Linköping University Medical Dissertations No. 1434

TOWARD AN INTEGRATED APPROACH IN RESEARCH ON INTERPERSONAL VIOLENCE

Conceptual and methodological challenges

Johanna Simmons

Linköping University
FACULTY OF HEALTH SCIENCES

Gender and Medicine
Department of Clinical and Experimental Medicine
Faculty of Health Sciences, Linköping University
SE-581 83 Linköping, Sweden

Linköping 2015

johanna.simmons@regionostergotland.se

ISBN: 978-91-7519-156-0
ISSN: 0345-0082

Printed in Linköping, Sweden 2015
LiU Tryck

ABSTRACT

Background: There is a growing understanding that different kinds of interpersonal violence are interrelated. Many victims report experiences of cumulative violence, i.e., being subjected to more than one kind of violent behaviour (sexual, physical, emotional) and/or violence from more than one kind of perpetrator (family members, partners, acquaintances/strangers). To gain a more comprehensive understanding of what violence entails for victims, how victims can be helped and how violence can be prevented, there is a need to learn more about the co-occurrence of violence. Also, despite strong associations repeatedly being found between exposure to violence and the reporting of different kinds of ill-health, only a minority of victims have told health care professionals about their victimization. Less is known about the process of disclosing victimization to health care professionals for men than for women.

Main aims: 1) Investigate the prevalence and co-occurrence of self-reported lifetime experiences of different kinds of interpersonal violence among male and female clinical and random population samples in Sweden (Study I-II). 2) Investigate whether cumulative violence is more strongly associated with self-reported symptoms off psychological ill-health than with any kind of victimization alone (Study III). 3) Develop a theoretical model concerning male victims' process of disclosing experiences of victimization to health care professionals in Sweden (Study IV).

Method: The self-reported prevalence of interpersonal violence as well as self-reported symptoms of psychological ill-health were estimated by means of secondary analyses of data collected with the NorVold Abuse Questionnaire (NorAQ). Both sexes were represented in clinical (women n=2439 men n=1767) and random population samples (women n=1168 men n=2924). Descriptive statistics as well as binary logistic regression and ordinal regression analyses were used (Study I-III). In study IV, constructivist grounded theory was used, and 12 men were interviewed concerning their experience of disclosing victimization to health care professionals.

Results: A large proportion of victims (women: 47-48%, men: 29-31%) reported experiences of more than one kind of violent behaviour. Many also reported being subjected to violence by more than one kind of perpetrator (women: 33-37%, men: 22-23%). Reporting cumulative violence had a stronger association with symptoms of psychological ill-health than reporting only one kind of victimization. In study IV, the interviewed men's own perceptions and considerations beforehand (e.g., perceived need for help and feelings of shame), as well as the dynamics during the actual health care encounter (e.g., patient-provider relationship and time constraints), were essential for understanding the process of disclosure. Also, the men's own conformity to hegemonic constructions of masculinity and professionals' adherence to gender norms had a strong negative influence on the men's process of disclosure.

Discussion: Experiences of cumulative violence were common. Prevalence rates of experiences of different kinds of interpersonal violence were compared to previous studies on interpersonal violence in Sweden. Large discrepancies were found between all studies, which is a symptom of methodological and conceptual difficulties within the research field. Violence is a gendered phenomenon. Differences were seen in the kind of violence men and women reported. In addition to this, the results in study IV indicate that gender affects how violence is perceived and how victims are treated by health care professionals.

Conclusion: Integrated approaches in research on interpersonal violence, as well as in clinical work, are needed. If the co-occurrence of violence is ignored, it may hamper our understanding of the experiences and consequences of interpersonal violence for victims. More research is needed into what produces the differences found in prevalence rates between studies to improve the methodology.

POPULÄRVETENSKAPLIG SAMMANFATTNING

Introduktion

Att ha varit utsatt för olika typer av våld är vanligt förekommande. På senare år har det uppmärksammats att många människor som har varit utsatta för en typ av våld (exempelvis sexuellt, fysiskt, emotionellt) också har varit utsatta för en annan typ. Det är också vanligt att personer utsätts för våld i mer än en slags relation. Exempelvis kan en individ ha varit utsatt av en eller flera familjemedlemmar (vilket i den här avhandlingen innebär förälder/styvförälder eller syskon), tidigare eller nuvarande partner och/eller bekanta/främlingar. För att bättre förstå vad våld innebär för den som utsätts, hur man bäst kan hjälpa utsatta och hur man kan förhindra att våld sker, behövs en större kunskap om hur olika typer av våld och våld från olika typer av förövare hänger samman.

Trots att flera rapporterar har påvisat ett starkt samband mellan att ha varit utsatt för olika typer av våld och att lida av både fysisk och psykisk ohälsa är det relativt få av dem som varit utsatta för våld som söker hjälp för detta inom sjukvården. Det finns mer forskning kring kvinnors upplevelser av att berätta om våldsutsatthet i vården än mäns.

Syfte

De huvudsakliga syftena med avhandlingen var att:

1) Bland män och kvinnor slumpmässigt utvalda ur befolkningen samt rekryterade på olika sjukhuskliniker undersöka den självrapporterade förekomsten av olika typer av våld, samt undersöka hur många som varit utsatta för mer än en typ av våld och/eller våld från mer än en typ av förövare (studie I-II).

2) Undersöka om kumulativt våld (att ha varit utsatt för mer än en typ av våld/våld från mer än en typ av förövare) var starkare associerat till självrapporterade symptom på psykisk ohälsa, än att bara ha varit utsatt för en typ av våld/våld från en typ av förövare (studie III).

3) Konstruera en teoretisk modell som beskriver den process som män går igenom för att berätta om sin våldsutsatthet för vårdpersonal (studie IV).

Metod

För att mäta förekomsten av våld användes ett frågeformulär, NorAQ (NorVold Abuse Questionnaire). Data fanns tillgängligt för båda könen och hade samlats in både i ett slumpmässigt urval i befolkningen (1168 kvinnor och 2924 män) och på olika sjukhuskliniker (2439 kvinnor och 1767 män). NorAQ innehåller frågor om erfarenheter av sexuellt, fysiskt och emotionellt våld. Dessutom finns frågor om symptom på psykisk ohälsa. För att undersöka samband mellan olika typer av våld/våld från olika typer av förövare användes beskrivande statistik och regressionsanalyser, liksom för att undersöka samband mellan kumulativt våld och självrapporterade symptom på psykisk ohälsa (studie I-III).

Studie IV är en kvalitativ studie som bygger på konstruktivistisk Grounded Theory. Djupintervjuer genomfördes med tolv män kring deras erfarenheter av att berätta om våld för vårdpersonal. Intervjuerna spelades in och transkriberades varefter texten analyserades och en teoretisk modell konstruerades.

Resultat

Bland de kvinnor som varit utsatta för någon typ av våld, rapporterade nästan varannan (47-48%) att de varit utsatta för mer än en typ av våld och drygt var tredje (33-37%) att de varit utsatta för våld av mer än en förövare. Bland de män som varit utsatta för någon typ av våld, rapporterade nästan var tredje (29-31%) att de hade varit utsatta för mer än en typ av våld och nästan var fjärde (22-23%) att de varit utsatta för våld av mer än en förövare (studie II). Att ha varit utsatt för kumulativt våld var starkare associerat till självrapporterade symptom på psykisk ohälsa än att bara rapportera utsatthet för en typ av våld eller våld från en typ av förövare (studie III).

