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Gender Differences in Intimate Partner Violence Outcomes

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Objective: This paper proposes a conceptual model for gender differences in outcomes of intimate partner violence (IPV) victimization, broadly conceived as including physical, sexual, emotional, and coercive control forms of abuse, as well as stalking. ***Method***: Literature review of PsycInfo and PubMed databases. ***Results:*** The literature reviewed suggests these negative effects are not equally distributed by gender—studies indicate that women suffer disproportionately from IPV, especially in terms of injuries, fear, and posttraumatic stress. The review also finds that women experience greater decreases in relationship satisfaction as a result of IPV. ***Conclusions:*** Our review largely supports the contention of feminist theory that gender matters—but we would go further and say that what really matters is power; gender matters because it is so highly correlated with power. We propose that, due to cultural factors that typically ascribe higher status to the male gender, and men's greater size and strength compared to women (on average), women are more likely than men to encounter contextual factors that disempower them and put them in situations—such as sexual abuse—that increase their risk of poor outcomes.

Keywords: intimate partner violence, gender differences, gender symmetry, feminist theory, power

Intimate partner violence (IPV) is a costly and debilitating health and social concern for families, communities, mental and physical health practitioners, the criminal justice system, policymakers, and society at large. In the past, IPV was conceptualized primarily as something men do to women; however, recent research has demonstrated that IPV is much more complex and multidimensional, defying simplistic explanations. For instance, gender symmetry, the notion that women are similarly or more aggressive than males in their intimate relationships (Johnson, 2006; Melton & Belknap, 2003; Straus, 2006; White, 2009), seems to apply for some types of IPV, but not others. Numerous studies have found that women commit equal (e.g., Katz, Kuffel, & Coblentz, 2002) or higher (Archer, 2000; Magdol et al., 1997) rates of physical aggression toward partners as compared to men, supporting gender symmetry theory. However, feminist theory, which views IPV as a gendered issue, is supported by studies finding that, relative to men, women experience more injuries (Archer, 2000), sexual victimization (Coker et al., 2002; Harned, 2001; Romito & Grassi, 2007; Slashinski, Coker, & Davis, 2003), and stalking (Tjaden & Thoennes, 2000) from current and former intimate partners. In addition, law enforcement reports find that 75% of domestic violence offenders are male (Snyder & McCurley, 2008), and on a typical day in the United States, approximately three females, compared to one male, are the victims of intimate partner homicide (Domestic Violence Resource Center, 2011). These findings indicate that IPV is not the same phenomenon for men and women. This paper examines gender symmetry versus feminist theories in relation to two research questions: 1. Do outcomes differ for women and men who have been victimized by IPV? 2. If outcomes do differ by gender, why? These are important questions that affect policy, prevention, and intervention efforts to address IPV.

The controversy between gender symmetry and feminist theorists on gender differences in IPV perpetration and victimization has

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wide-ranging implications that go far beyond a dialogue of back and forth in empirical journals. The findings of each side's studies are used to influence funding decisions and policy. For instance, men's and "fathers' rights groups" have made attempts to impact victim services for female victims of IPV (Dragiewicz, 2008; Rosen, Dragiewicz, & Gibbs, 2009). They advocate for "formal equality" (Dragiewicz, 2008, p. 130) and make the claim that men are just as likely to be victims as women, based on gender symmetry studies. Such groups have promoted gender neutrality in IPV policy and funding, and have filed lawsuits against various victim services (Dragiewicz, 2008; Rosen et al., 2009). If the impact of IPV does not differ by gender, and the gender symmetry notion that equivalent numbers of men and women are victimized by IPV is true, then gender neutrality in IPV policy and funding makes sense. If, however, feminist theorists are correct that women suffer greater negative consequences from IPV as compared to men, gender neutrality is not a reasonable approach to IPV policy and funding.

To answer our first research question—do outcomes differ for women and men who have been victimized by IPV?—we review the empirical literature on the negative effects of IPV for men and women, focusing on the following outcomes of IPV: injuries, poor physical health, depression/anxiety, posttraumatic stress, substance abuse, and decreased relationship satisfaction. For the second research question—if outcomes do differ by gender, why?—we examine theoretical explanations for gender differences in effects of IPV victimization and propose a conceptual model of effects of IPV victimization. We also end up rejecting the notion that women experience more negative effects because of an inherent "feminine vulnerability" that predisposes women to greater posttraumatic stress and other poor outcomes. Rather, we find support for women's situational vulnerability, the idea that women are more likely than men to encounter contextual factors that disempower them, and put them in situations—such as sexual abuse—that increase risk of poor outcomes (Cortina & Pimlott-Kubiak, 2006).

