General, World Health Organization, World Report on Violence and Health 2002

About this publication

This publication is a summary of a study conducted to assess the health impact of intimate partner violence on women. The study was supported by VicHealth in partnership with the Department of Human Services and was conducted with contributions from a range of experts from across Victoria and elsewhere.

While focussing on health, it complements a vast body of evidence demonstrating the serious social and economic consequences of intimate partner violence for individuals, families and communities.

A link to the technical report providing further detail on the study, and in particular the methodology used to estimate the burden of disease contributed by intimate partner violence, is available at www.vichealth.vic.gov.au/ipv.

Definitions

Burden of disease methodology

Burden of disease methodology is an internationally accepted approach to estimating the impact of health problems, taking into account illness, disability and premature death. Burden of disease measures are used extensively by governments, researchers, health planners and advocates world wide.

The terms ‘health’ or ‘disease’ burden are also sometimes used when referring to other impacts of a health problem, such as its prevalence, the particular health problems caused or its broader social and economic impacts.

Intimate partner violence

Intimate partner violence, sometimes referred to as domestic violence, family violence or relationship violence, refers to violence occurring between people who are, or were formerly, in an intimate relationship.

Intimate partner violence can occur on a continuum of economic, psychological and emotional abuse, through to physical and sexual violence.

Although men are among the victims of intimate partner violence, evidence suggests that the vast majority of victims are women and that women are more vulnerable to its health impacts. Intimate partner violence occurs across cultural and socio-economic groups.

Women are particularly vulnerable to abuse by their partners in societies where there are marked inequalities between men and women, rigid gender roles, cultural norms that support a man's right to have sex regardless of a woman's feelings and weak sanctions against such behaviour.

World Report on Violence and Health 2002

Acknowledgements

This publication was made possible with the input, effort and expertise of a number of organisations and individuals. Special thanks are extended to:

- Women accessing the Women's Domestic Violence Crisis Service and their support workers, whose generosity allowed us to bring the voices and experiences of Victorian women to this publication
- Women's health advocates and women's health services, in particular Women's Health Victoria, whose advocacy about the health costs of intimate partner violence and the need for them to be considered in health impact assessments, and in particular Victorian burden of disease estimates, provided the impetus for this study
- The members of the Project Advisory Group (see page 40) who brought a range of resources and a breadth of expertise to the project, as well as linkages with other important initiatives. The group was ably chaired by Professor Jenny Morgan. Rachel Green and Deb Pietsch provided links with the Women's Safety Strategy and the Women's Health and Wellbeing Strategy
- Therese McCarthy, who undertook a scoping study to assist VicHealth to determine its role in supporting activity to address violence against women, and Yvonne Robinson, who offered generous support and guidance in establishing the project
- Associate Professor Bob Pease, Danny Blay and men associated with the No to Violence Male Family Violence Prevention Association for sharing their views and experiences on men's role in violence prevention
- Researchers associated with the Australian Longitudinal Study on Women's Health at the University of Newcastle and the University of Queensland, in particular the study co-ordinator, Christina Lee. Much of the analysis presented in this publication was based on unpublished data from the study, which is funded by the Commonwealth Department of Health and Ageing
- Researchers who made available their unpublished work based on the Australian Longitudinal Study on Women's Health, in particular Dr Angela Taft, Lyn Watson, Margot Schofield and Rafat Hussain
- Joy McLaughlin of the Australian Bureau of Statistics, who provided invaluable assistance with data from the Women's Safety Survey
- The women who participated in and contributed their data to the Australian Longitudinal Study on Women's Health and the Women's Safety Survey
- Betty Bougas, who provided administrative support to the project and its advisory group.

1. Intimate partner violence – a major burden on our health

Intimate partner violence is responsible for more ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking

In 1999, VicHealth undertook a wide-ranging investigation into factors contributing to the escalating incidence of mental health problems in our community. On the basis of this review we identified mental health as a priority area for action.

In the past, health promotion has focussed on supporting changes in the behaviour of individuals, so that they are better able to protect and promote their health. In the last 15 years, however, in response to increasing evidence of the influence of social and economic factors on health, our focus has shifted to also supporting positive changes in the environments in which people live, work, play and build relationships with one another.

In our mental health promotion work we have focussed on three factors as being particularly important for good mental health: social inclusion, economic participation and freedom from violence and discrimination.

Our 1999 review of the causes of poor mental health indicated that a range of forms of violence required attention, from work place violence and bullying in school environments, through to violence occurring in youth gangs and that perpetrated against racial and other minorities.

Among these, violence against women, particularly that occurring in the context of an intimate relationship, emerged as an especially common phenomenon having serious mental health impacts. Accordingly, in 2003 we conducted a more detailed study, to determine the contribution VicHealth could make to support primary prevention of violence against women.

This study, carried out by VicHealth in partnership with the Department of Human Services, is one of a number of current and planned activities to address this issue.

Too often intimate partner violence is trivialised in our society as somehow being less serious than violence committed in other contexts; as a matter to be resolved in the privacy of the home. The findings of this study present a serious challenge to these views.

They demonstrate that intimate partner violence is all too common, has severe and persistent effects on women's physical and mental health and carries with it an enormous cost in terms of premature death and disability. Indeed it is responsible for more preventable ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking.

This study is the first in the world to estimate the disease burden resulting from intimate partner violence.

While our work has focussed on the impact of violence on women, intimate partner violence diminishes and affects us all, marring not only relationships between men and women, but having long-term effects on their children and communities. Its seriousness demands that far greater efforts be placed on promoting respectful and equal relationships between men and women.

In a recent article in the *Medical Journal of Australia*, Professor Beverly Raphael, a leading practitioner and advocate in mental health in Australia, challenged the health sector to become one of the driving forces for change in the bid to reduce violence against women.

This partnership is a practical demonstration of this challenge being met in Victoria. Relying on the input of a range of experts, it would not have been possible without a collaborative, multi-disciplinary approach. I thank all of those involved for their input and for sharing so generously of their time, knowledge, resources and expertise.

We hope this project will make an important contribution to raising awareness of the prevalence and serious health consequences of intimate partner violence. In making visible the loss of life and health it causes, we also trust that our work will serve as a resource for setting priorities for action at the governmental, service and community levels.

Dr Rob Moodie

Chief Executive Officer
Victorian Health Promotion Foundation

This study is the first in the world to estimate the disease burden resulting from intimate partner violence

2. A summary of study findings

Women are more vulnerable to intimate partner violence than to violence in any other context and are overwhelmingly more likely than are men to be the victims of this form of violence

There is increasing recognition internationally that intimate partner violence is a common problem with serious health, social and economic consequences for women, their families and communities. Women are more vulnerable to intimate partner violence than to violence in any other context (OWP 2002) and are overwhelmingly more likely than are men to be the victims of this form of violence (ABS 2003; Bagshaw & Chung 2000) and to suffer its health consequences (Statistics Canada 2003).

This study assessed the health impact of this type of violence for Victorian women, in particular:

- Its prevalence
- The health problems it causes
- Its contribution to the total disease burden in Victorian women.

Its aims were to:

- Raise awareness of the seriousness of the problem of intimate partner violence
- Enhance understanding of violence and its health consequences
- Provide information to ensure that appropriate consideration is given to intimate partner violence when priorities are being set for expenditure, program development and other activities at the governmental, service and community levels
- Provide a resource for planning and monitoring the effectiveness of intervention strategies and for other research assessing the social and economic costs of violence.

It demonstrates that intimate partner violence is:

Prevalent

- Nearly one in five women report being subjected to violence at some time in their adult lives (ABS 1996a).

Serious

- Intimate partner violence has wide-ranging and persistent effects on women's physical and mental health.
- It contributes 8 per cent to the total disease burden in Victorian women aged 15–44 and 3 per cent in all Victorian women.
- It is the leading preventable contributor to death, disability and illness in Victorian women aged 15–44, being responsible for more of the disease burden than many well-known risk factors such as high blood pressure, smoking and obesity.

Preventable

The causes of violence are complex. However, accumulated evidence from around the world suggests that cultural, social and economic factors play a particular part. A significant underlying factor is the unequal distribution of power and resources between men and women (WHO 2002; OWP 2002).

There is a broad consensus internationally that intimate partner violence is best addressed in the context of a human rights, legal and health framework and through the development of multi-level strategies across sectors (WHO 2002; OWP 2002). In Victoria, this approach is co-ordinated through the whole-of-government Women's Safety Strategy, with intimate partner violence also being identified as a priority in the Women's Health and Wellbeing Strategy.

The findings of this study suggest the need to increase our efforts in policy implementation in these areas, with particular emphasis on the primary prevention of violence against women.

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Figure 1: Health outcomes contributing to the disease burden of intimate partner violence women, Victoria Australia, 2001

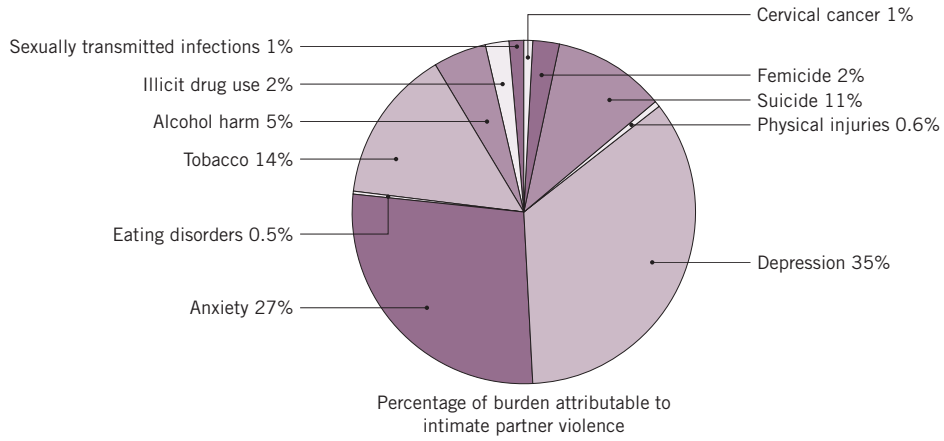
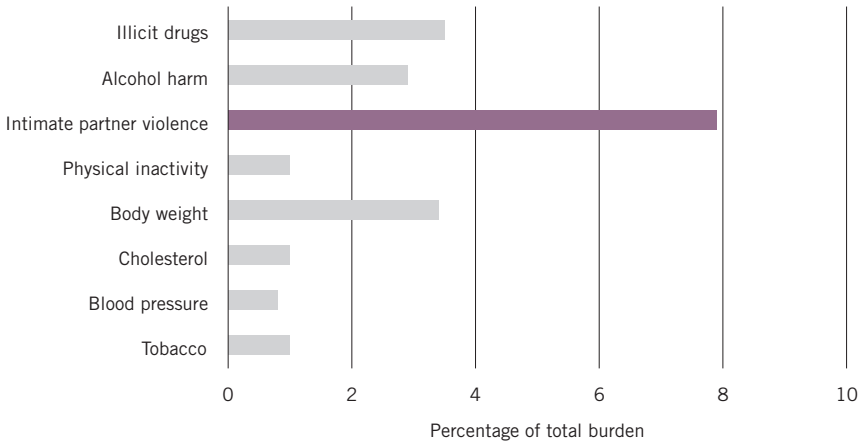


Figure 2: Top eight risk factors contributing to the disease burden in women aged 15-44 years, Victoria, Australia, 2001



3. Prevalent, serious and preventable: This is a public health issue

Nearly one in five Australian women report being subject to intimate partner violence at some time in their adult lives

Women who have been exposed to violence have a greater risk of developing a range of health problems including stress, anxiety, depression, pain syndromes, phobias, somatic and medical symptoms

Intimate partner violence has been identified as a significant health problem requiring urgent attention by a number of bodies at the international, national and local levels, including: the World Health Organization, in its landmark *World Report on Violence and Health* (WHO 2002); the Australian Government, through its 1999 Partnerships Against Violence Initiative (OSW, 1999); the Victorian Government in its 1992 Women's Safety Strategy (OWP 2002) and its Women's Health and Wellbeing Strategy (VDHS 2002); the Australian Public Health Association (2001); and the Australian Medical Association (1998).

Evidence accumulated by these bodies indicates that intimate partner violence is extremely common with:

- The World Health Organization estimating prevalence rates of between 10 per cent and 69 per cent in countries around the world (WHO 2002)
- Nearly one in five Australian women reporting being subject to this type of violence at some time in their adult lives (ABS 1996a).