Män och kvinnor rapporterade delvis erfarenheter av olika typer av våld. Det var i båda urvalen fler män än kvinnor som rapporterade erfarenheter av fysiskt våld (kvinnor: 20-21%, män: 29-35%) och fler kvinnor än män som rapporterade sexuellt våld (kvinnor: 17% i båda urvalen, män: 4-5%) Det var också vanligare att kvinnor rapporterade utsatthet för alla tre typerna av våld (kvinnor: 6-7% män: 1-2%). Både kvinnor och män rapporterade i ett livstidsperspektiv mest utsatthet för våld från bekanta/främlingar (kvinnor: 18-22%, män:29-37%). Kvinnor rapporterad dock i högre utsträckning än män våld från en partner (kvinnor: 15-16%, män: 3-5%). Fler kvinnor än män rapporterade också att de varit utsatta för våld från alla tre typerna av förövare (kvinnor: 3%, män 1% i båda urvalen).

Männens process att berätta om sin våldsutsatthet för vårdpersonal påverkades såväl av deras egna tankar, upplevelser och erfarenheter innan de kom i kontakt med vården, som av det som hände under själva mötet med vårdpersonalen. Känslor av skam och att inte identifiera vården som en plats att söka hjälp på gjorde det mindre sannolikt att männen berättade om sin utsatthet för våld. Könsnormer gjorde det också svårare, vilket visade sig både genom det sätt varpå männen konstruerade manlighet och i det könsstereotypa bemötande de berättade att de fått av vårdpersonal.

Diskussion

Bland våldsutsatta var det mycket vanligt att ha varit utsatt för mer än en typ av våld och/eller våld från mer än en förövare. Erfarenheter av kumulativt våld var starkare associerat till symptom på psykisk ohälsa än att bara rapportera erfarenheter av en typ av våld.

Avhandlingen resultat avseende förekomsten av våld har jämförts med tidigare publicerade svenska studier om våldsutsatthet. I jämförelsen syns att det finns stora skillnader i den rapporterade förekomsten av olika typer av våld, vilket är ett tecken på metodologiska och definitionsmässiga svårigheter i forskningsfältet.

Erfarenheter av våld skiljer sig mellan könen. Studie II visade att män och kvinnor rapporterade delvis olika typer av våld och resultatet i studie IV indikerar att könstereotypa föreställningar påverkar mäns möten med vårdpersonal då det handlar om att berätta om våldsutsatthet.

Konklusion

Det finns ett behov av att i större utsträckning undersöka hur olika typer av våld/våld från mer än en typ av förövare hänger samman. Om sambanden ignoreras kan det leda till en sämre förståelse för hur våld upplevs för den som är utsatt, samt vilka konsekvenser det kan få. Det finns ett stort behov av metodutveckling inom våldsforskningen. En förutsättning för att nå bättre metoder är studier som syftar till att förstå hur metodologin påverkar den uppmätta förekomsten av våld.

LIST OF ORIGINAL PAPERS

This thesis is based on the following four original papers, which are referred to in the text with Roman numerals (I-IV):

I. Swahnberg K, **Davidsson-Simmons J**, Hearn J, Wijma B. Men's experiences of emotional, physical, and sexual abuse and abuse in health care: A cross-sectional study of a Swedish random male population sample. *Scandinavian Journal of Public Health*, 2012; 40:191-202

II. **Simmons J**, Wijma B, Swahnberg K. Associations and Experiences Observed for Family and Nonfamily Forms of Violent Behavior in Different Relational Contexts Among Swedish Men and Women. *Violence and victims*. 2014; 29:152-170

III. **Simmons J**, Wijma B, Swahnberg K. Cumulative violence and symptoms of psychological ill-health: the importance of the interplay between exposure to different kinds of interpersonal violence in Swedish male and female clinical and population samples. *Submitted manuscript.*

IV. **Simmons J**, Brüggemann AJ, Swahnberg K. Disclosing victimization to health care professionals in Sweden: A gendered analysis of experiences among men exposed to interpersonal violence. *Submitted manuscript*

CONTENTS

BRIEF DEFINITIONS

Some of the terms used within this thesis are briefly defined on this and the next page. More extensive definitions of terms and concepts used can be found in section 1.2.

Terms used for variables included in analyses in this thesis	
Acquaintance/Stranger (Acq/Str) perpetrator	In NorAQ, the perpetrator is reported to belong to one or more of the following categories: 1) same age playmate, schoolmate or other person under 18, 2) a known person who does not belong to your family 3) a person totally unknown to you 4) other
Cumulative violence	Refers to respondents reporting more than one kind of perpetrator and/or more than one kind of violent behaviour.
Family perpetrator	In NorAQ, the perpetrator(s) is reported to belong to one or more of the following categories: 1) parent 2) step-parent 3) sibling
Self-reported symptoms of psychological ill-health	Refers to the ordinal measure used in study III composed of answers on six items in NorAQ and intended to measure symptoms of depression, anxiety, insomnia as well as three symptoms of post-traumatic stress (flashbacks, avoidance, numbing)
Kind of perpetrator	The kind of perpetrator as reported by victims. In analyses the reported perpetrator is coded as belonging to one or more of the following categories: family, partner and/or acquaintance/stranger.
Partner perpetrator	In NorAQ, the perpetrator(s) is reported to belong to one or more of the following categories: 1) former partner 2) present partner
Violent behaviour	The kind of violent behaviour as reported by victims. In analyses acts of sexual, physical, and/or emotional violence are considered

Previous studies and instruments used for the comparison of results in section 4.1.	
CBS	Controlling Behaviour Scale (Graham-Kevan and Archer, 2003). Instrument including the subscale "isolating control" which was used in the study by Lövestad and Krantz (2012) to measure controlling behaviour by an intimate partner.
CTS2	The revised Conflict Tactic Scale (Straus, Hamby et al. 1996). One of the most established instruments to measure intimate partner violence in the U.S. Instrument includes the "physical assault" and "sexual coercion" subscales which were used in the study by Lövestad and Krantz (2012) to measure physical and sexual violence by an intimate partner.
Lövestad study	Refers to the study on intimate partner violence against men and women by Lövestad and Krantz (2012). Uses CTS2 and the CBS.
NCK study	NCK refers to Nationellt Centrum for Kvinnofrid (The National Centre for Knowledge on Men's Violence Against women). NCK study refers to the study about exposure to physical, sexual and emotional violence among men and women in Sweden presented by NCK in 2014.
Extended NTU	NTU refers to Nationella Trygghetsundersökningen (the Swedish Crime Survey), published annually by the Swedish National Council for Crime Prevention (BRÅ). Extended NTU refers to the section added in 2012, focusing on intimate partner violence (National Council for Crime Prevention, 2014a).
Nybergh study	Refers to the study about intimate partner violence among men and women in Sweden by Nybergh, Taft, Enander and Krantz (2013a) Uses the WAVI
VAWI	World Health Organization Violence Against Women Inventory (García-Moreno, Jansen, Ellsberg et al., 2005). Used to measure physical, psychological and sexual violence by an intimate partner in the study by Nybergh, Taft, Enander and Krantz (2013).