Gender and IPV Victimization Outcomes

Theories of gender describe cultural norms that support men's greater power in most interactions with women, including intimate relationships (Ridgeway & Smith-Lovin, 1999; Stark, 2006). Traditional gender socialization in virtually all cultures stipulates that men have a right to authority in their families and over their female partners (Anderson, 2002; Anderson & Umberson, 2001; Dobash & Dobash, 1998). Aside from men's greater power as a result of cultural norms, men are also typically larger and stronger than their female partners. Thus, men will have greater physical power than their female partners in most cases. Likely due to these factors, numerous studies have found that women report greater fear of violent male partners, as compared to men with violent female partners (Fergusson, Horwood, & Ridder, 2005; Langhinrichsen-Rohling, Neidig, & Thorn, 1995; Walton et al., 2007). For example, Phelan and colleagues (2005) found that 70% of female victims in their sample were "very frightened" in response to physical aggression from their partners, but 85% of male victims endorsed "no fear" in response to IPV. Similarly, in the National Violence Against Women Survey (NVAWS), women who were stalked were 13 times more likely than men who were stalked to be "very afraid" of the stalker (Davis, Coker, & Sanderson, 2002). These factors provide a context for IPV in which women may be at greater risk of detrimental outcomes of IPV, as compared to men.

Limitations of the Literature

An important question raised by this literature review is as follows. Is the effect being examined actually caused by IPV? Or, was it caused by something else, such as depression or poor health that existed before the IPV occurred? A limitation of the literature is that most of the studies we review are cross-sectional; it is unclear from these studies if IPV caused the effect that is examined, or the effect caused IPV, or (most likely) the relationship is reciprocal. However, for convenience, we refer to effects as outcomes throughout the paper. A second limitation of the literature is that only some of the studies examining outcomes of IPV victimization directly assessed gender differ-

ences by conducting gender × victimization interactions, thus controlling for baseline gender differences. That is, a finding that female victims are more likely to experience depression than male victims may simply reflect the fact that women are, on average, twice as likely to suffer from depression as compared to men (Nolen-Hoeksema, 2001). The gender × victimization interaction term eliminates this possibility. However, many studies did not conduct gender × victimization interactions and did not test differences in effect sizes by gender. Findings from these studies are less clear. Throughout the paper, we note which studies conducted gender × victimization interactions. A third limitation is that while most studies examined covariates that could account for outcomes, such as childhood abuse or socioeconomic indicators, some did not. The studies that did not control for covariates are noted.

We now turn to the empirical literature to examine gender differences/similarities in outcomes of IPV. Articles for this literature review were found in the PsycInfo and PubMed.gov databases. The search terms used were various combinations of depression, anxiety, posttraumatic stress, injuries, substance abuse, relationship satisfaction, physical health, psychological health, mental health, outcomes, consequences, health consequences, aggression, violence, domestic violence, abuse, men, women, dating violence, IPV, partner violence, partner aggression, couples aggression, male victims, male victimization, female perpetration, gender differences, and gender.

Injuries

Almost all studies have shown more injuries as a result of IPV for female victims (Archer, 2000; Bookwala, Sobin, & Zdaniuk, 2005; Cho & Wilke, 2010; Hamberger, 2005; Krahé, Bieneck, & Moller, 2005; Morse, 1995; Phelan et al., 2005; Romans, Forte, Cohen, Du Mont, & Hyman, 2007; Walby & Allen, 2004; Whitaker, Haileyesus, Swahn, & Saltzman, 2007), including injuries requiring medical attention (Ehrensaft, Moffitt, & Caspi, 2004; Hamberger, 2005; Morse, 1995). In a national sample of adults from the NVAWS, Arias and Corso (2005) found almost 21% of male and around 39% of female victims had been injured during the latest occurrence of IPV. Most injuries were not severe, but almost all injuries, from nonsevere to severe, occurred in female victims more often than males (Arias & Corso, 2005). However, Fergusson et al. (2005) found no gender difference in injuries for individuals who experienced IPV, using longitudinal data from an unselected sample. The lack of gender differences in injuries in the Fergusson et al. study may be due to floor effects—only 3.9% of women and 3.3% of men in the sample experienced injuries due to IPV. As the authors stated, "the range of domestic violence studied within this cohort was confined to relatively mild or moderate incidents of violence . . . extreme violence involving severe injury or death was not present with sufficient frequency for analysis" (p. 1106).

Physical Health Outcomes

Numerous physical health consequences of IPV victimization for women have been noted in the literature. Studies with female victims have found links between IPV and poor general health (Campbell, 2002; Plichta, 2004) and functioning (Campbell, 2002; Krahé et al., 2005), disability (Krahé et al., 2005; Plichta, 2004), and frequent receipt of medical treatment (Campbell, 2002; Plichta, 2004). Very few studies examine male victims. Using NVAWS data, Coker, Weston, Creson, Justice, and Blakeney (2005) reported that 13% of female and 10% of male IPV victims reported poor health.