It also has serious social, economic and health consequences for women, their families and communities:

- Women who have been exposed to violence have a greater risk of developing a range of health problems including stress, anxiety, depression, pain syndromes, phobias, somatic and medical symptoms (WHO 2000).
- They report poorer physical health overall, are more likely to engage in practices that are harmful to their health and experience difficulties in accessing health services (WHO 2000).
- An estimated one in four Victorian children and young people have witnessed intimate partner violence (OWP 2002). This exposure increases their risk of mental health, behavioural and learning difficulties in the short term, and of developing mental health problems later in life (Edleson 1999).
- While the economic costs are the subject of a study being conducted by the federal Office of the Status of Women, existing studies suggest that Australian businesses are losing at least $500 million per year because of the effects of intimate partner violence. Victims take just under $30 million per year in sick leave. Associated staff turnover costs a further $6 million annually (Henderson & Associates 2000).

There is also evidence to suggest that:

- The influence of abuse can persist long after the abuse has stopped.
- The more severe the abuse the greater its impact on women's physical and mental health.
- The impact over time of different types and multiple episodes of abuse appears to be cumulative (WHO 2000; Taft 2003; Golding 1999).

A public health response

Accompanying increased awareness of the extent of the problem is an emerging consensus that:

- It is a problem best addressed within a human rights, legal and health framework, through the development of multi-level strategies across sectors (OWP 2002; WHO 2002).
- Although its causes are complex, factors in our social, economic and cultural environments play a significant part. Addressing these factors can help to prevent the occurrence and consequences of intimate partner violence (WHO 2002).
- Significant among these factors are the unequal distribution of power and resources between men and women (WHO 2002; OWP 2002; Heisse 1998).

A scoping study on violence against women commissioned by VicHealth in 2003 found that given the prevalent, serious and preventable nature of the problem, there was an urgent need for further development of a public health response (McCarthy 2003).

Significant health gains have been made through such an approach in addressing other major public health issues. Prominent examples include tobacco control and road safety, where major reductions in avoidable death, injury and illness have been achieved through a combination of legislative reform, law enforcement, communications and marketing, and services and programs to support individuals.

In the case of intimate partner violence, this would involve emphasis being placed on:

- Supporting research and evaluation to increase understanding of such violence and assess the effectiveness of prevention strategies
- Developing the capacity of organisations to work collaboratively across sectors to develop preventive initiatives
- Supporting community development approaches to foster understanding of the problem and encourage dialogue and action to address it at the local level
- Developing education and training programs to strengthen the capacity of work forces across sectors to implement evidence-based prevention strategies
- Sharing information about intimate partner violence through local, regional and national media as well as other avenues such as community meetings, conferences and forums
- Advocating for policy and program development, resource allocation and legislative reform.

A scoping study on violence against women commissioned by VicHealth in 2003 found that given the prevalent, serious and preventable nature of the problem, there was an urgent need for further development of a public health response

He used to threaten me constantly that he would send me back to Poland without the children if I did not do what he wanted. The lawyer the refuge found for me has told me that he can't do that and that's made a big difference to me. I can now plan for a good future for me and the children.

Annette

4. Study focus and approach

An emphasis on physical and sexual violence

Intimate partner violence is widely recognised as occurring on a continuum of psychological, economic and emotional abuse through to physical and sexual violence. These forms of violence frequently occur together. However, there is also evidence that emotional abuse, such as intimidation, the exercise of excessive control over women's lives and forced isolation from others, occurs independently of physical and sexual violence in an estimated one per cent of Australian women (ABS 1996a).

An emerging body of evidence demonstrates that emotional abuse can have serious health impacts

An emerging body of evidence demonstrates that emotional abuse can have serious health impacts (Coker, Davis, Arias et al., 2002).

This study focussed on physical and sexual violence. It was initially anticipated that the impact of emotional abuse would be considered. However, this was not possible because of the paucity of research and data in this area.

Evidence indicates that women are overwhelmingly more likely to be the victims and to suffer associated health impacts

Assessing the impact on women's health

This study assessed the health burden of intimate partner violence in three ways:

- It documented its prevalence.
- It identified the specific health problems that affect Australian women exposed to violence.
- Using burden of disease methodology (explained in greater detail on page 25), it estimated the contribution intimate partner violence makes to illness, injury and premature death among Victorian women.

This is a crime perpetrated primarily against women

The study focussed on the health impacts of intimate partner violence on women. This is because the evidence indicates that women are overwhelmingly more likely to be the victims (ABS 2003; Bagshaw & Chung 2000) and to suffer associated health impacts.

Compared with male victims of relationship violence, women are:

- Three times more likely to be injured as a result of violence
- Five times more likely to require medical attention or hospitalisation
- Five times more likely to report fearing for their lives (Statistics Canada 2003).

The kids saw it all. I was grabbed by the hair and he slammed my head into the shed wall. I fell and while I was on the ground he kicked me. Now the kids and I all sleep in the lounge. We are afraid he will break in and hurt us.

Karen

5. The prevalence of intimate partner violence

Nearly one in five Australian women identified at least one experience of physical or sexual violence by a current or former partner since the age of 15

The prevalence of intimate partner violence is notoriously difficult to determine. Studies consistently show that compared with victims of other forms of violence women affected are:

- Less likely to disclose
- Less likely to report to the police
- Less likely to go to court
- Less likely to seek support
- Less likely to name the act as violence (Heenan & Astbury 2004; WHO 2002).

This is due to a number of factors, including fear of reprisal, the shame and secrecy surrounding this type of violence, women's ongoing economic or social dependence on a male partner, the trivialisation of intimate partner violence and women's belief or fear that they may not be taken seriously (WHO 2002; OWP 2002).

The Women's Safety Survey, although undertaken some years ago, is the most reliable source of information on the prevalence of intimate partner violence. Prevalence estimates for Victoria are very similar to those for Australia. Australian figures are presented here and were used in calculating burden of disease estimates (see page 25), since they were based on larger numbers of women and hence are more robust.

Table 1: The prevalence of intimate partner violence among Australian women

Age group (years)	*% reporting recent physical or sexual violence (< 12 months ago)*	*% reporting past physical or sexual violence (>12 months ago)*
18–24	5.2	9.0
25–34	4.6	19.1
35–44	3.2	22.7
45–54	2.0	23.0
55+	0.8	11.7
% of all women reporting intimate partner violence	2.9	17.0

Source: ABS 1996a.

He was angry this morning because I had not cleaned his clothes. Then he lost the back gate key and came back into the house and hit me in the head. He gave me a black eye, broken nose and dislocated shoulder, and bruises all over my neck.

Kaye

Data from the survey indicates that nearly one in five Australian women identified at least one experience of physical or sexual violence by a current or former partner since the age of 15. Specifically:

- Almost 195,000 or 2.9 per cent of women had experienced recent physical or sexual violence
- Over one million or 17 per cent of women had experienced past physical or sexual violence (ABS 1996a).

There are other indications that violence is all too common in Victoria:

- While it is understood that less than 20 per cent of women exposed to violence report to authorities (OWP 2002), in 2000–2001, the Victoria Police attended 21,618 incidents involving violence between intimates. There were 19,933 children present during these incidents (Victorian Community Council Against Violence 2002).
- In the same year Victorian housing agencies assisted 10,200 clients who gave intimate partner violence as their reason for seeking assistance, and of these 95 per cent were female (OWP 2002).
- The risk is higher in pregnant women and in the period following the birth of a child (WHO 2000; Taft 2002; Gazmararian & Lazorick 1996). Some 42 per cent of all women responding to the Australian Women's Safety Survey who reported they had experienced violence at some time in their lives were pregnant at the time of the violence (WHO 2000).

6. Health problems experienced by women affected by intimate partner violence

Over 57 per cent of deaths in women resulting from homicide or violence were perpetrated by an intimate partner, with women being over five times more likely to be killed by an intimate partner than are men

Women who have experienced violence in the past have lower rates of mental health problems than women reporting current intimate partner violence, but significantly higher rates than those who have never experienced this type of violence

To establish what health problems have been found to result from violence, an extensive review of relevant studies and published and unpublished government reports and research was undertaken. This included the Australian Longitudinal Study on Women's Health, a study that began in 1996 and enrolled 40,000 women with the intention of periodically surveying them about their health over a 20-year period. The specific health outcomes associated with intimate partner violence are summarised in Table 2.

Health outcomes

Premature death and injury

- Between 1989 and 1998, over 57 per cent of deaths in women resulting from homicide or violence were perpetrated by an intimate partner, with women being over five times more likely to be killed by an intimate partner than are men (Mouzos 1999).
- In a study of patients attending a Brisbane Hospital Emergency Department, women reporting intimate partner violence were nine times more likely to report having harmed themselves or having recent thoughts of doing so than women who had never experienced violence (Roberts, Lawrence, O'Toole, et al. 1997).
- Injuries to the eyes, ears, head and neck as well as the breasts and abdomen, especially during pregnancy, are common in women attending hospital for treatment. Where sexual violence is involved bruising, tears and lacerations to the vaginal area and anus are common (Resnick, Acierno & Kilpatrick 1997; Campbell 2002).

Poor mental health

- Shock, fear and feeling numb are common psychological responses to intimate partner violence (WHO 2002). However, the mental health effects persist long after a violent episode.
- Middle-aged women are significantly more likely to experience anxiety and depression (Parker & Lee 2002), with one study of women attending GPs reporting a five-fold increased risk of depression (Hegarty, Gunn, Chondros et al. 2004), even after other contributing factors, such as low income, were considered.
- The effects of violence can persist for many years. Women who have experienced violence in the past have lower rates of mental health problems than women reporting current intimate partner violence, but significantly higher rates than those who have *never* experienced this type of violence (Loxton, Schofield & Hussain n.d.; Golding 1999).
- Women reporting intimate partner violence are more likely to use medication for depression and anxiety (Resnick, Acierno & Kilpatrick 1997; Hathaway, Mucci, Silverman et al. 2000; Coker, Davis, Arias et al. 2002; Campbell 2002; Janssen, Holt, Sugg et al. 2003; Loxton, Schofield & Hussain n.d.).
- Some other psychiatric disorders (namely phobias, somatisation and dissociative disorders) are more common in women reporting intimate partner violence than those not affected (Roberts, Williams & Lawrence et al. 1998; WHO 2000).

Table 2: Summary of known health outcomes of intimate partner violence

Fatal impacts	
	• Femicide • Suicide • Life-threatening sexually transmitted infections (eg HIV) • Death of mother or infant during or following childbirth
Non-fatal impacts	
Physical injuries	• Bruising • Lacerations or tears • Fractures
Reproductive health	• Sexually transmitted diseases • Urinary tract infections • Human papilloma (wart) virus • Abnormal Pap tests • Termination of pregnancy • Complications of pregnancy (eg inadequate weight gain, infections during pregnancy, miscarriage, haemorrhage, low birth weight)
Mental health	• Attempted suicide • Self-harming behaviours • Depression • Anxiety • Eating disorders • Traumatic and post-traumatic stress symptoms • Other psychiatric disorders such as phobias and dissociative and somatisation disorder (involving the physical expression of psychological symptoms)
Behaviours and practices affecting health	• Harmful tobacco and alcohol use • Illicit and licit drug use (eg tranquillisers and sleeping pills)
Other	• Chronic pain disorders (eg headaches, neck pain) • Gastrointestinal and digestive disorders • Sleep problems

See References and bibliography for sources.

If someone knocked on the door when I was arguing with my wife, I could stop mid-sentence – I would instantly become MISTER NICE GUY. The second they left it was like turning a tape recorder back on – I could start EXACTLY where I left off.

George

Practices and behaviours affecting health

- Women affected are more likely to have alcohol problems as well as to smoke and use non-prescription drugs, amphetamines and solvents (Quinlivan & Evans 2001; Roberts, Lawrence, O'Toole et al. 1997; Roberts, Williams, Lawrence et al. 1998; Roberts, Lawrence, Williams et al. 1998; Golding 1999).
- The use of tranquillisers, sleeping pills and anti-depressants is more common in women exposed to this type of violence than those who are not (Resnick, Acierno & Kilpatrick 1997; Hathaway, Mucci, Silverman et al. 2000; Coker, Davis, Arias et al. 2002; Campbell 2002; Janssen, Holt, Sugg et al. 2003).