Note: Items used to measure violence in each instrument can be found in table 2, page 28-29.

INTRODUCTION

Interpersonal violence is prevalent and associated with psychological and physical ill-health among victims. Historically, studies concerning interpersonal violence have to a large extent been conducted in isolation from each other in diverse fields of, for example, childhood abuse, intimate partner violence and sexual violence. Recently however, there has been a growing understanding that different kinds of violence can be interrelated and that many victims of violence have experienced more than one kind of violent behaviour (e.g., physical, sexual, emotional) as well as violence from more than one kind of perpetrator (e.g., family member, intimate partner, acquaintance, stranger). Co-occurrence of violence has in some studies been reported to have a stronger association with psychological and physical ill-health than any single form of victimization alone. In this thesis I examine the co-occurrence of interpersonal violence among adult men and women in Sweden.

Different kinds of interpersonal violence need to be understood in light of each other. The most important reason for using an integrated approach in research on interpersonal violence is that the result more closely reflects the experiences of victims than when only a single kind of violence is considered. To more accurately understand how violence affects people's lives and to find strategies to counteract interpersonal violence, as well as help victims within the health care system, there is a need to learn more about how different kinds of violence are interconnected. Gender is also an essential factor. Not only are men and women subjected to partly different kinds of violence, gender also influences both the experience and the perception of violence. Hence, a gender perspective needs to be integrated into research concerning interpersonal violence.

Also, even though strong associations between interpersonal violence and different kinds of psychological and physical ill-health have repeatedly been found, only a minority of victims have told health care professionals about their victimization. Less is known about male than female victims' health care encounters, but it is known that the help-seeking process is gendered. Therefore, male victims' process of disclosing victimization to health care professionals is investigated in this thesis.

The term violence is elusive: it is difficult to define what it entails. As a consequence, there are considerable methodological and conceptual challenges within the research field, many of which pertain to the perspective taken in different research projects. Hence, before elaborating on previous research within the field (section 1.5) and what has been researched in this thesis (section 2 and forward); I will introduce my epistemological assumptions (section 1.1) and outline some difficulties in conceptualizing violence (1.2). This will be followed by an introduction to the theoretical framework that has guided my work (1.3) and an overview of some of the methodological challenges in researching violence (1.4).

BACKGROUND

1.1 EPISTEMOLOGICAL ASSUMPTIONS

Epistemology is the study of knowledge. It asks questions such as what is knowledge and how can we acquire it? Medical sciences are historically rooted in positivism and its more modern version logical positivism in which the ideal is to describe and explain reality in an objective way (Birkler, 2008). The goal is to reach an informed, unbiased decision about a theory's merits by objectively justifying the theory through comparing and testing it against reality (Okasha, 2002). In order to discover true knowledge the knower must be objective, i.e., detached from the subject of study because if a particular point of view or attachment to a certain belief is taken, this is believed to introduce a bias in studies (Wylie, Potter and Bauschspies, 2010). Among others, feminist scholars have questioned this view, claiming that it is neither possible, nor desirable, to acquire this kind of objectivity. Instead, the perspective and position of the scientist are understood as important elements of the production of knowledge (Wylie et al., 2010). In 1988 Donna Haraway introduced the concept 'situated knowledge' which positions knowledge as constructed and interpreted in a specific cultural setting. Haraway rejects the traditional idea of objective knowledge as an impartial view-from-nowhere and suggests that all knowers have a perspective (Haraway, 1988). Situated knowledge recognizes that people may understand the same object of study in different ways, depending on their relation to it. For example, beliefs about an object or a situation are created depending on the background beliefs and experiences of the knower (Anderson, 2011). It is therefore argued by feminist scholars that acknowledging the researcher's position makes research transparent and enhances its validity and quality (Skeggs, 1997; Wylie et al., 2010).

I am a physician, and as such I have been educated within a logical positivistic tradition. In this thesis I use descriptive and deductive hypothesis-driven methods in the first three studies, methods rooted in logical positivism. Despite this, and largely as a consequence of writing this thesis, I find the feminist, constructivist research paradigm more appealing. As researchers adhering to constructivism often seek to explore how reality is constructed and understood in specific contexts rather than to examine the universality of a phenomenon, they often use qualitative methods in research. However, to understand constructivism as synonymous with qualitative methods is a misperception (Miller, Kulkarni and Kushner, 2006). Rather, quantitative methods can be essential for constructivist researchers and the constructivist perspective can be of value for quantitative hypothesis-driven knowledge. For example, in-depth interviews can help us understand phenomena whose magnitude can be explored using quantitative methods (Miller et al., 2006; Hester and Donovan, 2009). I agree with those suggesting that all research methods have limitations, and thus neither quantitative nor qualitative methods should be prioritized. Instead, using a diversity of methods, which have been chosen dependent on the research question, is of value to help us acquire better knowledge about a greater range of research questions (McHugh, Livingston and Ford, 2005; Miller et al., 2006). Though my epistemological assumption does not necessarily affect my choice of method it affects how I interpret the results of my studies. I do not claim that the studies in this thesis unravel *the true* prevalence rates and *true* associations between different kinds of violence or the *true* association between violence and symptoms of psychological ill-health. Rather, I claim to present *one perspective on* these matters. In this case, a perspective rooted in the victim's experiences, but filtered through my own perceptions and values. Likewise, many of the

studies that I will refer to in this thesis build upon a positivist research paradigm and traditionally positivistic research methods. Hence, I want to emphasise that using a constructivist epistemology does not mean rejecting all knowledge created with other perspectives. However, it does mean, in the words of Haraway, remembering the "embodied nature of all vision". This means that all studies have a perspective, whether explicitly stated or not (Haraway, 2008). One way of clarifying what perspective is used in research and to better understand the knowledge gained is to carefully scrutinize the methods used by myself and others to construct knowledge.

My agreeing with Haraway's thinking, that all knowledge is constructed and situated is largely founded in the experience of researching violence. I find that the logical positivistic assumption of a universal truth that can be discovered by an objective researcher is contradicted by practice. As I will examine in more depth in the next section (1.2), there is no universal truth as to how violence should be defined. Rather, the concept of violence and what it constitutes is socially constructed and understood differently between different individuals (Muehlenhard and Kimes, 1999). There are discrepancies between researchers' and respondents' ways of understanding what constitutes violence (Muehlenhard and Kimes, 1999; McHugh et al., 2005). Also, the individuals involved in an act of violence can interpret what happened in different ways. For example, within the field of intimate partner violence, both partners within a relationship have often been found to disagree on what constitutes violence and how prevalent it is in their relationship. The reasons for this can of course be multifaceted but it has been suggested that the individuals construct and remember what happened to them in different ways (Muehlenhard and Kimes, 1999; McHugh et al., 2005). The individual's experience and understanding of victimization and/or perpetration is filtered through previous experiences as well as factors such as gender, sexual orientation, ethnicity, culture and social class (Follingstad and Ryan, 2013). Such factors will also influence the researcher's position and understanding of what violence is. American social psychologist Maureen McHugh argues that the researchers' conceptual and methodological perspectives will largely influence what they find. She illustrates this with the famous proverb about the blind men examining an elephant. The man positioned at the tail cannot comprehend what the trunk is any more than the man standing at the trunk can comprehend the tail (McHugh, 2005).