Only one study examining physical health outcomes of IPV victimization conducted gender × victimization interactions (Porcerelli et al., 2003). See Table 1 for an overview of study findings for health and all subsequent outcomes. This study of family practice patients found that women who were victimized by partners reported more physical symptoms than women who were not victims. There was no impact of victimization from partners on men's physical symptoms. Other studies that did not directly compare effect sizes by gender found negative health outcomes for male and female victims, as compared to nonvictims (Coker et al., 2002; Fletcher, 2010). Using time-corrected data so that illnesses developed prior to victimization were excluded, Coker et al. (2002) found, after controlling for childhood victimization and other relevant variables, that both male and female victims of physical, sexual, or psychological aggression (especially coercive control)

Table 1
Summary Table of Study Findings for Each Outcome

Outcome	Female victims more likely to experience outcome; study conducted gender × victimization interactions	Female victims more likely to experience outcome; Study did not directly compare effect sizes by gender	Outcome occurred for both genders; study conducted gender × victimization interactions	Outcome occurred for both genders; Study did not directly compare effect sizes by gender	Male victims more likely to experience outcome; Study did not directly compare effect sizes by gender	Outcome occurred for neither gender
Health	**Porcerelli et al., 2003**			Coker et al., 2002 Fletcher, 2010	Romito & Grassi, 2007	Slashinski et al., 2003
Depression	**Anderson, 2002**	Romito & Grassi, 2007	**Porcerelli et al., 2003**	Roberts et al., 2003	none	
	Harned, 2001 (significant gender × victimization interaction for psychological and physical abuse)	Slashinski et al., 2003	**Fergusson et al., 2005**	Coker et al., 2002		
	Walton et al., 2007	Ehrensaft et al., 2006 Wong et al., 2008	**Magdol et al., 1997**	Fletcher, 2010		
Anxiety	**Magdol et al., 1997**	Romito & Grassi, 2007 (symptoms of panic attack)	**Fergusson et al., 2005**		none	
	Harned, 2001 (significant gender × victimization for psychological abuse)	Ehrensaft et al., 2006	**Harned, 2001** (no gender × victimization interaction for physical abuse)			
PTSD	**Harned, 2001** (significant gender × victimization interaction for psychological and physical abuse)				none	
		Coker et al., 2005 Ehrensaft et al., 2006				

Table 1 (*continued*)

Outcome	Female victims more likely to experience outcome; study conducted gender × victimization interactions	Female victims more likely to experience outcome; Study did not directly compare effect sizes by gender	Outcome occurred for both genders; study conducted gender × victimization interactions	Outcome occurred for both genders; Study did not directly compare effect sizes by gender	Male victims more likely to experience outcome; Study did not directly compare effect sizes by gender	Outcome occurred for neither gender
Substance use	**Anderson, 2002** (significant effect for drug/alcohol problem)	Ehrensaft et al., 2006 (significant effect for marijuana dependence but not alcohol dependence)	**Magdol et al., 1997** (alcohol abuse/dependence, number of illicit drugs used)	Wong et al., 2008 (women: significant effect for problem drinking; men: significant effects for soft and hard drug use)	Romito & Grassi, 2007 (heavy alcohol use)	**Porcerelli et al., 2003** (alcohol use problems)
		Slashinski et al., 2003 (Significant effect for painkillers/ tranquilizers and illegal drugs; not significant for alcohol)	**Afifi et al., 2009,** (alcohol abuse and drug abuse)	Coker et al., 2002 (heavy alcohol use, tranquilizers, painkillers, recreational drug use)		
		Roberts et al., 2003 (smoking, alcohol, marijuana use)				
Relationship Satisfaction	**Williams & Frieze, 2005** **Katz et al., 2002**				none	

Note. **Bold:** study directly compared effect sizes of victimization by gender by conducting gender × victimization interactions.

from partners had a greater likelihood of poor health. Male and female victims of physical aggression, and female victims of psychological aggression were also more likely to have a chronic disease. Finally, Romito and Grassi's (2007) study of college students found that men who experienced high levels of partner violence reported poorer health than men who experienced low or no IPV. In contrast, women's health was not affected by IPV.

To summarize, the evidence from the few studies regarding the impact of IPV on health is mixed, with one study finding more negative health effects of victimization for women, another finding more negative effects for men, and three studies finding no gender difference. Perhaps these conflicting findings are due to the multidimensional nature of health, assessed different ways in different studies. Porcerelli et al. (2003) examined 18 physical symptoms during the past year; Coker et al. (2002) used three items including self-reported health status from poor to excellent and a history of a serious injury/health condition that interferes with normal activities; Fletcher's (2010) three items were the same self-reported health status item and indicators of hospitalization and emergency room visits in the past five years; Romito and Grassi (2007) used a single-item measure (How is your health now?); and Slashinski et al. (2003) used the single self-reported health status item.

Depression and Anxiety

Depression is a very common outcome of IPV; a meta-analysis of studies of female victims of IPV found the mean prevalence of depressive symptoms was almost 50% (Golding, 1999). Far fewer studies have examined depressive symptoms for male victims of IPV. Rates of major depression among men who were victims of IPV in the New Zealand birth cohort study (Fergusson et al., 2005) ranged from 6% for those experiencing low frequencies of violence to 15% for those reporting high frequencies of violence.