Women affected are more likely to have alcohol problems as well as to smoke and use non-prescription drugs, amphetamines and solvents

Reproductive health

- Women reporting intimate partner violence are more likely to have an abnormal Pap smear, and to report having a vaginal or endo-cervical infection (Quinlivan & Evans 2001).
- Young women who have been exposed to this type of violence are more likely to have an unplanned pregnancy, a termination or a miscarriage (Taft 2002). They are slower to make contact with medical services for antenatal care than women who are not exposed to violence and their babies are more likely to have a problem diagnosed after birth (Quinlivan & Evans 2001).

Young women who have been exposed to this type of violence are more likely to have an unplanned pregnancy, a termination or a miscarriage

We must acknowledge that violence is not the same as anger. While anger is an emotion, violence is a behaviour. We must also acknowledge that violence is always a choice, noting that most men who are violent towards their partners do not usually display similarly violent or abusive behaviour towards others.

Danny Blay > Manager, No to Violence Male Family Violence Prevention Association

7. Understanding 'burden of disease' methodology: How it can be used to measure intimate partner violence

Burden of disease methodology is an internationally accepted approach to estimating the impacts of health problems across a population, taking into account illness, disability and premature death. Burden of disease measures are used extensively by governments, researchers, health planners and advocates world wide. They provide a standard measure which can be used to:

- Help make a health problem visible
- Compare health problems for the purposes of setting priorities
- Compare the health impact of various health problems between groups in the population
- Estimate the health benefits of interventions in cost effectiveness analyses.

Burden of disease measures are used extensively by governments, researchers, health planners and advocates world wide

The first estimates were developed for Victoria in 1996 for over 176 diseases and 10 risk factors. The results are currently being updated, providing the opportunity to include an estimate for intimate partner violence for the first time.

The first estimates were developed for Victoria in 1996 for over 176 diseases and 10 risk factors. The results are currently being updated, providing the opportunity to include an estimate for intimate partner violence for the first time

Estimates of the contribution to illness, injury and premature death made by intimate partner violence were developed for each of the main health problems found in the review of the evidence on the health impacts. These estimates were made using prevalence data from the Women's Safety Survey and data on the link between intimate partner violence and health outcomes found in the evidence review on the health impacts of intimate partner violence. This included data from the Australian Longitudinal Study on Women's Health. To find out how much of the disease burden can be attributed to intimate partner violence these data sources were used to estimate how much less disease there would have been in the whole population if no woman had ever been the subject of intimate partner violence. This proportion was then multiplied by the overall estimates of the burden for each of the relevant diseases. These results were summed to calculate the burden of disease that occurs due to women being exposed.[1] It was found that:

- In women under the age of 45 years, this type of violence is responsible for an estimated 8 per cent of the total disease burden. It is less for older women and 3 per cent of disease burden in all Victorian women.
- The greatest proportion of the disease burden is associated with anxiety and depression (62 per cent). Suicide, drug use and risky levels of smoking and alcohol consumption are also significant contributors.
- Intimate partner violence has a greater impact on the health of Victorian women under the age of 45 than any other risk factor. The burden contributed by this form of violence is greater than that for many other risk factors, such as obesity, high cholesterol, high blood pressure and illicit drug use.

[1] A detailed description of the methodology is contained in the technical report of this study (see page 5).

After I moved out of the refuge, I went to another place far away from where I used to live. My new doctor has helped me to think differently about my depression. I am gradually coming off the medication and getting out more, to the parents' club at the school and things like that. I could never have done that when I was with my ex – he just didn't let me go anywhere.

Angela

Figure 1: Health outcomes contributing to the disease burden of intimate partner violence women, Victoria Australia, 2001

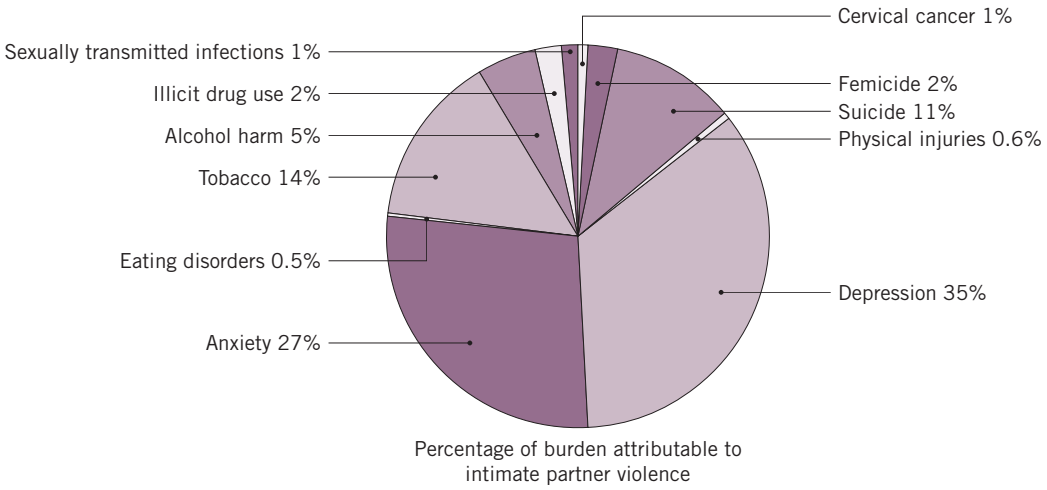


Figure 2: Top eight risk factors contributing to the disease burden in women aged 15-44 years, Victoria, Australia, 2001

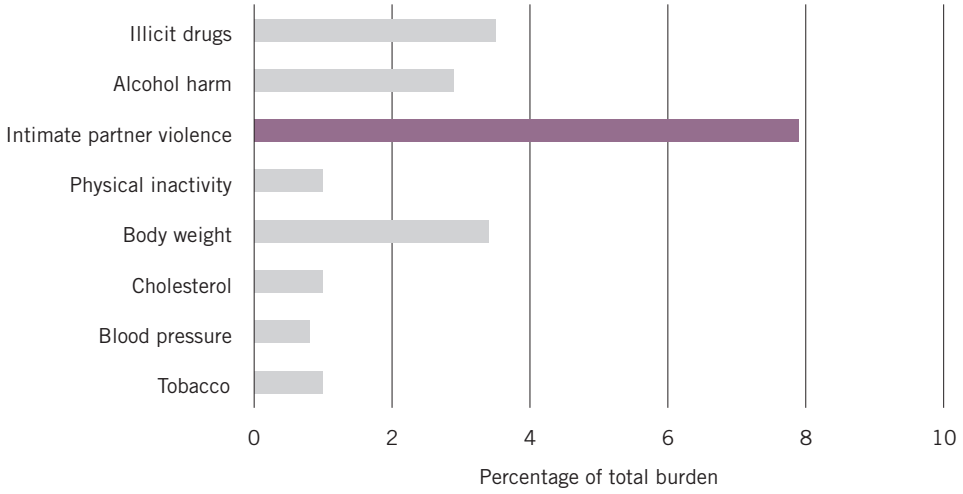
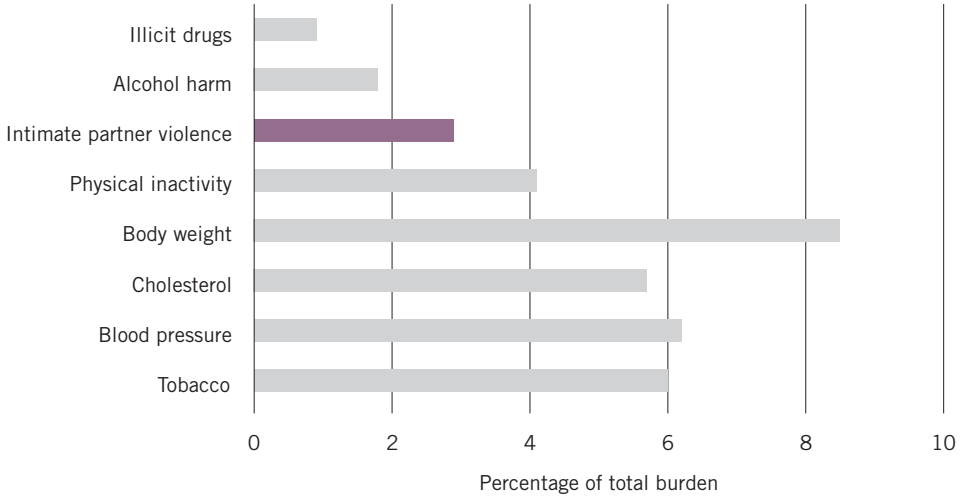


Figure 3: Top eight risk factors contributing to the disease burden in all women, Victoria, Australia, 2001



Cross cultural research demonstrates that gender inequality is the most significant cause of men's violence against women. The policy implications for reducing gendered violence seem clear from this research. We need to reduce the gender power inequality between men and women if we are going to effectively address the problem of men's violence.

Bob Pease > Associate Professor Social Work, RMIT University

8. Study strengths and limitations

The estimates of the health impacts of intimate partner violence in this study are likely to be conservative:

- While the best available sources for the prevalence of violence were chosen, it is widely accepted that any existing measures are likely to under-estimate the actual size of the problem. This is also likely to have affected the burden of disease estimates, since they were derived from prevalence data.
- Only the main health problems affecting women exposed to intimate partner violence were included in the disease burden estimates (eg mental health, substance use), rather than all the problems found in the review of the evidence on the health impacts.
- The impacts of emotional abuse could not be included owing to the paucity of research and data in this area. This also meant that it was not possible to separately examine how much the different forms of abuse contribute to disease burden.
- Women from non-English-speaking and Indigenous backgrounds and women with disabilities are under-represented in existing prevalence studies. These women may be particularly vulnerable to violence or its health impacts, primarily because they are less likely to have the social supports and economic resources required to protect themselves from or to leave a violent relationship. Low participation in existing studies by these women also worked against comparing the burden experienced by them in this particular study. Similarly under-represented in existing studies are women who are homeless and those in prison.

Women from non-English-speaking and Indigenous backgrounds and women with disabilities are under-represented in existing prevalence studies

Calculating the burden of disease associated with a risk factor involves using data from different sources. In many areas of health care, data collection is imperfect or sources of data are not directly compatible. This is no different in the case of data for intimate partner violence.

The strength of burden of disease methodology is that it provides a standard framework for resolving some of these issues so that the most plausible estimates can be made from the available information. The approach used in this study was the same as those used for calculating many other risk factors such as smoking, cholesterol and high blood pressure.

9. What the findings mean

Given the serious health impacts of the problem and evidence that broader social and economic factors contribute, there is a need for a greater emphasis on primary prevention

The findings of this study are a stark indicator of the serious impacts of intimate partner violence and provide compelling evidence of the need for governments, communities and service providers to increase their efforts to address this problem.

- When it comes to setting priorities for action and program development, intimate partner violence warrants attention at least equal to that of many other well-established diseases and risk factors, such as high blood pressure, cholesterol and obesity.
- Given the serious health impacts of the problem and evidence that broader social and economic factors contribute, there is a need for a greater emphasis on primary prevention. This has implications not only for planners and service providers in the health sector, but also for those in the areas of law enforcement, education, housing and social and economic policy.
- In demonstrating that this type of violence is implicated in the burden associated with other major public health problems (such as mental health, smoking and substance abuse), this study suggests that more substantial health gains could be made in these areas by attending to the alarming incidence of violence. Similarly, initiatives to address these problems are more likely to be successful if they take account of intimate partner violence as a contributing factor.
- Addressing this type of violence is important not only to reduce the contemporary health burden, but also that of future generations. This is due to the association between intimate partner violence and reproductive and mental health outcomes, both of which have immediate and long-term impacts on the physical and mental health of the children of women exposed.

10. Taking action on intimate partner violence: A public health approach

In its *World Report on Violence and Health*, the World Health Organization challenges the international community and governments at all levels to address the unacceptable prevalence of violence, identifying violence against women in the context of an intimate relationship as a particular issue for action. It stresses that the fundamental solutions to violence lie in collaborative action between government and the community and across a range of sectors and disciplines.

In Victoria, this response is co-ordinated through the whole-of-government Women's Safety Strategy. Intimate partner violence has also been identified as a priority in the Department of Human Services Women's Health and Wellbeing Strategy.