When feminist scholars view knowledge as something that we construct, and that is dependent on social interactions with others they also reveal that the production of knowledge has ethical dimensions. For example, as researchers, we decide which areas are of interest to study and which are not (Skeggs, 1997; Grasswick, 2013). The choice pf perspective is another ethical consideration. For example, violence is understood differently by different researchers, and also differently by victims, perpetrators and bystanders as well as by representatives of the legal system, health care professionals and social workers, so decisions have to be taken as to what perspective should be used (McHugh, Rakowski and Swiderski, 2013). In this thesis the victim's perspective is prioritized. This can be seen in that I have only investigated experiences of victimization, and not perpetration of violence. Also, the instrument used to measure violence in this thesis has been validated using victims' accounts of their experiences as the gold standard. However, how I interpret and understand the data acquired within the thesis is filtered through my own experiences and position as a never victimized, white, middle-class, Swedish female physician. I do have some limited experience of meeting victims of violence in my clinical work but my main source of knowledge comes from theoretical and empirical work and discussions with my co-workers.

In the process of working on this thesis a multitude of decisions have been made that have affected the knowledge produced. The first choices were made already before I was included in the project, by the researchers constructing the instrument used. They made basic choices about what questions to include and not include. My handling of the data required that I made choices concerning what variables to include and not include, and how to handle variables, for example, the choice about whether variables should be merged or dichotomized. But my thesis has been shaped most by my theoretical standpoints and interests. My interest in the field of violence originated from an interest in women subjected to intimate partner violence. As the work progressed, my interest in the co-occurrence of violence as well as the gendered nature of violence grew, and the importance of these themes is now the main focus of this thesis. As the title implies, I find there is a need for an integrated approach in the field of research on interpersonal violence. Different kinds of interpersonal violence need to be understood in light of each other. The sociocultural context of victims and perpetrators needs to be integrated in the understanding of interpersonal violence, as does the gendered experience of violence. However, my original interest in intimate partner violence has, as will become evident, greatly influenced my work. Though I do not claim that my account of intimate partner violence is comprehensive, most of the theories and examples concerning interpersonal violence given in the thesis come from that field of research. Theoretical perspective of childhood abuse is considered to some extent, mainly through theories of poly-victimization. However, community violence is only briefly touched upon, and elder abuse as well as neglect and witnessing violence are virtually absent. The same can be said for online specific manifestations of violence as well as a series of other potentially important kinds of violence. My thesis is limited to a Western perspective, with theories and examples rooted in Europe, Australia and North America. Violence occurring in war or that is guided by political, racial, religious or other motives cannot be distinguished within the data. Also, abuse in health care is a specific form of violence which is included in the first study of this thesis, but not in the subsequent three nor in the introductory summary chapters. That is not because I do not find it important, but it was not my main focus of interest. Two other recent theses as well as a series of scientific papers have explored the topic of abuse in health care (Brüggemann, 2012; Zbikowski, 2014). Hence, in this thesis I offer only glimpses of the integrated approach I call upon, but these glimpses all underline the need for more integrative perspectives in research on interpersonal violence.

1.2 THE ELUSIVENESS OF THE TERM 'VIOLENCE'

1.2.1 PROBLEMS OF DEFINING VIOLENCE

There is no universal definition of the term 'violence' (Hamby, 2005; McHugh et al., 2013; Woodin, Sotskova and O'Leary, 2013). Elisabeth A. Stanko was the director of the Economic and Social Research Council's five-year-long Violence Research Program in the United Kingdom. She made the following remark in an article about lessons learned from the program (Stanko, 2006)

"Our internal debates often retuned to trying to come up with a definition of what violence means, justifying one position or another through the voices of those many research participants. […] Violence as a term is ambiguous and its usage is in many ways moulded by different people, as well as by different social scientists, describing a whole range of events, feelings and harm. What violence means is and will always be fluid." (Stanko 2006:552)

Despite the impossible mission, it is however essential to find a way of defining or at least operationalizing violence, if one wants to study this elusive phenomenon. As stated previously, the researcher's conceptualization of violence will affect research results, and consequently may also affect interventions in health care, in a judicial setting, or elsewhere (Follingstad and Rogers, 2013; Woodin et al., 2013).

The World Health Organization (WHO) defines violence in the following way:

"the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation." (Krug et al., 2002:5)

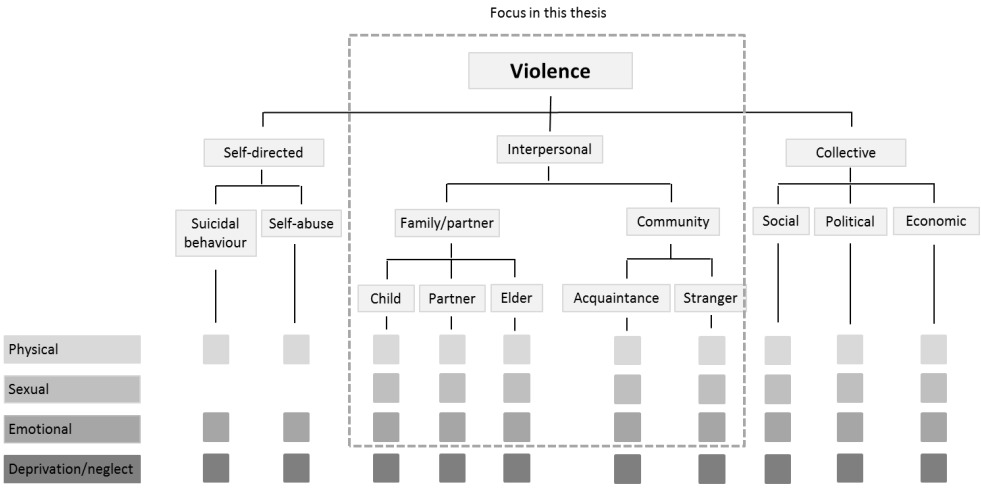
By including the word 'power' in addition to 'physical force' the WHO intended to make the definition of what constitutes violence broader than the conventional understanding of violence as a physical act. In their definition they include acts resulting from a power relationship, and state that "the use of physical force or power" should be understood as including neglect and all types of physical, sexual and psychological violence. The WHO have also created a typology of violence that makes distinctions between four types of violent behaviours (physical, sexual, psychological and deprivation/neglect) as well as between three groups of violence depending on the victim-perpetrator relationship: interpersonal violence (family/partner and community), self-directed violence (self-abuse and suicide) and collective violence (social, political and economic violence by a larger group of individuals)(Krug, Dahlberg, Mercy et al., 2002)(Figure 1, page 8). However, it is important to remember that the separation of violence into different kinds of behaviours is arbitrary and often done for the purposes of research. Many victims of violence report experiences of several different kinds of violence and it is often difficult to make meaningful distinctions between them (Hamby and Grych, 2013; Hamby, 2014a).