Depression also shows large gender differences in the general population. Women are, on average, twice as likely to suffer from depression (Nolen-Hoeksema, 2001); lifetime prevalence rates of major depressive disorder are estimated to be 20% for women and 13% for men (National Comorbidity Survey, 2011). Women are also more likely to develop most kinds of anxiety disorders. For example, the National Comorbidity Survey (2011) found that the lifetime prevalence of generalized anxiety disorder was 7% for women, compared to 4% for men; similarly, prevalence rates of panic disorder were 6% for women and 3% for men.

Studies examining gender differences in depression as an outcome of IPV are mixed (see Table 1). The one clear finding is that male IPV victims are not more likely than female victims to experience depression—no study found this result. However, several studies found gender differences indicating that female victims are more likely to experience depression in response to IPV than victimized males, and several found that depression occurred for both female and male IPV victims. Focusing only on the studies that conducted gender $\times$ victimization interactions, three found no gender difference, and three found depression as a more likely outcome for women than for men. In a college sample, Harned (2001) found that female and male victims of physical and psychological IPV endorse similar degrees of depressive and anxious symptoms at lower intensities of aggression; however, with higher intensity of aggression, female victims endorsed more depressive and anxious symptoms. The Harned study did not include covariates in analyses. Anderson (2002), examining a large nationally representative sample of heterosexual couples, found that in couples in which both partners are physically aggressive, the effects are more detrimental in terms of depressive symptoms for women than men.

Romito and Grassi (2007) found that women who experienced high levels of partner violence evidenced increased depression and greater frequencies of panic than women who experienced low or no IPV. In contrast, men's depressive and panic symptoms were not affected by IPV. Using NVAWS data, Slashinski et al. (2003) found that for women, physical IPV victimization related to increased depression and antidepressant utilization, whereas these relationships were not found for men. Similarly, Ehrensaft, Moffitt, and Caspi (2006), using longitudinal data from an unselected sample followed from birth, examined individuals experiencing severe IPV, defined as IPV that resulted in injury, medical care, or victim or legal service involve-

ment. Women who experienced IPV were significantly more likely to have major depression and generalized anxiety disorder at the age of 26 than female nonvictims. However, males in abusive relationships were not more likely to have either diagnosis, subsequent to controlling for previous mental illnesses.

In contrast, Fergusson et al. (2005) found no gender difference in major depression or anxiety for individuals who experienced IPV, also using birth cohort study data. Rather, IPV victimization was equally related to increased depression and anxiety for both men and women.

Similarly, using NWAWS data, Coker et al. (2002) found both male and female victims of physical, sexual, coercive control, and psychological aggression from partners had higher depression scores compared to nonvictimized individuals. Fletcher's (2010) and Robert's et al.'s (2003) studies using National Longitudinal Study of Adolescent Health data also found greater depression for both male and female youth who experienced IPV. In sum, although depression and anxiety are common for both female and male victims of IPV, more women likely experience this outcome.

Posttraumatic Stress

Posttraumatic stress symptoms are a very frequent outcome of IPV victimization. Golding's (1999) meta-analysis of studies of female victims of IPV found the mean prevalence of posttraumatic stress was almost 64%. Again, while few studies have examined posttraumatic stress among male victims of IPV, Coker et al.'s (2005) study with NVAWS data found that 20% of male IPV victims reported moderate to severe posttraumatic stress symptoms. Only one study was identified that examined an exclusively male victim sample and the outcome of posttraumatic stress. In this study of male students from 60 universities in different countries, results indicated that after controlling for relevant variables, severe physical victimization was related to increased posttraumatic stress symptoms. This was true across universities (Hines, 2007).

Like depression and anxiety, base rates of posttraumatic stress show large gender differences. The lifetime prevalence of PTSD (posttraumatic stress disorder) was 10% for women and 4% for men, according to the National Comorbidity Survey (2011). The few studies that assessed both men's and women's experience of posttraumatic stress symptoms after IPV victimization have consistently indicated the presence of a gender difference, with more women than men experiencing this outcome. We were able to find only one study examining posttraumatic stress symptoms that conducted gender $\times$ victimization interactions (Harned, 2001). In this study, female and male victims of physical and psychological IPV endorsed similar degrees of posttraumatic stress symptoms at lower intensities of aggression; however, with higher intensity of aggression, female victims endorsed greater posttraumatic stress symptoms. Coker et al. (2005) also found a higher rate of clinically significant posttraumatic stress symptomatology for female compared to male victims. The Coker and Harned studies did not include covariates in analyses. Ehrensaft et al. (2006) found women in aggressive relationships had an increased likelihood of PTSD at the age of 26 compared to women who were not in aggressive relationships. Men in aggressive relationships did not have an increased likelihood of PTSD, subsequent to controlling for previous mental illness. In sum, while modest gender differences are seen in depression and anxiety as outcomes of IPV, a larger gender difference appears to be present for posttraumatic stress.

