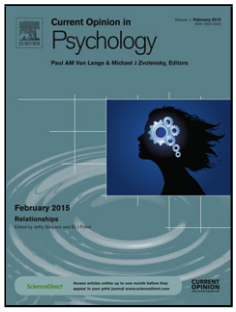

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Violence against Women

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Highlights Krahé: Violence against women

- In a WHO study, 30% of women experienced violence from an intimate partner.
- In the same WHO study, 7.2% of women reported non-partner sexual assault.
- Violence against women has adverse effects on victims' physical and mental health.
- Societal responses include restraining orders and mandatory arrest policies.
- More effective interventions are needed to reduce sexual violence against women.

Abstract

Violence against women causes suffering and misery to victims and their families and places a heavy burden on societies worldwide. It mostly happens within intimate relationships or between people known to each other. Violence against women is a social construction based on a societal consensus about the roles and rights of men and women. Two prevalent forms of violence against women are physical and sexual victimization by an intimate partner, and sexual victimization outside intimate relationships. Explanations of why men engage in aggressive behavior towards women address different levels, including the macro-level of society, the micro-level of dyadic interactions, and the individual level of perpetrator characteristics. Prevention efforts are needed that address each of these levels.

Key words: violence against women; sexual violence; intimate partner; physical violence; sexual violence; trauma; prevention

Violence against Women

Violence against women is recognized as a serious social problem and a criminal offence in many, but by no means all countries in the world [1]. Violence against women is a form of gender-based aggression because it is connected to the membership of perpetrator and victims in distinct gender groups. It comprises any behavior intended by a male actor to cause harm to a female target. This review presents studies that refer to physical and sexual violence against women. Studies examining psychological maltreatment are covered in other recent reviews [2**], [3].

Definition and Prevalence of Physical and Sexual Violence against Women

According to the World Health Organization (WHO) [4**], *physical violence* is defined as "being slapped or having something thrown at you that could hurt you, being pushed or shoved, being hit with a fist or something else that could hurt, being kicked, dragged or beaten up, being choked or burnt on purpose, and/or being threatened with, or actually, having a gun, knife or other weapon used on the person". *Sexual violence* is defined as "being physically forced to have sexual intercourse when you did not want to, having sexual intercourse because you were afraid of what your partner might do, and/or being forced to do something sexual that you found humiliating or degrading [4**, *p.* 6].

Based on these definitions, the WHO compiled a report including evidence from 151 original population-based studies from 81 countries to establish the life-time prevalence rate of women's experience of physical and sexual victimization by an intimate partner from the age of 15 years. Only women who had ever been in a relationship were included, and countries were classified into regions as shown in Table 1.

- Insert Table 1 about here –

Across all 81 countries, the mean rate of women experiencing physical assault, sexual assault, or both from an intimate partner was 30 percent. However, there was considerable variation by region. The report also compiled prevalence rates of non-partner sexual assault

among women regardless of whether they had ever been in a relationship. Across all countries, 7.2% of women reported non-partner sexual assault, but again there was a substantial variability between regions.

In combination with other recent reviews and cross-cultural research [5**] [6,7] [8*], these figures clearly show that physical and sexual violence inflicted by an intimate partner is a reality for many women. The likelihood of being sexually assaulted by a man outside an intimate relationship is far lower than being sexually assaulted by a romantic or dating partner, contradicting the stereotype of the "real rape" as an attack by a stranger (see [9*] on the "real rape" stereotype).

Explanations of Violence against Women

Explanations of why men show physical and sexual violence against women focus on three levels: (a) the macro-level of the society, or social group, in which violence against women occurs; (b) the dyadic level of relationship functioning and interaction patterns between the partners, and (c) the individual level of the perpetrator.

Macro-level explanations

Theories at the macro-level consider causes of violence against women that lie in the social structure and value systems of a society or a particular social group [10] [11*]. The acceptance of violence has been linked to the patriarchal structure of societies that create a favorable context for men's violence against female partners [12]. Patriarchal societies are characterized by a clear-cut power differential between men and women, with men dominating women in most areas of public and private life. Male dominance is linked to a positive evaluation of male assertiveness and aggressiveness. A study including victimization rates in 16 countries showed that the less power women had in the respective country, the higher women's victimization rates were compared to those of men [13].

Dyad-level explanations

At the level of dyadic interactions, explanations look at the couple as the unit of analysis and try to identify features of relationship functioning and situational interactions that increase the likelihood of aggression. Low marital satisfaction was identified as a risk factor for physical partner violence in a meta-analysis [14]. In specific situations, alcohol use by one or both of the partners plays a major role in precipitating violent interactions [15,16,17]. Meta-analytic evidence showed small to moderate associations between drinking and perpetration of intimate partner violence among both men and women [18]. Moreover, acts of physical aggression tend to be more severe and more likely to lead to serious harm when the perpetrator, the victim, or both are drunk, as shown in data from 13 countries across the world [19].

Individual-level explanations

Finally, research has examined causes for intimate partner violence at the level of the individual perpetrator, considering a range of socio-demographic and personal characteristics of men acting violently against their female partners. A meta-analysis of risk factors for physical partner abuse showed that younger, less educated, and less affluent men were more likely to abuse their partners than were older, more educated, and more affluent men [20]. Individuals suffering from personality disorders or mental illness have a higher risk of abusing their partners [21,22]. Endorsement of the traditional male gender role and attitudes condoning violence, dispositional proneness to anger, and attachment difficulties, particularly jealousy, were found to increase the likelihood that men become abusive towards an intimate partner [20].