One problem with the WHO definition is the use of the word 'intentional'. It is a word that intuitively might seem reasonable to include, but may be argued to give the perpetrator the privilege of defining what violence is, because only he or she knowns the intention behind his/hers action. However, excluding the word is also problematic because there are many situations where intention makes all the difference. For example, spilling a cup of tea on somebody can hardly be considered as

an act of violence, while on the other hand intentionally pouring hot water on someone is likely to be considered an act of violence by many.

The WHO has also chosen to define violence in relation to its (potential) consequences. This choice is motivated by acknowledging violence as socially constructed. They argue that because hitting a spouse may be regarded in some cultures as an acceptable social practice rather than as violence, it is important to relate the definition to the health or well-being of individuals rather than to the intent to use violence. They also acknowledge that the potential consequences reach far beyond injury and death to include also physical, psychological and social problems that can be immediate or latent and last for a long time after violence has occurred (Krug et al., 2002).

Figure 1. WHO typology of violence (Krug et al., 2002)



1.2.2 OPERATIONALIZATION OF VIOLENCE IN THIS THESIS

The conceptualization of violence used in this thesis is made tangible through the operationalization of violence in the instrument used, the NorVold Abuse Questionnaire (NorAQ). To make visible what is included and excluded in NorAQ I use the WHO definition and typology of violence as a point of reference.

NorAQ was originally developed to estimate the self-reported exposure to sexual, physical and emotional violence as well as abuse in health care in a Nordic study of violence against women (Wijma, Schei, Swahnberg et al., 2003). Later a male version (m-NorAQ) of the questionnaire was developed (Swahnberg, 2011). Only sex-specific words differ between the two questionnaires and both will henceforth be referred to as NorAQ. The question used to operationalise violence in NorAQ can be found in table 1, page 9.

Table 1. Questions about violence in the NorVold Abuse Questionnaire (NorAQ).

EMOTIONAL VIOLENCE	
Mild	Have you experienced anybody systematically and for a long period trying to repress, degrade or humiliate you?
Moderate	Have you experienced anybody systematically and by threat or force trying to limit your contacts with others or totally control what you may and may not do?
Severe	Have you experienced living in fear because somebody systematically and for a long period has threatened you or somebody close to you?
PHYSICAL VIOLENCE	
Mild	Have you experienced anybody hitting you, smacking your face or holding you firmly against your will?
Moderate	Have you experienced anybody hitting you with his/her fist(s) or with a hard object, kicking you, pushing you violently, giving you a beating, thrashing you or doing anything similar to you?
Severe	Have you experienced anybody threatening your life by, for instance, trying to strangle you, showing a weapon or knife, or by any other similar act?
SEXUAL VIOLENCE	
Mild	Has anybody against your will touched parts of your body other than the genitals in a 'sexual way' or forced you to touch other parts of his or her body in a 'sexual way'?
Mild (sexual humiliation)	Have you in any other way been sexually humiliated; e.g. by being forced to watch a pornographic movie or similar against your will, forced to participate in a pornographic movie or similar, forced to show your body naked or forced to watch when somebody else showed his/her body naked?
Moderate	Has anybody against your will touched your genitals, used your body to satisfy him/herself sexually or forced you to touch anybody else's genitals?
Severe	Has anybody against your will put his penis into your vagina, mouth or rectum or tried any of the following: inserted or tried to insert an object or other part of the body into your vagina, mouth or rectum?

Note: The word 'vagina' has been omitted from the male version of NorAQ. Also questions about experiences of abuse in health care are included in NorAQ but have been omitted here. They can be found in the first article of the thesis, which is the only one including experiences of abuse in health care.

NorAQ has been validated both in a male and female sample using an interview as the gold standard (Swahnberg and Wijma, 2003; Swahnberg, 2011). When using this procedure, the victims' own accounts and definitions of their experiences become the reference and hence they are the foundation for the conceptualization of violence in this thesis. Perpetrators and bystanders might have a different opinion of what happened. In line with the WHO definition, NorAQ includes acts of physical, sexual and emotional violence. In contrast to the WHO definition however, neglect and deprivation are not included in NorAQ. The data is also focused on interpersonal violence. Though self-directed and collective violence are not explicitly mentioned, it is however possible that some respondents have included experiences of such violence when responding to NorAQ. Also, the WHO distinguishes between childhood abuse, intimate partner violence and violence against elders. NorAQ distinguishes between violence occurring in childhood (<18 years), adulthood (≥18 years) or both, but cannot distinguish violence against elders.

I sympathize with the inclusive nature of the WHO definition of violence. However, the negative side of such a wide definition is that it has the risk of including too many behaviours. If every insult is considered an act of violence, even if it is rather mild and an isolated incident, it may lead to the term 'violence' being diluted and losing its value. In NorAQ, efforts have been made not to be too inclusive in the conceptualization of violence. This is especially evident in the questions concerning emotional violence where the words 'systematically' and 'for a long period' are used as prerequisites for victimization. Likewise, when NorAQ was validated it was found that the question covering mild physical violence was too wide; informants tended not to consider this kind of behaviour as abusive. For this reason those experiencing only mild and not moderate or severe physical violence are considered as non-victims of physical violence in studies II-III of this thesis. Another way of filtering out more severe kinds of violence used in NorAQ is the use of a follow-up question concerning whether victims suffer today as a consequence of the violence they have endured. However, it is possible to report no current suffering but still have previously suffered greatly as a consequence of violence. The level of suffering is only considered in study I of this thesis.

In contrast to the WHO definition, NorAQ does not include intention of the act in any of the items. Rather, as is standard within the research field, NorAQ asks questions about the specific behaviours of a perpetrator. Consequence is only included in the definition of severe emotional violence where respondents are asked if they have experienced *living in fear* because someone threatened them.

1.2.3 PROBLEMS OF LABELS IN RESEARCH ON INTERPERSONAL VIOLENCE

Related to the problems of defining violence is the problem of labelling violence. Many terms have been used, sometimes interchangeably for the same concept and sometimes meaning different things. It is also difficult to label the involved individuals. How a concept is labelled and constructed will affect how researchers understand it and interpret the data. It will also affect research subjects since the wording we use will direct memory and impact the informant's construction of his/her experiences (McHugh et al., 2005).

Violence – Abuse

The terms 'violence' and 'abuse' are sometimes used interchangeably and sometimes used differently to refer to qualitatively different kinds of violence. For example, concerning intimate partner violence, some argue for an *inclusive* labelling of violence, meaning that all acts of physical violence within an intimate partner relationship should be called 'abuse' or 'battering'. The major

argument for this stand is that differentiating between acts of violence can promote a perception of tolerance for violence. Others argue that labelling all experiences of violence in the same way tends to trivialize what victims of the most severe forms of violence have experienced. They argue for a *differentiating* approach, i.e. saving labels such as 'battering' and 'abuse' for more severe acts of violence (Hamby and Gray-Little, 2000; Woodin et al., 2013).