Both of these strategies incorporate a focus on integration of services and preventive activity at the state and regional level. The findings of this study indicate the importance of continued support for these strategies and, in particular, the need for a renewed focus on primary prevention.

VicHealth has a role to play in adding value to this whole-of-government approach through the application of a range of public health strategies. It funds a number of initiatives, particularly through its arts, community festivals and physical activity programs, which seek to promote a safe environment for women, encourage their participation, foster their social connections, build self-esteem and confidence and reflect positive images of women and their contributions. VicHealth also funds programs aimed at supporting women who have been exposed to intimate partner violence, a notable example being the Women's Circus.

The following are other ways in which VicHealth currently contributes to addressing the issue or plans to contribute:

Research and evaluation

- Research to gain further understanding of this type of violence and to document good practice in prevention at both primary and secondary levels will continue to be supported.
- A bi-annual survey on community attitudes to intimate partner violence is planned.
- Data from this current study will be shared with other researchers. This will include those undertaking burden of disease studies internationally and in other states and territories, as well as those doing the study to determine the economic costs of intimate partner violence (supported by the Office of the Status of Women).

Intimate partner violence has also been identified as a priority in the Department of Human Services Women's Health and Wellbeing Strategy

VicHealth also funds programs aimed at supporting women who have been exposed to intimate partner violence, a notable example being the Women's Circus

Community development

- Forums and conferences providing opportunities to discuss and develop local responses to intimate partner violence will continue to be supported.
- Strategies that focus on strengthening intimate relationships and mutual respect between men and women will be supported.

Workforce development

- Opportunities will be taken to ensure that this type of violence is addressed in relevant education and training programs across sectors.
- This publication will be disseminated to relevant workforces in the health, education, community service and legal sectors.

Policy development, advocacy and legislative reform

- Opportunities will be taken to ensure that the health impact of intimate partner violence is considered in relevant local, state and national policy forums.
- Advocacy will be undertaken with other bodies responsible for funding, supporting and conducting research, regarding the need for further research into the impacts of emotional abuse, as well as research involving Indigenous women, women from non-English-speaking backgrounds, women with disabilities, homeless women and women in prison.
- This publication will be distributed to relevant state and national ministers, departmental personnel and peak policy advocacy bodies.

Communications and marketing

- Media activity will be undertaken to raise awareness of the findings of this study.
- The results of the community attitudes surveys (see page 31) will be circulated widely.

A scoping exercise will be undertaken to document research, interventions and communications and marketing strategies that focus on the connections between alcohol and the escalation of violence against women and to identify future activity to progress work in this area.

Supporting future assessment of the health burden of intimate partner violence

In the course of conducting this research, it became apparent that there were a number of gaps and problems in existing data sources required to assess the health impact of this type of violence, as well as opportunities for further development.

Accordingly, in the course of disseminating this publication, VicHealth will make representations to:

- Those conducting the Australian Women's Safety Survey and the Australian Longitudinal Study on Women's Health to propose that consideration be given to making the adjustments necessary to more comprehensively assess the health burden, including that contributed by emotional abuse
- The Australian Government to advocate for the continuation of the Women's Safety Survey and the Australian Longitudinal Study on Women's Health as vital sources of information about this issue, and to support additional funding so that these studies can more reliably assess the prevalence and health impacts for Indigenous women, women with disabilities, women from non-English-speaking backgrounds and women who are homeless or in prison
- State, Commonwealth and professional bodies responsible for data collection to advocate the need to consolidate or establish national and international collaborations to standardise approaches to data collection on intimate partner violence
- The Commonwealth Department of Health and Ageing to propose that questions on recent and past physical, sexual and emotional abuse be included in the next Mental Health Survey.

The course has made me aware that I can change and that I am responsible for my self and behaviour. I feel that I am in touch with myself and my feelings and it is my choice how I act and relate to my partner. I could have stayed as I was and destroyed everything I hold dear. I chose to seek help. I'm glad I did and stuck to it. I've given my wife, my son and myself a chance to be happy and I am at peace instead of out of control.

Royce

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I used to drink a lot during the day – just to cope with the stress really. Now that I've left my violent ex, I still drink, but only when I go out with my friends. I just don't feel the need to drink during the day to block things out any more.

Bella

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Understanding and addressing violence against women

Health consequences

Violence has immediate effects on women's health, which in some cases, is fatal. Physical, mental and behavioural health (1) consequences can also persist long after the violence has stopped.

Violence against women and girls occurs in every country and culture, and is rooted in social and cultural attitudes and norms that privilege men over women and boys over girls. The abuse takes many forms, including:

- intimate partner violence (sometimes called domestic or family violence, or spousal abuse) which can be physical, sexual or emotional;
- dating violence;
- sexual violence (including rape) by strangers, acquaintances or partners;
- systematic rape during armed conflict;
- forced prostitution, trafficking or other forms of sexual exploitation;
- female genital mutilation (FGM) and other harmful traditional practices;
- dowry-related violence;
- forced marriage or cohabitation, including forced wife inheritance and 'wife kidnapping';
- femicide and the killing girls or women in the name of 'honour'; and
- female infanticide and deliberate neglect of girls.

While the prevalence and forms of violence against women in low- and middle-income countries may differ from those in higher-income countries, the health consequences seem to be similar across all settings (**Table 1**). However, the nature or severity of the effects of violence can be influenced by context-specific factors such as: poverty; gender inequality; cultural or religious practices; access to health, legal and other support services; conflict or natural disaster; HIV/AIDS prevalence; and legal and policy environments.

Effects on physical health

The health consequences of violence can be immediate and acute, long-lasting and chronic, and/or fatal. Research consistently finds that the more severe the abuse, the greater its impact on women's physical and mental health. In addition, the negative health consequences can persist long after abuse has stopped. The consequences of violence tend to be more severe when women

TABLE 1

Common health consequences of violence against women (*2–5*)

Physical	Sexual and reproductive
• acute or immediate physical injuries, such as bruises, abrasions, lacerations, punctures, burns and bites, as well as fractures and broken bones or teeth • more serious injuries, which can lead to disabilities, including injuries to the head, eyes, ears, chest and abdomen • gastrointestinal conditions, long-term health problems and poor health status, including chronic pain syndromes • death, including femicide and AIDS-related death	• unintended/unwanted pregnancy • abortion/unsafe abortion • sexually transmitted infections, including HIV • pregnancy complications/miscarriage • vaginal bleeding or infections • chronic pelvic infection • urinary tract infections • fistula (a tear between the vagina and bladder, rectum, or both) • painful sexual intercourse • sexual dysfunction
Mental	**Behavioural**
• depression • sleeping and eating disorders • stress and anxiety disorders (e.g. post-traumatic stress disorder) • self-harm and suicide attempts • poor self-esteem	• harmful alcohol and substance use • multiple sexual partners • choosing abusive partners later in life • lower rates of contraceptive and condom use

experience more than one type of violence (e.g. physical and sexual) and/or multiple incidents over time (*6,7*).

Acute or immediate physical injury

Women are far more likely than men to experience physical injury as a result of physical violence by intimate partners (*6*). In the *WHO multi-country study on women's health and domestic violence*, between 19% (Ethiopia) and 55% (Peru) of women who had ever experienced physical violence by their intimate partner reported being injured as a result (*4*).

Chronic health problems

In most settings, women who have experienced physical or sexual violence by a partner at any time after age 15 are significantly more likely than other women to report overall poor health, chronic pain, memory loss, and problems walking and carrying out daily activities (*4*). Studies have also found that women with a history of abuse are more likely than other women to report a range of chronic health problems such as headaches, chronic pelvic pain, back pain, abdominal pain, irritable bowel syndrome, and gastrointestinal disorders (*2,3*).

Femicide[1]

Globally, women are most likely to be killed by someone close to them – male intimate partners commit 30–70% of all murders of women in settings as diverse as Israel, South Africa and the USA (*7*). In certain parts of the Middle East and south Asia, women are sometimes killed by close family members in the name of 'honour', for perceived sexual transgressions (*8*), while in settings

[1] For more information see the information sheet *Femicide* in this series.

such as the Indian subcontinent, newly married women are sometimes killed by members of their husband's family because of conflicts related to dowry (9).

However, just like men, women are also murdered by criminal elements in the community. Such killings can be random, but there are disturbing examples of systematic murders of women, particularly in Latin America.

Female genital mutilation[1]

FGM has serious health implications and no health benefits. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies. All forms of FGM can cause immediate bleeding and pain and are associated with risk of infection. The presence of FGM increases the risks of obstetric complications and perinatal death (10). The more severe forms of FGM cause the greatest harm. Sexual problems are also more common among women who have undergone FGM – they are 1.5 times more likely to experience pain during sexual intercourse, experience significantly less sexual satisfaction, and are twice as likely to report a lack of sexual desire (11).

Effects on sexual and reproductive health

Gynaecological disorders and trauma

Women who experience sexual violence experience higher rates of gynaecological problems than other women, including vaginal infection, pain during intercourse, chronic pelvic pain and urinary tract infections (3,5). For example, population-based research from the USA found that women who experienced intimate partner violence had three times the risk of gynaecological problems compared to non-abused women (12). Even without sexual abuse, however, women who experience partner violence appear to have increased risk of gynaecological problems, though the reasons for this are not well understood (2).

Sexual violence sometimes produces gynaecological trauma, most notably in cases of rape with objects, or when a girl is forced to have sexual intercourse and give birth before her pelvis is fully formed (13,14). Gynaecological trauma may include tearing of the vagina; fistula (a tear between the vagina and bladder or rectum, or both); haemorrhaging, infection or ulceration; and other genital injury or complications during childbirth.

Unintended and unwanted pregnancy

Women who experience physical intimate partner violence or forced sexual intercourse by any perpetrator appear to be at greater risk of unintended or unwanted pregnancy than women with no history of abuse, both in the short term and over the course of their reproductive lives (1). Studies have documented pregnancy rates after non-partner rape ranging from 5% among women in the USA (15) to 17% among adolescents in Ethiopia and 15–18% among girls and women seeking help at rape crisis centres in Mexico, Thailand and the Republic of Korea (16). The risk of unwanted pregnancy may occur, directly through forced sexual intercourse or difficulty in negotiating condom or contraceptive use in an abusive relationship, or indirectly via high-risk sexual behaviours linked to a history of sexual abuse in childhood or adolescence (5).

[1] For more information see the information sheet *Female genital mutilation* in this series.

Abortion/unsafe abortion

Girls and women who become pregnant as a result of forced sexual intercourse often terminate their pregnancy, whether or not safe abortion is available. Intimate partner violence, rape by non-partners and transactional sex are all associated with higher rates of termination of pregnancy. For example, the *WHO multi-country study* found that, in nearly all settings, women who had experienced physical or sexual violence by an intimate partner also reported significantly higher rates of induced abortion than other women (*4*).

For example, in southern Nigeria, where abortion is often unsafe, young women who had experienced transactional or forced sexual intercourse were significantly more likely than other women to report ever having an abortion (*17*). In a 1996 study from the USA, 32.2% of pregnant rape survivors kept the infant; 50% underwent induced abortion; and smaller proportions gave the infant up for adoption or had a miscarriage (5.9% and 11.8%, respectively) (*15*).

HIV and other sexually transmitted infections

Studies from many high- and low-income settings have found that women who are HIV positive are more likely than other women to have experienced physical and sexual violence (*18*). In research from India and South Africa, for example, intimate partner violence was found to be strongly associated with a woman's risk of contracting HIV (*19,20*). Violence may increase women's vulnerability to HIV and other sexually transmitted infections, through direct and indirect pathways – for example:

- intimate partner violence makes it difficult for women to refuse sexual intercourse or negotiate condom use (*18*);
- forced sexual intercourse may tear the vagina, increasing the risk of HIV transmission (*18*);
- childhood sexual abuse may increase rates of high-risk sexual behaviours later in life, including less condom use, multiple partners, and experiencing subsequent violence (*21*); and
- fear of violence may prevent women from seeking HIV testing, counselling or services, including services for preventing the transmission of HIV to infants (*18*).

It is important to note that violence against women is not only a possible risk factor for HIV, but, can occur as a consequence of disclosure of HIV-positive status (*18*).

Maternal mortality and other pregnancy-related consequences

Evidence links physical and sexual violence during pregnancy to many complications, including: low maternal weight gain, miscarriage and stillbirth (*3,21,22*), and low-birth-weight babies. For example, a study in Nicaragua found that nearly one quarter of mothers of low-birth-weight infants had experienced physical intimate partner violence during pregnancy, compared with 5% of mothers who had not (*23*).