Substance Abuse

Another important mental health outcome of IPV victimization is substance abuse. Golding's (1999) meta-analysis found the average prevalence of alcohol abuse among female victims of IPV was almost 20%, with greater percentages noted in shelter samples compared to national or health care setting samples. The weighted average prevalence across samples of drug abuse in female victims of IPV was almost 9% (Golding, 1999). Using NVAWS data, Slashinski et al. (2003) found that 7% of male IPV victims reported alcohol abuse and 5% reported drug use. Here, baseline gender differences are the opposite of what we have seen for mood and anxiety disorders. The lifetime prevalence of alcohol abuse is 20% for men and 8% for women, while the prevalence of drug abuse is 12% for men and 5% for women (National Comorbidity Survey, 2011).

Looking at Table 1, studies examining the associations between IPV victimization and substance use are mixed. Some studies found greater substance abuse for women IPV victims, some found no gender differences, and one found greater substance use for male victims. Anderson (2002) conducted gender × victimization interactions and found that in couples in which both partners are physically aggressive, the effects are more detrimental in terms of alcohol and drug abuse for females than males, although both partners showed increased rates of alcohol and drug abuse. In contrast, Magdol et al. (1997), examining an unselected birth cohort of young adults, found that IPV victimization was related to greater alcohol and drug use for both men and women. The Magdol study did not include covariates in analyses. Other studies not conducting gender × victimization interactions found greater substance abuse for women following IPV victimization. For instance, Ehrensaft et al. (2006) found that women in aggressive relationships had an increased likelihood of marijuana dependence, but not alcohol dependence, at the age of 26 compared to women not in aggressive relationships. Men in aggressive relationships did not have an increased likelihood of marijuana or alcohol dependence, subsequent to controlling for previous mental illness. Similarly, Slashinski et al. (2003) found that physical and stalking victimization was related to increased use of drugs for women, whereas these relationships were not found for men.

Some studies that compared substance use for victimized men and women, but did not examine effect sizes for IPV victims as compared to nonvictims by gender, found substance use as an outcome for both genders experiencing victimization (Coker et al., 2002; Wong, Huang, DiGangi, Thompson, & Smith, 2008). Using NVAWS data, Coker et al. (2002) found subsequent to controlling for childhood victimization and other relevant variables, both male and female victims of physical and psychological aggression from partners were more likely to abuse alcohol. Male victims of physical and psychological aggression were also more likely to use illicit drugs, while female victims of coercive control, but not physical aggression, were more likely to use illicit drugs. Wong et al.'s (2008) study of South African adults found that women victimized physically and/or sexually by partners had an increased likelihood of alcohol problems, while men victimized by partners had an increased likelihood of drug use. Finally, a study of college students found increased heavy alcohol use among male IPV victims, but no effect of IPV on women's alcohol use (Romito & Grassi, 2007).

In sum, the findings regarding substance use are mixed, with some studies finding greater substance use for female victims, others finding no gender differences, and one study finding greater substance use for male victims. The mixed findings may be due to the multidimensional nature of substance use and the many ways it was assessed across different studies, ranging from a single item assessing self-reports of problems with drinking or drug use, to frequency and amount of substance use, to substance dependence diagnoses (as shown in Table 1). More women than men may experience this outcome as a result of IPV, but if so, the gender difference is likely small.

Relationship Satisfaction

In addition to negative effects on victims' physical and psychological health, IPV victimization is also detrimental to the quality of intimate relationships. One important aspect of relationship quality is the partners' satisfaction with the relationship. We could only find two studies that examined gender differences in relationship satisfaction in response to IPV victimization; both of these studies conducted gender by victimization interactions (Katz et al., 2002; Williams & Frieze, 2005). Using a sample of married or cohabiting adults from the National Comorbidity Survey, Williams and Frieze (2005) found women were dissatisfied with their relationships when they experienced mild or severe victimization. Men were dissatisfied only when they experienced severe victimization; mild victimization had no effect on relationship satisfaction. In a college population, Katz et al. (2002) found IPV victimization decreased relationship satisfaction only for women in serious dating relationships. Victimization did not affect relationship satisfaction for men, or for women in less serious dating relationships. Katz et al. (2002) proposed that men's satisfaction was not affected since less fear and injury could be associated with their victimization.

Summary of Gender Differences in Outcomes

In sum, both women and men experience negative effects of IPV, but many of these effects do appear to be more likely for women. Numerous studies indicate that women are more likely to be injured as a result of IPV, and findings consistently point to higher rates of posttraumatic stress for women as a result of IPV. The two studies examining the effect of IPV on relationship satisfaction also indicate a more negative effect of IPV for women. Depression and anxiety show a modest gender difference indicating that women are more likely to experience these outcomes. The few studies of gender differences in physical health find that poor health is most likely related to IPV for both genders. Substance use may show a gender difference with women at greater risk, but the construct is so multifaceted and measured in so many different ways that conclusions cannot be drawn from current studies.