Not every man growing up in a patriarchal society turns into an abuser, nor does everyone experiencing marital conflict or drinking in sexual interactions. It is the combination and interaction of these different risk factors that may eventually precipitate physical and sexual aggression toward women.

Consequences of Violence against Women

Violence against women leads to a variety of adverse effects on victims' physical and mental health as well as their economic situation [23**] [24] [25*]. Many victims of physical partner violence are traumatized by the experience, especially because severe forms of partner abuse tend to persist over time. A recent meta-analytic review found a two- to threefold increased risk of developing major depressive disorder in women who experience intimate partner violence in comparison to non-victimized women [26]. The WHO report [4**] summarized evidence on the adverse health effects of exposure to intimate partner violence and non-partner sexual assault across studies from a wide range of countries, as presented in Table 2.

- Insert Table 2 about here –

The figures show that women who experienced physical violence from an intimate partner were almost twice as likely as women without a victimization history to suffer from mental health problems, such as depression and alcohol-related problems, and were 1.5 times more likely to be infected with HIV. Women who suffered sexual violence from a non-partner were 2.5 times more likely to suffer from depression and alcohol-related problems compared to non-victimized women. Furthermore, many victims developed the symptomatology of PTSD in the weeks and months following the assault, and sexual assault has been identified as one of the strongest risk factors for PTSD in women [27]. Women who experienced sexual assault also had a higher risk of suicide [28], and women who experienced repeated victimization had higher rates of PTSD than first-time victims [29].

Intimate partner violence also carries high costs for societies as a whole [30]. A report by the World Health Organization details the economic burden of different forms of intimate partner violence [31]. In a survey of over 3,000 women in the United States, the annual health care costs were found to be 19% higher among victims of intimate partner violence than among non-victimized women [32].

Preventing Violence against Women

To prevent violence against women, a wide range of approaches at the macro level of society and the individual level of perpetrators and victims has been proposed [33*] [34].

Societal-level measures

Different criminal justice responses have been introduced to enhance the protection of victims and improve the sanctioning of intimate partner violence. For example, the instrument of *restraining orders* has been implemented to stop abusers from getting close to the persons they threaten to attack and enforces legal sanctions in case the order is violated. In addition, *warrantless arrests* or *mandatory arrest* policies appear to have some success in protecting women [35**]. However, it has been argued that restraining orders may serve to escalate rather than de-escalate intimate partner conflicts because they lead to anger and frustration in the aggressor, and that mandatory arrest policies have increased the number of victims who were arrested alongside the aggressor [e.g., 36,37].

Societal approaches to the prevention of sexual violence against women have sought to address the low conviction rates in the criminal prosecution of rape by implementing changes in the treatment of rape victims by the police and the medical system. In the United States, programs have been put in place to ensure that sexual assault victims are cared for by specialized teams, such as sexual assault nurse examiners (the SANE program) [38]. In Britain, specialized Sexual Assault Referral Centres were introduced to better meet the needs of victims and improve the chances of criminal prosecution, and further recommendations for change were made in an independent report to the government [39].

Individual-level measures

Two meta-analyses investigated the effectiveness of interventions directed at men who had shown violence toward an intimate partner. The first meta-analysis included 44 effect sizes from 22 treatment studies that compared treated abusers with a non-treatment comparison group and found only small treatment effects on recidivism rates [40]. The second

meta-analysis considered 10 rigorously conducted studies in which participants had been mandated by a court to participate in an intervention program and found that participants in the treatment groups had a somewhat lower rate of continuing violence than untreated controls [41].

Many studies have addressed the effectiveness of rape prevention programs [e.g., 42,43,44,45]. These studies provided evidence for short-term reductions in the acceptance of rape myth downplaying the seriousness of rape and assigning blame to the victim [e.g., 46], but the effects tended to disappear within a few weeks post-intervention. Recent studies of the effects of promoting bystander interventions offer more promising results [42]. Based on evidence that men tend to overestimate the extent to which their peers accept and use sexual aggression, the "social norms approach" considers a correction of these misperceptions as a central element of rape prevention [47].

Conclusion

The research reviewed in this article has provided ample evidence that violence against women is a worldwide problem. It may serve an important function in documenting the scale of violence against women and its consequences. The scientific evidence contributes to the understanding of the causes of violence against women, which is crucial for the development of theory-based, effective measures of prevention and intervention.

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****** **of outstanding interest**

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Table 1

Lifetime Prevalence in % of Violence against Women Worldwide (WHO, 2013)

	Physical and/or sexual intimate partner violence among ever-partnered women	Non-partner sexual violence
Low- and middle-income regions		
Africa	36.6	11.9
Americas	29.8	10.7
Eastern Mediterranean	37.0	-[a]
Europe	25.4	5.2
South-East Asia	37.7	4.9
Western Pacific	24.6	6.8
High income regions	23.2	12.6
Overall rate	**30.0**	**7.2**

Adapted from WHO, 2013. See p. 17 and p. 19 for the figures in this table and p. 18 for countries included in each category. [a] No studies were found for countries in this region.

Table 2

Selected Health Outcomes among Women Victimized by an Intimate Partner (based on WHO, 2013, p. 29-30).

Intimate partner violence	N Studies	Odds Ratio[a]
Sexual health		
AIDS/HIV	17	1.52
Sexually transmitted disease	21	1.81
Mental health		
Unipolar depressive disorder	16	1.97
Alcohol use disorders	36	1.82
Injuries	11	2.92
Non-partner sexual violence		
Unipolar depressive disorder	5	2.59
Alcohol use disorders	5	2.33

[a] Denotes the increase in likelihood of suffering the respective adverse health outcome in victimized compared to non-victimized women.