Another often overlooked consequence of violence against women during pregnancy is maternal death. In settings as diverse as Bangladesh (*24*), India (*25*) and the USA (*26*), intimate partner violence accounts for a substantial proportion of deaths among pregnant women. For example, a study in

400 villages in rural India found that 16% of deaths among women during pregnancy resulted from partner violence (25); and femicide was the leading cause of pregnancy-associated death in the USA state of Maryland between 1993 and 1998 (27). In the UK, more than 14% of maternal deaths occur in women who have told their health professional they are in an abusive relationship (28).

Effects on mental and behavioural health

Both physical and sexual violence have been linked to a greater risk of adverse mental health outcomes among women (3). The most prevalent include depression (14), suicide attempts, post-traumatic stress disorder, other stress and anxiety disorders, sleeping or eating disorders and psychosomatic disorders (5,6). Physical and sexual abuse in childhood have also been associated with a host of subsequent risk behaviours, including early sexual activity; alcohol, tobacco and drug abuse; multiple sexual partners; choosing abusive partners later in life; and lower rates of contraceptive and condom use (21,29). Women who report a history of early sexual abuse often report feelings of worthlessness and difficulty distinguishing sexual from affectionate behaviour, maintaining appropriate personal boundaries, and refusing unwanted sexual advances. Studies have consistently linked a history of child sexual abuse with a higher risk of experiencing sexual violence later in life (21,29).

Increased use and cost of health services

Women who experience intimate partner violence have more health needs and seek health services more frequently than the general population, and their use of these services rises as the frequency and severity of violence increases (30). A large US study found that the use of health services was highest among women in ongoing abusive relationships (31).

By contrast, women who experience intimate partner violence are less likely to seek preventive care, such as mammograms, cholesterol and blood pressure checks and cancer screening. This has clear implications for the overall health of women who experience violence, and also for health-care costs, since prevention is usually more cost effective than treatment (30). In a study of more than 3000 women in the USA, annual health-care costs were 42% higher among those currently experiencing physical intimate partner violence, and 19–24% higher among those who had experienced it within the past five years (31).

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Further information is available through WHO publications, including:

Summary of the expert meeting on health-sector responses to violence against women
http://whqlibdoc.who.int/publications/2010/9789241500630_eng.pdf

WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses
http://www.who.int/gender/violence/who_multicountry_study/en/

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"Gender Symmetry" in Domestic Violence: A Substantive and Methodological Research Review

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"Gender Symmetry" in Domestic Violence

A Substantive and Methodological Research Review

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Despite numerous studies that report the preponderance of domestic violence is perpetrated by men against women, other empirical studies suggest that rates of domestic violence by women and men are equivalent. This article explores these claims of gender symmetry in intimate partners' use of violence by reviewing the empirical foundations of the research and critiquing existing sources of data on domestic violence. The author suggests methods to reconcile the disparate data and encourages researchers and practitioners to acknowledge women's use of violence while understanding why it tends to be very different from violence by men toward their female partners.

Domestic violence has emerged as one of the world's most pressing problems. The United Nations estimates that between 20% and 50% of all women worldwide have experienced physical violence at the hands of intimate partners or family members (Leeman, 2000; United Nations Population Fund, 2000). In the United States, more than 1 million cases of intimate partner violence are reported to police each year according to the U.S. Department of Justice (see Goldberg, 1999). One of the major platforms for action adopted at the World Conference on Women in Beijing in 1995 was the prevention and elimination of violence against women and girls.

Efforts to prevent domestic violence and to facilitate the successful prosecution of batterers have followed research and

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advocacy on behalf of its victims. New laws, police procedures, and medical and forensic efforts to collect and preserve evidence have all encouraged prosecution; at the same time, refuges and shelters for battered women and education and therapy groups for men who are violent toward their partners have sought to transform the conditions that have traditionally supported and sustained domestic violence (see, for example, McNeely & Jones, 1980; Pence & Paymar, 1993).

In recent years, a serious debate has erupted among activists, activist organizations, and individuals about the nature of domestic violence and, especially, the gender of the perpetrators. Decades after first bringing the problem to public awareness, feminist activists now confront a growing chorus of researchers and political activists who claim that women and men are victimized by domestic violence in roughly equal numbers (see Pleck, Pleck, Grossman, & Bart, 1978; Schwartz & DeKeseredy, 1993; Steinmetz, 1978; Straton, 1994).

Despite numerous studies that report the preponderance of domestic violence to be perpetrated by men against women, there are also now more than 100 empirical studies or reports that suggest that rates of domestic violence are equivalent (see, for example, Archer, 2000; Fiebert, 1997.) In the United States, numerous studies have found that women and men are equally likely to report to researchers that they have hit their partners during the preceding 12 months. In Great Britain also, 4.2% of women and men said they had been physically assaulted by partners during the previous 12 months (Tendler, 1999).

Thus, activists for "men's rights" have suggested that policy-oriented efforts for women have been misplaced because they focus entirely on women as the victims of domestic violence. Instead of the picture painted by feminist researchers and activists, these activists argue, as one writer put it, "Men are the victims of domestic violence at least as often as women" (Brott, 1994). Domestic violence, they argue, exhibits gender symmetry; that is, an equal number of women and men are its victims.

Although such activists draw our attention to the often-ignored problem of men as victims of domestic violence, their efforts are also often motivated by a desire to undermine or dismantle those initiatives that administer to female victims. To many of these advocates of gender symmetry, compassion is a

zero-sum game, and when we show any compassion for women who are the victims of domestic violence, we will never address the male victims.

These apparent discrepancies between claims of gender symmetry and claims of dramatic asymmetry have led to significant confusion among policy makers and the general public. Is domestic violence a "women's issue," or do equivalent rates indicate that domestic violence is a problem shared by women and men equally or even not a problem at all? In this article, I examine the claims of gender symmetry in domestic violence. I review existing sources of data on domestic violence and suggest why the rates of domestic violence appear so varied. I offer some ways to understand and reconcile these discordant data so that both scholars and policy makers alike may acknowledge the male victims of domestic violence within the larger context of domestic violence. In particular, I argue that claims about gender symmetry exclude a thorough analysis of gender and how gender identity and ideology—the cultural definitions of masculinity and femininity—may help to clarify these seemingly discordant claims.

THE IDEA OF GENDER SYMMETRY

Reports of gender symmetry have come to play a significant role in public and media discussions of domestic violence. Because these reports run counter to existing stereotypes of male-female relationships, they often have the headline-grabbing value of a "man bites dog" story. One review of the literature (Fiebert, 1997) found 79 empirical studies and 16 reviews of literature that demonstrated gender symmetry among couples. In a more recent meta-analytic review of this literature, Archer (2000) looked at 82 studies that found gender symmetry.

These empirical studies raise troubling questions about what the public is thought to "know" to be true of domestic violence: It is something men overwhelmingly "do" to women and not the other way around, it is among the leading causes of serious injury to women every year; and worldwide, men's violence against women is one of the world's most widespread public health issues.

The questions these studies raise are indeed troubling, but the questions they themselves ask are far from clear. For example,

does gender symmetry mean that women hit men as often as men hit women? Or does it mean that an equal number of men and women hit each other? Does symmetry refer to men's and women's motivations for such violence, or does it mean that the consequences of it are symmetrical? These questions are often lumped together in reviews of literature and meta-analyses, which review existing data sets.

The two large-scale reviews of literature that demonstrate gender symmetry are useful indicators of the types of evidence offered and arguments made by their proponents (Archer, 2000; Fiebert, 1997). Of the 79 empirical articles that Fiebert reviewed, 55 used the same empirical measure of family conflict, the Conflict Tactics Scale (CTS), as the sole measure of domestic violence. This scale was also used in 76 out of the 82 studies that Archer examined. In addition, 28 of those studies noted by Fiebert discussed samples composed entirely of young people—college students, high school students, or dating couples younger than 30—and not married couples. (These two groups overlap somewhat, as 13 of those studies of young, dating couples also used the CTS.) I will discuss the CTS at some length below and also examine some of the reasons that studies of college-age and dating couples yield different rates of violence and aggression than do studies of somewhat older married couples.

Of the remaining nine studies in Fiebert's (1997) survey that used neither the CTS nor sampled only young, dating, unmarried couples, two were based on people's perceptions of violence but offered no data about violence itself, whereas another was based on reports of witnessing violence that contained no useful data (Fiebert, 1997). Another was a study of spousal homicide that did not include homicides by ex-spouses (to which I shall also give some attention). One was a study of young people that had no comparisons by gender (Elliott, 1997), and one was based on violence in American comic strips in 1950 (Saenger, 1963).

Of the three remaining studies, two were based on clinical samples undertaken by my colleagues (O'Leary et al., 1989; Tyree & Malone, 1991). Although these studies suggest that couples that seek clinical therapeutic help have high rates of mutual aggression, O'Leary (1999, 2000) has insisted that the age of the individuals dramatically changes the data and that clinical samples cannot necessarily be generalized to a national population. Even so, as

Fiebert (1997) noted, the study by Tyree and Malone found that women's violence was a result of a "desire to improve contact with partners" (p. 11), by which they meant that women tended to slap or push their partners to get them to pay attention but not to hurt them.

It would appear, therefore, that Gonzalez's (1997) unpublished master's thesis, written apparently under Fiebert's supervision, is the only quantitative survey that purports to find gender symmetry without relying on the CTS. Although it may be of interest that most of the women said their violence was a "spontaneous reaction to frustration," Gonzalez did not survey men nor administer the same questionnaire to a sample of men; thus, one can make no inferences whatsoever about gender symmetry.

Fiebert's (1997) scholarly annotated bibliography thus turns out to be far more of an ideological polemic than a serious scholarly undertaking. But because it has become a touchstone for those who support a gender symmetry analysis, it is important to consider the studies on which it is based. Despite the vituperative ideological debates, there are serious and credible social science researchers who have used reliable social science and found gender symmetry. As follows, I examine (a) the CTS, especially what it measures and what it does not measure; and (b) the effects of age and marital status on domestic violence.

Those who insist on gender symmetry must also account for two statistical anomalies. First, there is a dramatic disproportion of women in shelters and hospital emergency care facilities. Why is it that when we begin our analysis at the end point of the domestic violence experience—when we examine the serious injuries that often are its consequence—the rates are so dramatically asymmetrical? Second, claims of gender symmetry in marital violence must be squared with the empirical certainty that in every single other arena of social life, men are far more disproportionately likely to use violence than are women. Why are women so much more violent in the home that their rates approach, or even exceed, those of men, whereas in every other nondomestic arena, men's rates of violence are about nine times those of women (on rates of violence generally, see Kimmel, 2000)?

HOW DO WE KNOW WHAT WE KNOW: TYPES OF DATA

Our understanding of domestic violence has relied on a wide variety of evidence, from clinical observations to narrative accounts of victims and batterers, the experiences of advocates, and qualitative data gleaned from police and medical sources. Large-scale surveys have fallen into two distinct types (see, for example, Bachman, 1998, 2000; Nazroo, 1995; see also Walby, 1999). These are crime victimization studies, which rely on large-scale aggregate data on crime victimization, and family conflict studies, which measure the prevalence of aggression between married or cohabiting couples. These two sources of data find very different rates of domestic violence, in part because they are measuring two different things.

CRIME VICTIMIZATION STUDIES

Data about crime victimization are gathered from a variety of sources. Some are obtained from household surveys, such as the National Violence Against Women Survey (NVAW), sponsored by the National Institute of Justice and the Centers for Disease Control and Prevention (see Tjaden & Thoennes, 1998, 2000a, 2000b). This nationally representative sample surveyed 8,000 women and 8,000 men representing 16,000 households in the United States. Other crime studies are compiled from police statistics, the National Crime Survey, and the National Crime Victimization Study in which 60,000 households are surveyed annually. Police data typically rely on calls to domestic violence hot lines or calls to police departments.