An important point to keep in mind is that the prevalence rates of men and women victimized by IPV who experience depression, anxiety, and posttraumatic stress are strongly affected by overall gender differences in these mental health disorders. For example, as discussed earlier, women in the general population are twice as likely to suffer from depression and most anxiety disorders, and 2.5 times more likely to have PTSD, compared to men (National Comorbidity Survey, 2011; Nolen-Hoeksema, 2001). This means that, even if there were no gender difference at all in the effect of IPV on these outcomes, base rates in the general population would lead us to expect gender differences in prevalence rates in the population of people victimized by IPV—that is, twice as many women victimized by IPV would experience depression, anxiety, or posttraumatic stress as compared to men victimized by IPV. However, there is evidence that these outcomes are more strongly associated with IPV for women than for men. The large effect of gender differences in base rates in the general population, together with the evidence that there are stronger associations of IPV and negative outcomes for women, lead to a strong argument that gender neutrality in IPV policy and funding does not make sense. More resources need to be devoted to the treatment of depression, anxiety, and posttraumatic stress for female IPV victims than for male IPV victims.

Substance abuse is worth special mention, as it is the one outcome examined in this review that shows higher prevalence in men in the general population. Men are about 2.5 times as likely to abuse alcohol or drugs as women (National Comorbidity Survey, 2011). If there was no gender difference in the effect of IPV on substance abuse, we would expect higher substance abuse rates among men in the population of people victimized by IPV. However, some studies do suggest a stronger association between substance abuse and victimization for women, suggesting that there may be a narrower gap between victimized men's and women's substance abuse as compared to prevalence rates in the general population.

Why Are There Gender Differences in Outcomes of Intimate Partner Violence?

Given that there are gender differences in outcomes of IPV, our next questions is: How and why is IPV related to these negative effects, and why are there gender differences? We propose several answers to this question, illustrated in the proposed conceptual model in Figure 1. We propose the same basic model structure regardless of gender, but we expect that there will be larger effect sizes of victimization on these outcomes for women than for men (i.e., gender is a moderator of the relationship between victimization and outcomes). Given the literature reviewed above, we expect that the moderating effect of gender should be larger for some effects (fear, injuries, posttraumatic stress, relationship satisfaction) and smaller for others (depression/anxiety, substance abuse).

Contextual Factors that Disadvantage Women

The model in Figure 1 shows IPV victimization and its effects occurring within contextual factors that often put women at a disadvantage in IPV situations. These contextual factors will lead to more negative outcomes for a victimized person when cultural norms stipulate that the person should have less power than their partner, and when the person is physically smaller and weaker than their partner. Obviously, these two factors correlate highly with gender. While

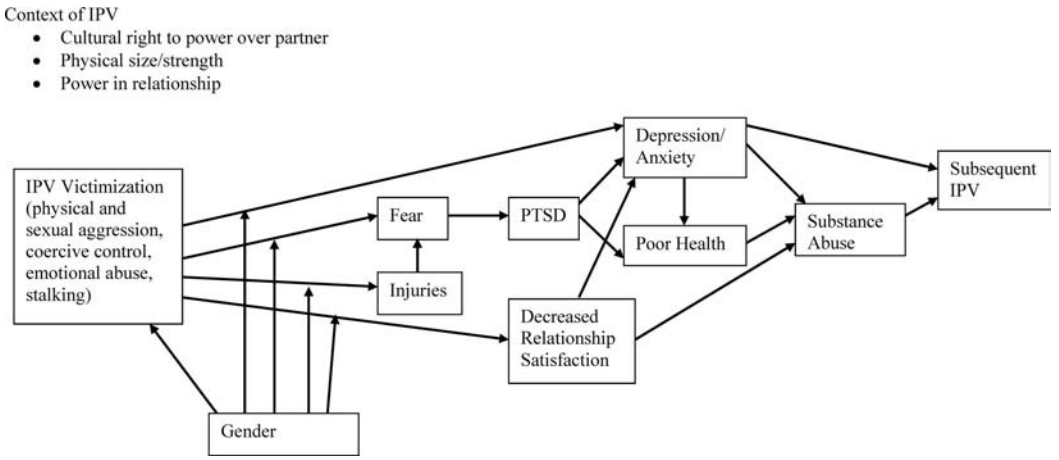

Figure 1. Conceptual model for IPV outcomes of victimization. Paths moderated by gender will be stronger for female victims and weaker for male victims.

some societies have made marked steps toward gender equality, in others women are still largely seen as second-class citizens. Even in societies that have made substantial gains in gender equality, such as the United States, sexist attitudes that men should have power over women are still common (Glick & Fiske, 2001). Most women are physically smaller and weaker than their male partners. On an individual level of analysis, there may also be a greater likelihood of women having less power than male partners in their intimate relationships, due to beliefs still prevalent in many cultures that grant men more power to make decisions, earn higher incomes, act against their partners' wishes, and control their partners' actions (Filson, Ulloa, Runfola, & Hokoda, 2010). However, regardless of cultural norms that accord more status to the male gender, these norms may not operate within a particular relationship. Even within patriarchal societies, there are egalitarian intimate relationships between men and women, and relationships in which women clearly dominate. The third contextual factor recognizes this individual difference variable, unique to each relationship.