In NorAQ the Swedish word 'övergrepp' is used, which is closer to the term 'abuse' than the term 'violence'. Also, in the validation of NorAQ, informants were asked about experiences of different kinds of abuse. 'Abuse' is the term used in the first article of this thesis, in line with other publications using NorAQ (Wijma et al., 2003; Swahnberg, Wijma, Schei et al., 2004; Swahnberg, Hearn and Wijma, 2009). However, in study II-IV as well as in the introductory summary chapter I have chosen to use the term 'violence' rather than 'abuse'. I concur with the reasoning described in the previous paragraph and want to save the term 'abuse' for more severe acts of violence; hence though all acts of abuse may be labelled violence, I find that all acts of violence should not be labelled abuse. The questions in NorAQ have been labelled mild, moderate and severe. This is however arbitrary, the severity of a violent behaviour is dependent on the context. An action called "mild" in NorAQ can be very serious and definitely abusive in one context, and of little importance in another. Hence, I find there is a difference between the term violence and abuse, but this difference is elusive and cannot be distinguished when using NorAQ. Though the terms overlap substantially and the choice is far from obvious I have chosen to use the term 'violence' in this thesis. However, when referring to violence in childhood perpetrated by parents or other adults I use the more common term 'childhood abuse', not 'childhood violence'.

It can also be noted that in a data collection using NorAQ, conducted in 2012 the term "abuse" was substituted with "violence". The prevalence rates of sexual, physical and emotional violence in that data collection are almost identical to the data presented in this thesis, where "abuse" has been used in data collections. Hence, the difference does not seem to be of great importance for respondents.

One set-back to using the term 'violence' can be the intuitive connection made by many that violence equals *physical* violence. In line with the WHO definition I include physical, sexual and emotional violence in the term.

Emotional violence – Psychological violence – Controlling behaviours

There is no consensus on how to label non-physical violence and also different terms have been used for much the same phenomenon. The WHO uses the term '*psychological*' while the term '*emotional*' is used in NorAQ. The meaning of emotional violence is even more elusive than the terms 'sexual violence' and 'physical violence' and may entail very different things for different persons as well as in different research projects. Also, the meaning of 'emotional violence' has recently been found to vary substantially between the sexes (McHugh et al., 2013). I will return to some of the ambiguities with the term in section 1.4.4.

Controlling behaviour is often understood as an important aspect of intimate partner violence. Aspects of controlling behaviours are sometimes included in measures of emotional violence (which is the case in NorAQ), and sometimes not. There are also specific instruments intended to measure controlling behaviour as distinct from emotional/psychological violence.

Throughout this thesis the terms 'emotional violence', 'emotional abuse', 'psychological violence' and 'psychological abuse' are used synonymously. Controlling behaviour is considered an aspect of emotional violence and is included in the term, if not explicitly stated otherwise.

Co-occurrence of violence – cumulative violence – re-victimization – poly-victimization

Because studies on the co-occurrence of violence have evolved from different times and fields, the terminology is not established and many terms have been used to describe the co-occurrence of violence. Two of the most commonly used terms are 're-victimization' (patterns of victimization across time, often repeat experience of one kind of violent behaviour such as physical violence or sexual violence) and 'poly-victimization' (patterns of victimization across types of violence, when first introduced reporting 4 or more experiences of violence in the previous year) (Hamby and Grych, 2013). Because neither of these terms fits with what has been investigated in this thesis I chose to use the term 'cumulative violence' in study III. This term refers to reporting experiences of more than one kind of violent behaviour (sexual, physical, emotional) or violence from more than one kind of perpetrator (family, partner, acquaintance/stranger).

The term 'co-occurrence of violence' is used as a bonding term for all possible kinds of overlaps of violence, i.e., both different kinds of violent behaviours as well as victimization in different time frames and by different perpetrators.

Victim – Perpetrator

There are difficulties with the term 'victim'. Violence is often assumed to be perpetrated by a perpetrator against a victim, excluding the possibility of bi-directional violence. However, the distinction between victim and perpetrator may not be so straightforward. Many victims of violence are perpetrators of violence in a different context. Also, many violent incidents are bidirectional, which calls into question the use of labels such as 'victim' and 'perpetrator' (McHugh et al., 2005; Hamby and Grych, 2013; Woodin et al., 2013; Hamby, 2014a). Labels also tend to represent a single dimension of an individual, which is problematic because again, how we name a phenomenon will affect how we understand it (McHugh et al., 2005). Many individuals who have experienced acts of violence reject labels such as 'victim', 'abused' or 'battered' (Hamby and Gray-Little, 2000).

In this thesis, only victimization has been examined, not perpetration of violence. In the absence of a better alternative I use the terms 'victim' and 'perpetrator' throughout this thesis.

Family violence – Domestic violence – Intimate Partner Violence

These terms are sometimes used interchangeably in the literature and sometimes they refer to violence in different relational contexts. 'Family violence' is generally understood as violence between different family members, i.e. between intimate partners and between parents and children. 'Intimate partner violence' is restricted to violence between intimate partners while 'domestic violence' is sometimes used as a synonym for family violence and sometimes as a synonym for intimate partner violence.

Though the words 'domestic' and 'intimate' may be interpreted as referring to an ongoing relationship, much violence is perpetrated by former partners and both the terms 'domestic' and 'intimate' concern ongoing as well as previous relationships (Langhinrichsen-Rohling, 2010).

To make the situation even more complex, it has become increasingly clear that there are qualitatively distinct forms of intimate partner violence (Smith, Thornton, Devellis et al., 2002; Langhinrichsen-Rohling, 2010; Woodin et al., 2013). For example, Smith and colleagues distinguish between intimate partner violence and battering, claiming the latter to be characterized by its chronicity rather than the specific acts of physical violence (Smith et al., 2002). They define battering as *"a process whereby one member of an intimate relationship experiences vulnerability, loss of power and control and entrapment as a consequence of the other member's exercise of power through the patterned use of physical, sexual, psychological and/or moral force"* (Smith et al., 1999:186). This then stands in contrast to intimate partner violence, when defined as every act of physical violence within an intimate partnership, even if it is a single, isolated act.

In a similar fashion, the American professor of sociology, Michael P. Johnson, makes distinctions between different kinds of intimate partner violence depending on the presence of controlling behaviours (Johnson, 2006, 2008). The two major kinds are situational couple violence and intimate terrorism. Situational couple violence refers to violence perpetrated as a way of solving conflicts in a couple where none of the parties try to control the other. Intimate terrorism on the other hand refers to a pattern of controlling and manipulative behaviours within a relationship where one partner uses physical violence, intimidation and isolation to gain a general control over the other partner (Johnson, 2006). Though situational couple violence can entail severe physical violence, generally the physical violence conducted within a relationship characterized by intimate terrorism is more severe (Johnson, 2008). Intimate terrorism is nearly identical to coercive control. In the latter, the role of physical violence is, however, somewhat downplayed. Rather, the critical element in coercive control is isolation of the victim, as well as exploitation and micro regulation of their everyday life (Stark, 2006). It is emphasised that both coercive control and intimate terrorism is mainly perpetrated by men towards women and is rooted in gender inequality in society (Stark, 2006; Johnson, 2008).

Some question the idea of distinct types of intimate partner violence and suggest that the degree of violence should rather be considered as a continuum where intimate terrorism is the most extreme form (Frieze, 2005).

In this thesis I used the term 'family violence' when the perpetrator is reported to be a parent, step-parent and/or sibling. Though NorAQ does include some sorts of controlling behaviour and separates between mild and severe acts of violence, it does not allow us to characterize violence as situational couple violence, intimate terrorism, coercive control or battering. Therefore I use 'intimate partner violence' for all violence reported to be perpetrated by a former or current partner.