Crime victimization studies have large sample sizes, in part because they are funded by national, state, and local government agencies. Crime victimization studies include a wide range of assaults, including sexual assault, in their samples. They ask not only about assaults by current partners (spouses or cohabiting partners) but also about assaults by ex-spouses or ex-partners. But they ask only about those events that individuals experience—or even report to municipal authorities—as a crime, and therefore

miss those events that are neither perceived nor reported as crimes. They also find significantly lower rates of domestic violence than do family conflict studies, ranging from significantly less than 1% to about 1.1% of all couples. Some reasons that they find lower rates of violence are that crime victimization studies include all individuals in a household older than age 12, although rates of domestic assault are far lower for women older than age 65 and between 12 and 18. All family members are interviewed, which also may prevent some respondents from disclosing incidents of violence out of fear of retaliation (for a summary of these findings, see DeKeseredy, 2000; Gelles, 2000; Straus, 1999).

These studies uniformly find dramatic gender asymmetry in rates of domestic violence. The National Crime Victimization Survey found women reported six times as many incidents of violence by intimates as men did in 1992 and 1993 (Bachman & Saltzman, 1995; see also Dawson & Langan, 1994). The NVAW found that in 1998, men physically assaulted their partners at three times the rate at which women assaulted their partners (Tjaden & Thoennes, 2000b).

Crime victimization studies further find that domestic violence increases in severity over time, so that earlier, "moderate" violence is likely to be followed by more severe violence (Johnson & Ferraro, 2000). This emerges also in discussions of spousal homicide, where significant numbers of women killed by their spouses or ex-spouses were also earlier victims of violence (see Browne, Williams, & Dutton, 1999; Dugan, Nagin, & Rosenfeld, 1999). In sum, crime victimization studies typically find that domestic violence is rare, serious, escalates over time, and is primarily perpetrated by men.

FAMILY CONFLICT STUDIES

By contrast, family conflict studies are based on smaller scale nationally representative household surveys such as the National Family Violence Survey (Straus & Gelles, 1990) or the National Survey of Families and Households and the British and Canadian national surveys. These surveys interview respondents once and ask only one partner of a cohabiting couple (older than 18) about their experiences with various methods of expressing conflict in the family. Other survey evidence comes from smaller scale

surveys of college students or dating couples, and some draw from clinical samples of couples seeking marital therapy. Still other data are drawn from convenience samples of people who responded to advertisements for participants placed in newspapers and magazines. According to Fiebert (1997), the total number of respondents for all studies that find gender symmetry is slightly more than 66,000—that is, slightly more than the single annual number of one of the crime victimization studies in any year.

These surveys both expand and contract the types of questions asked respondents compared to crime victimization studies. On one hand, they ask about all the possible experiences of physical violence, including those that are not especially serious or severe and that do not result in injury—that is, those that might not be reported or even considered a crime. On the other hand, they ask questions only about cohabiting couples (and therefore exclude assaults by ex-spouses or ex-partners) and exclude sexual assault, embedding domestic violence within a context of "family conflict." So, for example, the CTS asks respondents about what happens "when they disagree, get annoyed with the other person, or just have spats or fights because they're in a bad mood or tired or for some other reason" (Straus, 1997, p. 217).

Family conflict studies tend to find much higher general rates of domestic violence than do crime victimization studies—typically, about 16% of all couples report some form of domestic violence (Straus, 1990). One summary of 21 of the approximately 120 studies that have explored family conflict found that about one third of men and two fifths of women indicated using violence in their marriages (Sugarman & Hotaling, 1989). As surprising as it may be to see high levels of violence, the most surprising finding has been the gender symmetry in the use of violence to try to resolve family conflicts; as Fiebert (1997) wrote, "Women are as physically aggressive, or more aggressive, than men in their relationships" (p. 273).

These studies also find much lower rates of injury from domestic violence, typically about 3% (Stets & Straus, 1990). When "minor" forms of injury (such as slapping, pushing, and grabbing) are excluded from the data, the yearly incidence falls significantly from 16% noted previously to around 6% of all couples (Straus & Gelles, 1986). They also find that violence is unlikely to

escalate over time (see Johnson & Ferraro, 2000). In sum, then, family conflict studies tend to find high rates of domestic violence, stable levels of severity, and low rates of injury and find it perpetrated equally by women and men.

How are such different conclusions to be reconciled? A first step is to make the sources of data similar and make sure they are asking similar questions and comparing the same sorts of events. Crime victimization studies rely on two types of data: surveys of national probability samples that are representative of the population at large and "clinical" samples as well as calls to police and shelters and visits to emergency rooms. Family conflict studies are based on three sources of data: nationally representative probability samples, clinical samples, and convenience samples based on responses to advertisements.

Nationally representative probability samples are the only sources of data that are consistently reliable and generalizable. Whereas clinical samples may have important therapeutic utility, especially in treatment modalities, they are relatively easy to dismiss as inadequate empirical surveys because they do not offer control groups from the nonclinical population and therefore offer no grounds whatsoever for generalizability. Therefore, I shall omit further discussion of both types of clinical data—police, shelter, and emergency room data and data drawn from marital therapy cases.

Recruitment via ads in newspapers and magazines offers related problems of sample representativeness and therefore undermines efforts at generalizability. Often people who respond to such ads respond because they have a "stake" in the issue and feel they want to contribute to it somehow. The representativness of such people to the general population is unclear at best.[1]

Virtually all the "family conflict" surveys rely on the CTS and CTS2, survey measures developed by New Hampshire sociologist Murray Straus and his collaborators, so we must examine that scale a bit further.

THE CTS

Developed by Straus and his colleagues during the past two decades, the CTS is enormously useful, especially for eliciting the quotidian, commonplace acceptance of violence as a means to

"communicate." Let us begin our discussion where the CTS begins. Here is the opening paragraph to the survey as administered (Straus, 1990):

> No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, or just have spats or fights because they're in a bad mood or tired or for some other reason. They also use many different ways of trying to settle their differences. I'm going to read some things that you and your (spouse/partner) might do when you have an argument. I would like you to tell me how many times . . . in the past 12 months you . . . (p. 33)

Such a framing assumes that domestic violence is the result of an argument, that it has more to do with being tired or in a bad mood than it does with an effort to control another person (for critiques of the CTS and CTS2 generally, see Brush, 1993; Currie, 1998; DeKeseredy & Schwartz, 1998a, 1998b, 1998c; Dobash, Dobash, Wilson, & Daly, 1992; Kurz, 1993; Okun, 1986).

The CTS asks about frequency, although only for 1 year. Asking how often in the past year either spouse or partner hit the other may capture some version of reality but does not capture an ongoing systematic pattern of abuse and violence over many years. This is akin to the difference between watching a single frame of a movie and the movie itself.

Context

The CTS simply counts acts of violence but takes no account of the circumstances under which these acts occur. Who initiates the violence, the relative size and strength of the people involved, and the nature of the relationship all will surely shape the experience of the violence but not the scores on the CTS. Thus, if she pushes him back after being severely beaten, it would be scored 1 conflict tactic for each. And if she punches him to get him to stop beating their children or pushes him away after he has sexually assaulted her, it would count as 1 for her and none for him.

In response, Straus and his various colleagues acknowledged that the context is important but believed that it is preferable to explore the context separately from the incidence. This response is unpersuasive. Imagine simply observing that death rates soared for men between ages 19 and 30 during a period of a few years

without explaining that a country has declared war. Context matters.

Initiation

Some critics (see, for example, Currie, 1998; DeKeseredy & Schwartz, 1998a, 1998c) have argued that simply asking how many times a person or his or her spouse used a series of conflict tactics is inadequate to measure the initiation of the violence. Straus (1993) argued that using the CTS, initiation is about even and that self-defense is not the motivation for most women. Straus found that women initiated in 53% of the cases; in 42%, they reported their husbands initiated the aggression, and about 3% said they could not tell who initiated it. Data from other studies, however, indicated that women were far more likely to use violence defensively against the aggression of their partners (DeKeseredy, 1997). With such discordant findings, the CTS's value is limited unless there are a variety of measures incorporated to adequately ascertain the motivation for violence.

Intention and Motivation

Asking people how often they used various conflict tactics during an argument assumes that people use violence expressively—that is, in the heat of anger, as a way to settle an argument, to get one's point across, or to get a spouse or partner to listen or pay attention. It misses the way violence might be used instrumentally—to control or subdue and to reproduce subordination. Such an absence would be analogous to discussing rape and only focusing on those date and acquaintance rapes in which there had been some sexual foreplay and the boundaries were less than fully clear while ignoring, for example, rapes that ended in homicides, rape as a systematic policy of militarily subduing a population, rape in prison, and rape of strangers that has nothing to do with sexual ardor. In short, motivation for violence matters.

Does Location Matter? The Public-Private Split

In general, men are more aggressive than are women (for a summary of this research, see Kimmel, 2000). In fact, violence is the only behavioral variable for which there are intractable and

overwhelmingly skewed results showing gender differences. Although gender differences on a host of other variables—such as spatial orientation and visual perception and academic achievement and ability—have been demonstrated, these differences are typically quite small. Rates of violence based on gender, however, are large and consistent. In their path-breaking work, *The Psychology of Sex Differences*, Maccoby and Jacklin (1974) found that violence exhibits the greatest gender variation; 20 years later, an analysis by Baron and Richardson (1994) found the same thing. So we would have to ask why women would hit men inside the house in roughly equal numbers but almost never commit violence toward men—or women—outside the home.

Studies that propose gender symmetry must explain this apparent paradox. Some argue, for example, that women assume that their violence toward their male partners is harmless (see Fiebert & Gonzalez, 1997). Straus (1999) believed that slapping a man might actually be considered appropriately feminine behavior. It is likely that each of these has some validity, but neither addresses the motivation of women's violence nor the context in which it occurs. Actually, most empirical research on female aggression points in a very different direction. For example, Bjorkqvist and Niemela (1992) found that women are as aggressive as men but only when they are in no danger of being recognized, that is, when the target is not a family member, and there is no danger of retaliation. When parties know each other, women's violence tends to be defensive and men take the initiative (Adams, 1992). Obviously, domestic violence cannot fit the pattern of women retaining their anonymity.

Two final criticisms of the CTS, one methodological and one substantive, deserve somewhat fuller elaboration: the methodological problem of memory and retrospective analysis and reporting bias.

Methodological problems invariably skew substantive results. The CTS relies on retrospection, asking people to accurately remember what happened during the past year. (It shares this method with crime victimization studies, and these biases may well extend to those studies as well.) Retrospection may not be completely reliable because memory often serves our current interests but is unlikely to provide an accurate rendition of what actually happened. There is some evidence that the gender

symmetry of domestic violence breaks down when retrospective studies are used alone. Why?

One argument commonly made (see, for example, Brott, 1994) is that men would be likely to underestimate how often they were victimized because being hit by a woman is so emasculating that they would be too ashamed to admit it, wheras women would tend to overestimate how often they were hit because it might serve their interests to make false allegations of domestic assault in divorce or custody proceedings. Both of these assumptions turn out to be empirically groundless; in fact, the evidence points decidedly in the other direction.

Bringing Gender Into the Equation

What is missing, oddly, from these claims of gender symmetry is an analysis of gender. By this, I mean more than simply a tallying up of which biological sex is more likely to be perpetrator or victim. I mean an analysis that explicitly underscores the ways in which gender identities and gender ideologies are embodied and enacted by women and men. Examining domestic violence through a gender lens helps clarify several issues.

For example, both women and men tend to see their use of violence as gender nonconforming, but the consequences of this nonconformity might lead women and men to estimate their use of violence and their victimization quite differently. Women are socialized not to use violence, and as a result, they tend to remember every transgression. As Dobash, Dobash, Cavanagh, and Lewis (1998) wrote,

> Women may be more likely to remember their own aggression because it is deemed less appropriate and less acceptable for women than for men and thus takes on the more memorable quality of a forbidden act or one that is out of character. (p. 405)

Men, however, might find it emasculating to reveal that their assumed control over "their women" is so tenuous that they are forced to use violence to keep them "in line." They may find it difficult to admit that they cannot "handle" their wives. Thus, men might underestimate their violence, and women might tend to overestimate theirs.

Furthermore, in addition to overestimating their own violence, women may also tend to underestimate their partners' violence given the norms of domestic life, which frequently find women discounting, downplaying, normalizing, or even excusing their partners' violent behavior because they (the women) "deserved" it. By the same token, in addition to underestimating their own violence, men may overestimate their partners' violence for the same norms of masculinity. American men, at least, believe violence is legitimate if used as retaliation for violence already committed (see, for example, Kimmel, 1996; Mead, 1950). The expression "having a chip on one's shoulder" actually has its literal origin among young, southern White boys after the Civil War, who would place a piece of wood on their shoulder and dare someone to knock it off so they might legitimately fight and prove their manhood. Initiating violence is never legitimate according to the norms of traditional masculinity in America; retaliating against a perceived injustice with violence is always legitimate. As a result, men will tend to overestimate their victimization and women will tend to underestimate theirs (see also Archer, 1994; Bograd, 1990; Bowker, 1998).