Women and Men Tend to Experience Different Types of Abuse

Women are much more likely to experience sexual abuse from partners than men (Coker et al., 2002; Edwards, Black, Dhingra, McKnight-Eily, & Perry, 2009; Harned, 2001; Slashinski et al., 2003). Women are also more likely to experience stalking from partners (Slashinski et al., 2003), as well as fearful coercive control (Coker et al., 2002). The contextual factors in the model—that is, men's right to have power over women in many cultures and men's greater physical strength—likely play a large role in women's greater likelihood of being victimized by these forms of abuse.

The Types of Abuse That Women Are More Likely to Experience Have Worse Outcomes

A number of studies have demonstrated that, compared to outcomes of physical abuse only, effects of sexual abuse from partners are more severe (Dutton et al., 2006; Edwards et al., 2009; Harned, 2001; Pico-Alfonso et al., 2006). Sexual violence from partners has been shown to increase symptoms of posttraumatic stress (Dutton et al., 2006). Furthermore, of the types of traumas commonly recognized as causes of PTSD, rape has the highest likelihood of resulting in PTSD (Schnurr, Friedman, & Bernardy, 2002). Similarly, Coker et al. (2002) found worse physical health, mental health, and substance abuse effects for fearful coercive control as compared to verbal abuse. Logan et al. (2006) also found worse mental health outcomes for women who had been stalked and

experienced severe violence, as compared to women who experienced severe violence only.

Women Tend to Be More Afraid of Violent Partners

Large gender differences are found in fear of violent partners (Fergusson et al., 2005; Langhinrichsen-Rohling et al., 1995; Phelan et al., 2005; Walton et al., 2007). Women's greater fear of partners is not surprising, given that women experience more sexual violence, stalking, and injuries. Contextual factors of IPV also likely contribute to women's greater fear. Many cultures accord men rights to have authority over their female partners, or even to punish their female partners for misbehavior. Women tend to be smaller and have less physical strength than their partners, increasing risk of injury. While experiencing IPV is certainly detrimental for women and men, women may, on average, have more to lose, and thus more to fear, from IPV as compared to men.

Fear Contributes to Posttraumatic Stress

Fear may lead to worse outcomes through its strong relationship with posttraumatic stress (see Figure 1). Fear or helplessness is an essential component for the development and diagnosis of PTSD (American Psychiatric Association, 2000). By definition, people who are victims of IPV or other trauma but are not afraid will not develop posttraumatic stress. Women's greater fear of partners in IPV situations may explain why stronger gender differences are found for posttraumatic stress than some other outcomes.

Posttraumatic Stress May Be Key to the Negative Health Effects of IPV

Posttraumatic stress has been proposed as a critical factor in the relationship between IPV victimization and negative physical and mental health outcomes (Dutton et al., 2006). Studies have demonstrated that PTSD increases negative health symptoms, rates of illness, and use of medical services, and it negatively affects the course and impact of illness (Dutton et al., 2006; Schnurr & Jankowski, 1999). Posttraumatic stress has been found to mediate the relationship between violence and negative health outcomes (Dutton et al., 2006; Schnurr et al., 2002). PTSD also alters psychological functioning, with major depression being the most frequent comorbid condition, occurring in just under half of people with PTSD (Schnurr et al., 2002). PTSD may in some cases contribute to the development of depression. One study found the risk of depression was increased for people exposed to a trauma who developed PTSD, relative to trauma-exposed people who did not develop PTSD (Breslau, Davis, Peterson, & Schultz, 2000). In another study demonstrating the role of PTSD as an important risk factor for depression, Leiner, Compton, Houry, and Kaslow (2008) found that posttraumatic stress symptoms mediated the relationship between IPV and depression. In addition, Seedat, Stein, and Carey (2005) note that PTSD typically develops before depression and substance abuse. In sum, women's greater likelihood of experiencing posttraumatic stress from IPV, and the negative effects of posttraumatic stress on health, are likely important factors in gender differences in outcomes of IPV.