1.3 THEORETICAL FRAMEWORK

1.3.1 CO-OCCURRENCE OF VIOLENCE

Recently, there has been a growing understanding that different kinds of violence co-occur (Scott-Storey, 2011; Hamby and Grych, 2013; Woodin et al., 2013). Some links have been thoroughly investigated and have been well-known for some time. Examples of this are the associations found between sexual violence in childhood and adulthood (Messman-Moore and Long, 2003) as well as childhood abuse and intimate partner violence (Coid, Petruckevitch, Feder et al., 2001; Desai, Arias, Thompson and Basile, 2002; Whitfield, Anda, Dube and Felitti, 2003; Rich, Gidycz, Warkentin et al., 2005; McKinney, Caetano, Ramisetty-Mikler and Nelson, 2009; Renner and Whitney, 2012). Also, associations between witnessing interparental violence as a child and as an adult being exposed to intimate partner violence has been found (Ehrensaft, Cohen, Brown et al., 2003). Children who are exposed to one kind of abuse are also often the victims of another kind (Finkelhor, Turner, Ormrod and Hamby, 2009; Gilbert, Widom, Browne et al., 2009; Annerback, Sahlqvist, Svedin et al., 2012). Some even suggest that almost all kinds of interpersonal violence are interrelated, though naturally with stronger links between some kinds than between others (Hamby and Grych, 2013). American professors of psychology Sherry Hamby and John Grych have even suggested that co-occurrence of violence is the norm rather than the exception (Hamby and Grych, 2013). Despite this, much research concerning interpersonal violence continues to be specialized into fields of, for example, intimate partner violence, childhood abuse, sexual violence, bullying, criminal offences and so forth. This is not surprising given the vast amount of research conducted in each field, but this compartmentalization can be problematic. When prior victimization is not considered this might hamper our understanding of the origin as well as the consequences of both victimization and perpetration of interpersonal violence (Hamby, 2005; Stanko, 2006; Grych and Swan, 2012; Hamby and Grych, 2013; Hamby, 2014a).

Re-victimization

Re-victimization refers to experiences of victimization in different time periods, generally over developmental periods such as childhood and adulthood or childhood and adolescences. In particular, the association between childhood abuse and/or witnessing parental violence and later being exposed to intimate partner violence has been examined. The concept of re-victimization first evolved in studies of sexual violence among women, where it was found that sexual abuse in childhood was strongly correlated to being raped as an adult (for a review of empirical findings and a theoretical framework see Messman-Moore & Long, 2003). Over time the field has evolved to include physical violence and to some extent emotional violence (Arata, 2000; Coid et al., 2001; Kimerling, Alvarez, Pavao et al., 2007; Widom, Czaja and Dutton, 2008; Parks, Kim, Day et al., 2011). Men are also sometimes included in studies (Widom et al., 2008; Aosved, Long and Voller, 2011). A graded relationship has been reported by some: the likelihood of experiencing rape and/or intimate partner violence is higher the more violence one has been exposed to as a child (Whitfield et al., 2003; Messman-Moore and Brown, 2004; Cloitre and Rosenberg, 2006).

Poly-victimization

The term poly-victimization was introduced by U.S. sociologist professors David Finkelhor, Richard Ormrod and Heather Turner concerning victimization of children and adolescents (Finkelhor, Ormrod and Turner, 2007a). Poly-victimization entails not only physical, sexual and emotional violence but also experiencing crimes such as robbery, and witnessing violence is included. It is based on the

number of violent experiences a victim has had in a specific timespan. Counting violent events in this way has turned out to be a strong predictor of subsequent victimization as well as poor health beyond what could be explained by the individual types of victimization (Finkelhor et al., 2007a; Finkelhor, Ormrod and Turner, 2007b). How the term poly-victimization is used varies. When first introduced it was used both as a continuous variable (including the number of violent experiences in a year) and as dichotomous variable (with children reporting four or more kinds of victimization in a year referred to as poly-victims) (Finkelhor et al., 2007a). The term has also been used to include all victims reporting more than one experience of victimization in their lifetime, and it has been used for both children and adults (Hamby and Grych, 2013).

When introducing the concept poly-victimization, it was theorised that violence should not be considered as isolated, specific events. Rather, many victims have been found to live in a 'violent condition' (Finkelhor et al., 2007a). For poly-victims compared to other victimized children, more people and more environments are associated with traumatic reminders. When multiple stressors accumulate this may lead to more severe and less reversible consequences for victims. Self-blame has been suggested to be an important component of traumatization, and when a person is victimized in multiple ways by different people it may be more difficult to resist negative self-attribution, leading to a more severe traumatization than if victimized only once (Finkelhor et al., 2007a). Pathways that are proposed to lead to poly-victimization includes: 1) living in a dangerous family (e.g., reporting frequent arguments between children and adults, having been subjected to physical or emotional violence at home or having witnessed violence between caregivers towards a siblings), 2) living in a dangerous community (e.g., violence in school or in the neighbourhood), 3) having a family environment characterized by multiple problems (e.g., financial problems and other stressors) and 4) having emotional problems that limit the ability to protect oneself (Finkelhor, Ormrod, Turner and Holt, 2009).

1.3.2 ECOLOGICAL MODEL

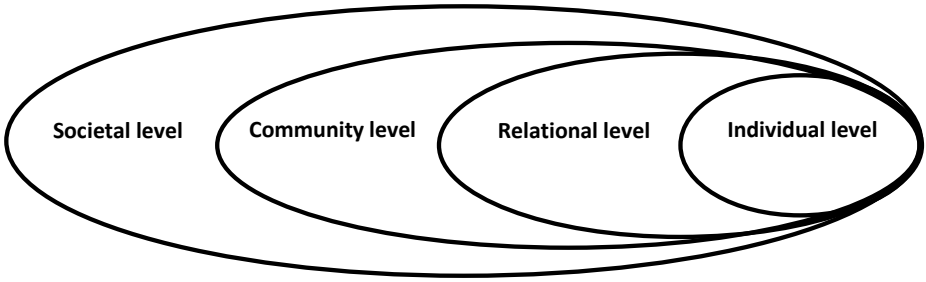
Interpersonal violence does not occur in a sociocultural vacuum. Context is important both for the experience and perception of interpersonal violence (Stanko, 2006).

Within ecological theory, people's experiences and behaviours are understood in a context where intersecting levels of an ecological system are considered to affect them (Bronfenbrenner, 1986). On the individual (ontogenic) level, factors internal to the individual are considered (e.g., personal characteristics and experiences). Interactions between the individual and his/her immediate context, for example family and friends are considered on the relational (microsystem) level. The formal and informal environments in which the person lives, including work, neighbourhood and social networks, are considered on the community (exosystem) level. Finally; economic, societal and political factors as well as norms that permeate society at large are considered on the societal (macrosystem) level (Heise, 1998) (Figure 3, page 16).