In response to the notion that men would be too ashamed or humiliated to call the police or go to the hospital if they were beaten by their wives, available empirical evidence suggests a very different picture: Men who are assaulted by intimates are actually more likely to call the police, more likely to press charges, and less likely to drop them (Ferrante, Morgan, Indermaur, & Harding, 1996; Rouse, Breen, & Howell, 1988; Schwartz, 1987). This makes sense in the terms outlined previously, as women would be more likely to forgive being hit and normalize it with statements about how he really does love her. Another study found that men underreport the violence they perpetrate against women by 50% (Edleson & Brygger, 1986; see also Browning & Dutton, 1986; Brush, 1993; and especially Dobash et al., 1998). Dobash et al. found a useful measure of the gender asymmetry in reporting: Women's narrative descriptions of the events of their experiences are far longer and more richly detailed, entering the narrative at a much earlier point in the unfolding drama and extending the narrative to include injuries and other consequences.

If men underestimate their own violence and overestimate their victimization while women overestimate their own violence and underestimate their victimization, this would have enormous consequences in a survey that asks only one partner to recall accurately how much they and their spouses used various conflict-resolution techniques.

The Causes and Consequences of Violence: Severity and Injury

A final substantive critique of the CTS is that it does not measure the consequences of physical assault (such as physical or emotional injury) or the causes of the assault (such as the desire to dominate). Straus (1997) responded that assessing causes and consequences may be interesting, but it is not a necessary part of the picture. He scolded his critics saying that to fault his research on this question "is akin to thinking that a spelling test is inadequate because it does not measure why a child spells badly, or does not measure possible consequences of poor spelling, such as low self-esteem or low evaluations by employers" (Straus, 1997, p. 218).

Were Straus not a credible social scientist, one might suspect the reply to be disingenuous. As such, it is simply inadequate. It is more akin to a teacher who does not look at how far off the spelling mistakes are or whether there is a pattern in the mistakes that might point to a physiological problem such as dyslexia or some other learning disability rather than academic laziness and thus leaves the learning problems untouched and misdirects funds away from remediation toward punitive after-school programs for lazy students. And even that analogy is imperfect because, unlike spelling, domestic violence is not about what happens to the perpetrator (the poor speller) but to someone else. Can one imagine any other issue in which causes and consequences are thought to be irrelevant?

The consequences of violence raise perhaps the most telling criticism of the CTS—a criticism, not incidentally, that Straus and his more thoughtful collaborators share. The CTS lumps together many different forms of violence so that a single slap may be equated with a more intensive assault. In the NVAW, for example, lifetime percentages of persons physically assaulted by intimate partners found dramatic differences in some types of assault but

not others. For example, just less than 1% of men and women (0.9% of women and 0.8% of men) said their attackers used a knife in the attack, but 3.5% of women and only 0.4% of men said their partners threatened to use a gun; 0.7% of women and 0.1% of men said their spouses actually did use a gun (Tjaden & Thoennes, 1998). (It is interesting to note that these differences inside the home are actually slightly smaller than the differences outside the home, where men are overwhelmingly more likely to use weapons in an attack.)

Even more telling are the gender disparities in serious physical injuries without weapons. For example, in a British study that found equal rates of reporting victimization of violence, there were no injuries at all reported in 59% of incidents that involved pushing, shoving, and grabbing (these are the behaviors more typically reported being committed by women than by men). In the NVAW Survey (a crime victimization–type study), half the number of men than women (4.4% of men and 8.1% of women) said their partners threw something at them, and three times as many women (18.1% of women and 5.4% of men) said their partners pushed, grabbed, or shoved them or that their partners slapped or hit them (16.0% of women and 5.5% of men). But more than 10 times as many women (8.5% of women and 0.6% of men) reported their partner "beat them up" (Tjaden & Thoennes, 1998).

The consequences of violence range from minor to fatal, and these are significant in understanding domestic violence in general and its gendered patterns. Far more men than women kill their spouses (and, of course, "couples" in which one spouse killed the other could not participate in the CTS studies because both partners must be cohabiting at the time of the study). And rates of homicides of ex-spouses are even more gender asymmetrical. According to the FBI, female victims represent about 70% of all intimate homicide victims (see Bachman, 2000). About one third of all female homicide victims in the United States were killed by intimate partners compared with 4% of male homicide victims (see, for example, Bachman & Saltzman, 1995; Kellerman & Mercy, 1992). (What this suggests, of course, is that both women and men are more likely to be killed by men; efforts to end all types of violence should properly focus on the association of masculinity and violence, the legitimacy of violence to men, and men's sense of entitlement to use violence.) In the United States,

the number of men killed by intimate partners has dropped by 69% since 1976. The number of women killed by intimates was relatively stable until 1993 when it too began to drop, but only by about 15% (Fox & Zawitz, 2001).

Gender symmetry tends to be clustered entirely at the lower end of violence (Dobash et al., 1998). According to some data, women are six times more likely to require medical care for injuries sustained by family violence (Kaufman Kantor & Straus, 1987; Stets & Straus, 1990). Straus (1997) also reports that in family conflict studies, the injury rate for assaults by men is about seven times greater than the injury rate for assaults by women (Stets & Straus, 1990). This dramatic difference in rates of injury, found in both types of studies, leads Straus, the creator of the CTS and the researcher who is most often cited by those claiming gender symmetry, to write that

> although women may assault their partners at approximately the same rate as men, because of the greater physical, financial, and emotional injury suffered by women, they are the predominant victims. Consequently, the first priority in services for victims and in prevention and control must continue to be directed toward assaults by husbands. (p. 219)

Straus also understands that women, on average, suffer much more frequent and more severe injury (physical, economic, and psychological) than do men (see also Stets & Straus, 1990; Straus, Gelles, & Steinmetz, 1980).

These different rates of injury are so pronounced that when injury data have been obtained in studies using the CTS, the rate of violence drops to that predicted by crime victimization studies and the gender asymmetry of such studies is also revealed (see Straus, 1997). This led another researcher to conclude that both husbands and wives may be said to be "aggressive," but many more husbands are "violent" (Frude, 1994, p. 153).

Age and Aggression

The CTS measures family conflict in intact partnerships between either cohabiting or married couples. However, as I have previously mentioned, more than one third of the studies noted

by Fiebert (1997) that found gender symmetry were surveys of college age, dating couples who were not cohabiting. About one half of Archer's (2000) samples in his meta-analytic review involved high school or college students. Therefore, it is important to examine the way age exerts an effect on domestic violence.

According to all available research, age, especially being younger than 30, is a strong predictor of partner violence (see Suitor, Pillemer, & Straus, 1990). O'Leary et al. (1989) have consistently found that age is a significant variable in the distribution of partner violence. Rates of violence rise significantly between ages 10 (less than 2% violent) and 25 when levels peak at 35% of all couples. But after 25, rates begin to drop and keep dropping to return to about 5% by age 75. This suggests that younger couples are most likely to have the highest rates of violence (O'Leary, 1999). The National Survey of Adolescents in the United States found that of 22.3 million adolescents (ages 12 to 17), 1.8 million had been victims of what researchers label *serious sexual assault* and 3.9 million had been victims of serious physical assault. Women were four times more likely to have been sexually assaulted (13% compared with 3.4% of men), and young men were significantly more likely to have been physically assaulted (21.3% compared with 13.4% of young women; Kilpatrick & Saunders, 1997, 2000). This is because violence means different things to younger dating couples than to married couples at midlife, when violence is usually associated with significant marital discord (O'Leary, 1999, 2000). The two populations—young, unmarried dating couples and older married couples at midlife—are so dissimilar that results from one population cannot be generalized to the other.

Younger people also report using only a few of the various forms of conflict: pushing and slapping. These are not typically associated with injury or with fear of partner (O'Leary, 2000). Stets and Pirog-Good's (1990) work on the centrality of control in dating violence also helps explain the relationship of age and gender on nonspousal violence. It is possible that men's rates of violence drop after marriage because they establish their (financial, physical, emotional) control over the relationship, and therefore, overt acts of violence are less necessary as long as the threat of violence is present (Stark & Flitcraft, 1988).

What the CTS Leaves Out

It is important not only to understand what the CTS measures but also to make explicit what it does not measure. First, the CTS does not include sexual assault in its definition of family conflict. This is crucial because a significant number of spousal assaults are sexual assaults. The NVAW found that 7.7% of all female respondents had been raped by intimate partners at some point in their lifetimes; this translates into approximately 201,394 U.S. women who are raped by intimate partners each year (Tjaden & Thoennes, 2000c). Yet, Straus and Gelles (1990) did not include rape as a category in the index.

Second, the CTS only includes violence by current spouses or cohabiting partners. It does not include violence by ex-spouses or partners. Crime victimization studies do include these. This is important because crimes by former spouses comprise a significant number of domestic assaults. It may be that when women exit relationships, they have no "need" for violence, whereas men tend to continue or even escalate their use of violence when women leave. The National Crime Victimization Survey found that rates of intimate-perpetrated violence for separated women are more than eight times higher than rates for married women (Bachman & Saltzman, 1995; see also Greenfeld et al., 1998). It may be true that these might be somewhat overrepresented in crime victimization studies because people who are assaulted by former spouses would be more likely to report that as a crime because former spouses clearly had no "right" to aggress against victims; therefore, it would clearly be seen as a crime and more likely to be reported. But to ignore these data would so skew any study as to make it unreliable. For example, in one Australian study, only 1% of all violent victimizations of men involved ex-spouses or ex-partners, but ex-spouses or ex-partners involved fully one third of all female incidents (Ferrante et al., 1996). Failure to include ex-spouses may fail to capture up to one third of all cases.

Failure to include sexual assault and assaults by ex-spouses or ex-partners compounds the problem that the CTS does not adequately measure rates of serious injury from domestic violence.[2] The NVAW Survey (Tjaden & Thoennes, 1998) found that 72.6% of rape victims and 66.6% of physical assault victims sustained injuries such as scratches, bruises, or welts and that 14.1% of rape victims and 12.2% of physical assault victims sustained broken bones

or dislocated joints. Rape victims were far more likely to sustain internal injuries (5.8% to 0.8%) or chipped or broken teeth (3.3% to 1.8%). On the other hand, physical assault victims were more likely to sustain lacerations or knife wounds (16.9% to 6.2%), head or spinal cord injuries (10.1% to 6.6%), and burns and bullet wounds (0.7% and 1.8%, respectively; rape rates too low to estimate; Tjaden & Thoennes, 1998).

Violence by ex-husbands also tends to be more serious. For example, the risk of spousal homicide goes up by about 50% for women who leave abusive husbands. (This may also help explain the "rationality" in the decision by women to stay in abusive relationships.) Men may kill their ex-wives because their ex-wives left them; women may kill their ex-husbands because they believe their ex-husbands will otherwise kill them for leaving. In both cases, then, the larger context for both women's and men's violence is men's violence. One study of spousal homicide (Barnard, Vera, Vera, & Newman, 1982) found that more than half of all defendants were separated from their victims at the time they were accused of committing the murder. (For more on relationship status and violence, see DeKeseredy, 1997.)

In sum, the gender symmetry found by CTS-based studies result from the omission of severity of injury, sexual assault, and assaults by former spouses. Some fail to adequately account for marital status and age. Including these would certainly make the gender asymmetry of domestic violence more clear.

HOW CAN WE UNDERSTAND THE USE OF AGGRESSION IN DOMESTIC LIFE?

These two different types of studies—crime victimization studies and family conflict studies—rely on two different theoretical perspectives and two different sources of data. They measure two different phenomena based on different conceptualizations of aggression in families. But they can be reconciled conceptually and methodologically.