Depression, Power, and the Negative Effects of IPV

Depression is strongly related to problems with physical health (Moussavi et al., 2007) and substance abuse (Hasin, Stinson, Ogburn, & Grant, 2007). Depression is a leading cause of disease burden, it frequently co-occurs with chronic diseases, and it can worsen the health outcomes of chronic diseases (Moussavi et al., 2007). Female victims of IPV are at increased risk of suffering from depression/anxiety as compared to male IPV victims—in large part, because of a main effect of gender; in smaller part, because of stronger relationships between IPV and depression for women. Substance abuse, in turn, may be a way for victims of IPV to cope or self-medicate for depression or posttraumatic stress (Stewart & Israeli, 2002). A study examining the role of power in relationships with respect to IPV found that inequality is a contextual factor that may contribute to depressive symptoms as a consequence of IPV (Filson et al., 2010). Filson et al.'s (2010) study of college women found that power served a meditational role—women victimized by IPV who also had less power in the relationship were more likely to exhibit depressive symptoms. Finally, studies have demonstrated that depres-

sion and substance abuse increase the risk of subsequent IPV (Lehrer, Buka, Gortmaker, & Shrier, 2006; Magdol, Moffitt, Caspi, & Silva, 1998).

Relationship Satisfaction

Our review suggests that the link between IPV victimization and dissatisfaction with the relationship may be stronger for women. Feeling dissatisfied with one's relationship may also contribute to negative health outcomes, such as depression/anxiety and substance use. For example, Testa, Livingston, and Leonard (2003) found prior IPV victimization increased relationship dissatisfaction, which then predicted increased alcohol abuse measured a year later.

Discussion

Our review of the evidence presented here largely supports the contention of feminist theory that gender matters. However, we do not subscribe to an "inherent feminine vulnerability" that predisposes women to greater posttraumatic stress and other poor outcomes in response to IPV, relative to men. Rather, we believe the preponderance of evidence supports situational vulnerability, the idea that women are more likely than men to encounter contextual factors that disempower them, and put them in situations—such as sexual abuse—that increase risk of poor outcomes (Cortina & Pimlott-Kubiak, 2006). Gender certainly matters, but we would go further and say that what really matters is power; gender matters because it is so highly correlated with power. If we are correct that power is what really matters, we would expect to see the model in Figure 1 operate in a similar way for gay or lesbian relationships involving IPV. For example, the model predicts that a gay man who was accorded less status than his partner (i.e., because of his race or class), who was smaller and weaker than his partner, and who was dominated by his partner within their relationship would suffer more negative outcomes from IPV, as compared to a gay man with a violent partner who was equivalent to his partner in status and physical strength.

Implications for Research and Practice

Understanding gender similarities and differences in IPV has significant implications for research and practice. We argue that power, and the abuse of power in intimate relationships, is the central issue in explaining why IPV occurs and why outcomes of IPV are typically more severe for women than for men. This is certainly not a new argument; it was proposed by the Duluth model almost 20 years ago (Pence & Paymar, 1993). Gender, then, serves as a proxy for power. We believe a fruitful area of future research is to explore the contextual factors that create and sustain power differences in relationships. Future studies should examine not just gender, but other status variables related to more or less power and privilege in a culture (race, class, immigration status, etc.), as well as physical size and strength. Studies could also examine individual difference bases of power within a particular relationship, which may include economic power, attachment to a partner who is the only source of emotional support, lack of access to resources, lack of education, fear of losing the children, disability status, and so forth. An examination of these factors in same-sex relationships, in which gender is held constant, would be informative.

The practice implications of understanding the relationship between gender and IPV are vital. Community agencies that serve IPV victims are facing lawsuits in the name of gender symmetry (Dragiewicz, 2008; Rosen et al., 2009); yet women are much more likely to be injured (Archer, 2000) or killed (Domestic Violence Resource Center, 2011) as a result of IPV. However, as we have argued, gender is not the only base of power. Victim services are needed for everyone who experiences significant negative consequences of IPV. We expect that the largest number of people experiencing significant negative consequences of IPV are women victimized by men, followed by lesbian and gay victims of IPV. Relative to these populations, we would expect a smaller number of men in heterosexual relationships experience significant negative consequences of IPV. However, evidence indicating that 21% of male IPV victims are injured (Arias & Corso, 2005); 15% experience depression (Fergusson et al., 2005); and 20% report posttraumatic stress (Coker et al., 2005) clearly point to the seriousness of IPV for men as well as women.

Services for male victims of IPV, or for lesbian or gay victims of IPV, may not—and probably should not—look exactly like traditional

services for female victims of IPV perpetrated by men. Consider the anecdotal example of one man who contacted a victim services agency, seeking help. He was a veteran who had recently returned from Iraq and was having difficulty adjusting to being home. His female partner was using drugs and using violence against him. This man contacted the agency not because he was in fear of his life, but because he was afraid he would end up using violence against his partner, and given his military training and posttraumatic stress issues, his violence would likely be severe. The services he received may have saved her life as well as his.

We hope that the model proposed here will stimulate new research to further develop our understanding of the complexities of IPV. Through continued research, efforts can be made to tailor prevention and intervention efforts to more adequately address the needs of both female and male victims.

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