If one is interested in the level of aggression in family conflict—that is, the likelihood of any type of aggression occurring when a couple has an argument—then the CTS may be somewhat useful. I say "somewhat" because among other problems that I have previously outlined, the utility of the CTS is limited by the fact that it

fails to take into account sexual assault and also assault by ex-spouses. But it does enable us to see the overall amount of a particular kind of violence in families, what we might call expressive violence—the way individuals might express anger, frustration, or loss of control. If, however, one were interested in the ways in which partners use violence not expressively but instrumentally to achieve some end of control, injury, or terror, then the CTS would be a poor measure. Then, crime victimization surveys will be more valuable because these measure serious injury and include sexual assault and assaults by ex-spouses in their purview. These surveys may capture those family conflicts in which the level of violence escalates beyond a mere "conflict tactic" to something far more ominous and perhaps lethal.

Some violence by men against women is motivated not by the desire to express anger, frustration, or some other immediate emotion during a family conflict but may be more instrumentally motivated by the desire to control. However, the use of violence may indicate not the experience of control but the experience of loss of control. "Violence is a part of a system of domination," writes R. W. Connell (1995), "but it is at the same time a measure of its imperfection" (p. 84).

In that sense, we might say that many men who assault their partners or ex-partners are using violence when they fear their control is breaking down, their ability to control their partners by the implicit threat of violence is compromised, and they feel compelled to use explicit violence to "restore" their control. Thus, men see their violence as restorative and retaliatory.[3] For example, in an earlier study, Dobash and Dobash (1979) found three antecedents of men's use of violence: their sexual jealousy, their perception that the women failed to perform a household task such as cleaning or preparing a hot meal, and women's challenging the men's authority on financial matters. All of these are indicators of a breakdown of men's expected dominance and control.

This understanding of control-motivated, instrumental violence is particularly important in our understanding of claims of gender symmetry. For one thing, men's control over women has clearly broken down when their spouses have left them; thus, measures of physical assault that do not include assaults by ex-spouses will entirely miss these events. Second, breakdowns of men's control over women may be revealed not by physical

assault but by women's withholding or refusing of sexual intimacy. They may exert what limited power they may have by attempting to refuse their partners' sexual advances. Thus, measures that do not include sexual assaults among acts of aggression will be equally inadequate to measure the problem.

Control-motivated instrumental violence is experienced by men not as an expression of their power but as an instance of its collapse. The men may feel entitled to experience that control over women, but they become violent when they do not feel that control. Masculinity, in that sense, has already been compromised; violence is a method to restore manhood and domestic inequality at the same time (see, for example, Kimmel, 1994, 1996, 2000). Such control-motivated, instrumental violence is more likely to escalate over time, less likely to be mutual, and more likely to involve serious injury. This difference between expressive and instrumental violence is a difference not only in purpose but also in frequency, severity, and initiation. It addresses whether the violence is part of a systematic pattern of control and fear or an isolated expression of frustration or anger. These two types of violence are so different that Johnson (1995; Johnson & Ferraro, 2000) has come to call instrumental violence "intimate terrorism" and the types of expressive violence measured by the CTS as "common couple violence."

Social control–motivated abuse can be illustrated in another form of domestic violence: stalking. Control-motivated abuse refers to intentionally inflicted physically or psychologically painful or hurtful acts (or threats) by individuals as a means of compelling or constraining the conduct, dress, or demeanor of their partners (Ellis & Stuckless, 1996). Rates of stalking by intimates, more prevalent than previously thought, can best be understood as an effort to restore control or dominance after partners have left. Stalking exhibits dramatic gender asymmetry: Nearly 5% of American women and about one half of 1% (0.6%) of men report being stalked by current or former intimate partners at some time in their lives (Tjaden & Thoennes, 2000a).

Claims about the gender symmetry of conflict-motivated expressive violence must be complemented with claims about the dramatic gender asymmetry in control-motivated instrumental violence. When these two are factored together, it is clear that women and men may express their anger or frustration during an

argument more equally than we earlier thought. This, however, is by no means fully symmetrical, because even the CTS leaves out two of the dominant forms of expressive, conflict-motivated aggression—sexual assault and assault by ex-spouses. And when control-motivated instrumental violence is added—the violence that more typically results in serious injury, is more systematic, and is independent of specific "conflict" situations—the gender asymmetry is clear (see Johnson, 2000).

WHY WE SHOULD BE CONCERNED ABOUT WOMEN'S VIOLENCE TOWARD MEN

Despite the evidence that gender symmetry is largely a myth, we should nonetheless be concerned about women's violence for a variety of reasons. For one thing, compassion for victims of violence is not a zero-sum game. Reasonable people would naturally want to extend compassion, support, and interventions to all victims of violence. It is an indication of the political intentions of those who argue for gender symmetry that they never question the levels of violence against women, only that the level of violence against men is equivalent. Their solution, however, is not more funding for domestic violence research and intervention but to decrease the amount of funding that women receive, although they never challenge the levels of violence against women.

Second, acknowledging women's capacity for intimate violence will illuminate the gender symmetry in intimate violence among gay men and lesbian couples. According to the NVAW Survey, slightly more than 11% of women living with same-sex partners report being raped, physically assaulted, or stalked by a female cohabitant (compared with 30.4% of women with a live-in male partner). About 15% of men living with male live-in partners report having experienced violence (compared with 7.7% of men with female live-in partners; Tjaden & Thoennes, 2000b).

Third, perhaps ironically, examining women's violence can better illuminate the dynamics of men's aggression against women. Because women's violence is often retaliatory or committed in self-defense, it may help to expose some of the ways men use violence to control women and women's perceived lack of options except "fighting back."

Fourth, acknowledging assaults by women is important, Straus (1997) wrote, because they "put women in danger of much more severe retaliation by men" (p. 210). In a recent interview, Straus elaborated that because women generally suffer greater fear and more injuries, "when she slaps, she sets the stage for him to hit her. The safety of women alone demands we make a big deal of women hitting men" (Slobodian, 2000, p. 1).

Finally, men actually benefit from efforts to reduce men's violence against women. It turns out that efforts to protect women in the United States have had the effect of reducing the homicide rate of men by their partners by almost 70% during the past 24 years. According to James Alan Fox, a professor of criminal justice at Northeastern University, homicides by women of their spouses, ex-spouses, or boyfriends have steadily declined from 1,357 in 1976 to 424 in 1999 (Elsner, 2001). Fox attributes this decline to the availability of alternatives for battered women. "We have given women alternatives, including hotlines, shelters, counseling and restraining orders. Because more battered women have escape routes, fewer wife batterers are being killed," Fox told reporters (as cited in Elsner, 2001). A 1999 study by the National Consortium on Violence Research found that the greater availability of hotlines and other resources for battered women, the greater was the decline in homicide of their male partners. (The study found that 80% of these male domestic homicide victims had abused their partners and that nearly two thirds of female homicide victims had been abused before they were killed.) It turns out that those very initiatives that have greatly benefited women—shelters, hotlines, and the like—save men's lives as well.

TOWARD AN INCLUSIVE EXPLANATION OF DOMESTIC VIOLENCE

It is certainly possible and politically necessary to acknowledge that some women use violence as a tactic in family conflict while also understanding that men tend to use violence more instrumentally to control women's lives. Furthermore, these two types of aggression must also be embedded within the larger framework of gender inequality. Women's violence toward male partners certainly does exist, but it tends to be very different from that of men toward their female partners: It is far less injurious and less

likely to be motivated by attempts to dominate or terrorize their partners (see, for example, Kaufman Kantor & Jasinski, 1998).

The different types of data sources, family violence studies and crime victimization studies, each point to different problems and each is useful to develop intervention strategies. As Straus (1999) wrote, "Research using a broad definition [of violence] and emphasizing injury may be most useful for informing programs designed to treat offenders or help victims of repeated severe assault" (p. 39). On the other hand, "research focusing on the act of assault, most of which does not involve injury but does involve millions of couples, may be most useful in informing programs of 'primary prevention' i.e., steps that will prevent physical assaults from ever happening" (p. 39). He concluded,

> I believe humanity needs research inspired by the moral agenda and perspective of those who focus on the *oppression of women*, regardless of whether the oppression is physical, sexual, psychological, or economic; and also research inspired by the moral agenda of those who focus on *physical assault*, regardless of whether the assault is by a man, woman or child. (p. 40)

Coupled with studies of parental violence toward children—which routinely find that more than 90% of parents aggress against their children—family conflict studies are useful in pointing out the ubiquity and the casualness with which violence structures our daily lives. Coupled with data about intimate partner homicide, rape, and other forms of sexual assault, crime victimization data are useful in pointing out the ways in which men's domination over women requires the implicit threat and often the explicit instrumental use of violence to maintain that power.

Claims of gender symmetry are often made by those who do not understand the data: what the various studies measure and what they omit. Others make claims of gender symmetry based on disingenuous political motives, attempting to discredit women's suffering by offering abstract statistical equivalences that turn out to be chimerical. Gelles and Straus (1999) themselves understood the political misuses to which their work has been put and strongly disavow those political efforts. In a summary of their work, they wrote,

> Perhaps the most controversial finding from our 1975 National Family Violence Survey was the report that a substantial number of women hit and beat their husbands. Since 1975 at least ten additional investigations have confirmed the fact that women hit and beat their husbands. *Unfortunately the data on wife-to-husband violence has been misreported, misinterpreted, and misunderstood* [italics added]. Research uniformly shows that about as many women hit men as men hit women. However, those who report that husband abuse is as common as wife abuse overlook two important facts. First, the greater average size and strength of men and their greater aggressiveness means that a man's punch will probably produce more pain, injury and harm than a punch by a woman. Second, nearly three-fourths of the violence committed by women is done in self-defense. While violence by women should not be dismissed, neither should it be overlooked or hidden. On occasion, legislators and spokespersons . . . have used the data on violence by wives to minimize the need for services for battered women. *Such arguments do a great injustice to the victimization of women* [italics added]. (p. 424)

Gelles (2000) underscored this disingenuous political use of their work with this clear and unequivocal statement: "It is categorically false to imply that there are the same number of 'battered' men as battered women." (Note how he even puts the word *battered* in quotations when describing men.) It is not surprising that credible researchers disavow the political ends to which their work is often put.

Despite the dramatic differences in frequency, severity, and purpose of the violence, we should be compassionate toward all victims of domestic violence. There are some men who are battered by their female partners, and these men are no less deserving of compassion, understanding, and intervention than are women who are battered. And male domestic violence victims deserve access to services and funding, just as do female domestic violence victims. They do not need to be half of all victims to deserve either sympathy or services.

But just as surely, compassion and adequate intervention strategies must explore the full range of domestic violence: the different rates of injury, the different types of violence including sexual assault, and the likelihood of violence by ex-spouses. Such strategies must also understand the differences between violence that is an expression of family conflict and violence that is instrumental to the control of one partner over the other.

With all the caveats and modifications I have suggested to the family conflict model and, especially, the CTS as the standard of measurement, I would therefore argue that violence as an expression of family conflict is somewhat less than symmetrical but would include a significant percentage of women. I would hypothesize that including assaults and homicides by ex-spouses, spousal homicide, and sexual assault, the gendered ratio of male-perpetrated violence to female-perpetrated violence would be closer to 4:1.[4] On the other hand, violence that is instrumental in the maintenance of control—the more systematic, persistent, and injurious type of violence—is overwhelmingly perpetuated by men, with rates captured best by crime victimization studies. More than 90% of this violence is perpetrated by men.

When sexual violence and violence by ex-spouses are considered, the evidence is overwhelming that gender asymmetry in domestic violence remains in full effect. Men are more violent than women, both inside the home and in the public sphere. The home is not a refuge from violence, and it is not a site where gender differences in the public sphere are somehow magically reversed. As citizens, we need to be concerned about all victims of violence. We must also be aware that the perpetrators of that violence—both in public and in private, at home or on the street, and whether the victim is male or female—are overwhelmingly men.

NOTES

1. In the best of these studies, O'Leary et al. (1989) found that about 31% of the men and 44% of the women indicated they had engaged in some aggression against their partners in the year before they were married. A year after marriage, rates dropped for both groups, and 27% of the men and 36% of the women indicated they had aggressed; 30 months into marriage, the rates for the previous year were 25% of the men and 32% of the women.

2. The Conflict Tactics Scale–2 does include a measure of sexual coercion, which seems to me a pretty cogent acknowledgement that it must be included in all understandings of gender symmetry.

3. It must be noted, of course, that the "retaliation" is more often for a perceived injury or slight than any real injury (see, for example, Beneke, 1982).

4. As this is a conjecture based on estimates, it remains an empirical question to coordinate the synthesis of these two approaches.

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