The ecological model has been used for a long time to understand and conceptualize violence as a multifaceted phenomenon residing in a complex interplay between personal and sociocultural factors. In 1998 Lori Heise used it as a practical tool to gain a better understanding of the origins of violence (Heise, 1998). She recognized that feminist scholars claiming patriarchy as the etiology of violence perpetrated against women could not explain why some men perpetrate violence and other do not. On the other hand, theories based on personal factors such as alcohol abuse, personality

disorders or stress did not adequately explain why violence to such a large extent was perpetrated by men against women. Heise used the ecological model to analyse how both societal and personal level factors interact to gain an understanding of why violence against women occurs. It can be difficult to identify the level in the model at which a specific factor should be placed. However, the value of the model lies not primarily in identifying at what level a specific risk or protective factor lies. Rather the model's value lies in illustrating how factors on the same and different levels interact, and that a specific risk or protective factor can operate in multiple layers of the model.

Figure 2. The ecological model (Bronfenbrenner, 1986; Heise, 1998)



Within the ecological model it is recognized that qualities of the individual interact with situational factors as well as cultural factors to make violence more or less likely to occur at a specific time. To understand violence, it is important to consider the specificities of the relationship in which violence occurs, as well as the specific stressors and cultural context in which the violence is embedded (McHugh et al., 2005). Hence, though cultural factors such as asymmetric power relations between the sexes are important, patriarchy alone cannot explain interpersonal violence, not even intimate partner violence perpetrated by men against women. In this thesis I use the ecological model as a theoretical tool for understanding violence against both men and women. One of the benefits of this is that the understanding of violence includes gender and gender relations but is not restricted to an understanding of violence as an expression of male dominance. It also underlines that gender is essential for the understanding of all kinds of violence, including male-to-male violence and violence perpetrated by women.

One of the strongest risk factor for a specific kind of violence is exposure to other kinds of violence (Hamby and Grych, 2013). Already in Heise's ecological model published almost two decades ago, a need to integrate knowledge about different kinds of violent behaviours within the same framework was emphasised. Also, the one factor on the ontogenic level that Heise found to be consistently related to victimization among adult women was witnessing violence between parents or caregivers in childhood (Heise, 1998). This underlines the importance of considering the co-occurrence of violence; both for understanding why violence occurs and what the consequence of violence are for victims.

1.3.3 GENDER

Defining gender

Throughout this thesis, gender is understood as relational social practices within our daily life. Social practices which references our bodies but are not reduced to our bodies (Connell, 1995; Connell, 2009). U.S. feminist theorists Candace West and Don H. Zimmerman introduced the concept 'doing gender' which they identified as a routine activity embedded in everyday interaction (West and Zimmerman, 1987). Gender is a situated social practice, i.e., it is constructed and reconstructed dependent on cultural context, and constantly changes (Connell, 1995). Though we construct our own gender, we are strongly guided by gendered patterns in society and our actions reinforce those same patterns. Gender patterns do not determine our actions but they define possible actions and consequences of actions (Connell, 2009).

Gender relations

Australian sociologist Raewyn Connell argues for a plurality of masculinities that relate to each other in a hierarchy (Connell, 1995; Connell and Messerschmidt, 2005). Placed at the top is *hegemonic masculinity*, i.e., practices of masculinities that are more socially idealised and associated with social power than others. For example sports stars or businessmen can enact hegemonic masculinity in a specific setting. Hegemonic masculinity is local in the sense that it varies with time and cultural context and hence does not have a fixed character (Connell, 1995). Hegemonic masculinity is not the most prevalent practice of masculinity, but it is normative and requires men to position themselves in relation to it. It is not physical force that maintains hegemonic masculinity but rather cultural consent and delegitimation of alternative practices (Connell and Messerschmidt, 2005). Though most men do not fully practice hegemonic masculinity, most men benefit from it because of the general advantages men gain due to the subordination of women, which hegemonic masculinity helps sustain. Connell refers to this as complicit masculinity (Connell, 1995). The general advantages men gain can for example be money, authority, and higher access to institutionalised power. It should be noted that these gains fall on men as group; individual men can gain more than others, or nothing, depending on their social position (Connell, 2009). Hegemonic masculinity should be considered in relation to the subordination of other practices of masculinity. For example, homosexual men have often been placed at the bottom of the masculine hierarchy, because of practices of femininity.

Masculinity and femininity are constructed in relation to each other and hierarchal structures of gender relations can also be found among constructs of femininity. Hegemonic masculinity helps maintain women's subordinate position in relation to men on a societal level. However, it is not a simple, single pattern of power but rather an intricate interplay of social relations (Connell and Messerschmidt, 2005). We need to distinguish between social structure and individual men and women. Though men are structurally superordinate to women on a societal level, that does not mean all women are subordinate to all men (Gemzöe, 2013). And more specific to this thesis, though structural inequalities may promote men's use of violence against women *: "there is no simple causal relationship between the ideological framework of male supremacy and specific individual acts of intimate partner violence"* (Baker et al., 2013:186).

The term *homosociality* refers to a preference for the company of others of the same sex (Lipman-Blumen, 1975). Male homosociality is one way by which hierarchy between masculinities is

maintained and the position of hegemonic masculinity as a norm to which men are held accountable is ensured (Bird, 1996).

Further contributing to the complexity of gender relations is that they cannot be separated from other social structures such as ethnicity, class and sexuality (Connell, 1995). This perspective is referred to as *intersectionality*. Intersectionality is not about *adding* different structures of power to each other. Rather it is about understanding how different social structures *intra-act*, and how different social relations construct and transform each other (Lykke, 2005). For instance, femininity is not a homogenous category that relates to other social relations in a fixed way; rather, femininity is differently constructed in different classes and cultural contexts (Skeggs, 1997; Ambjörnsson, 2004; Brah and Phoenix, 2004).

Gender and interpersonal violence

The majority of physical interpersonal violence is perpetrated by men (Hamby, 2014a). Therefore the question of how masculinity causes physical violence is sometimes asked. Considering gender as a situated social practice means understanding gender rather as an outcome of social practice than as an individual characteristic that predicts behaviour. This view changes the question from how masculinity causes physical violence to how physical violence can be used to construct masculinity (Anderson, 2005). It has been suggested that some men use violence as a way of showing others that they are a 'real man', especially when their masculinity has been called into question. In intimate partner relationships, findings from qualitative research imply that male-to-female violence can sometimes be a response to a challenge the man perceives to his authority (Anderson, 2005). Also, much interpersonal physical violence among young men has been proposed to be an activity intended to impress an audience of peers (Connell, 1995). Socially, the practice of physical violence is understood as masculine, and while women and girls are often discouraged from use of force, men and boys may be encouraged to learn and participate in activities involving physical violence (for example in military training or in some sports) (Anderson, 2005).

The construction of violence as masculine influences the perception of violence. The same act of violence can be perceived in different ways depending on the perceived sex of the victim and perpetrator. The most obvious example of this is perhaps intimate partner violence. Male perpetration is considered serious while female perpetrators might not be seen as dangerous or be taken as seriously by the victim, perpetrator, bystanders or support systems (Anderson, 2005; Baker, Buick, Kim et al., 2013; McHugh et al., 2013). However, some men are subjected to serious violence from their (male and female) intimate partners (Hines and Douglas, 2010a, b) and the construction of victimization and perpetration of violence may be problematic for them. An example of this is that for a man to be labelled 'victim' by a female perpetrator may be threatening to his sense of masculinity (Anderson, 2005). Also, male victims of intimate partner violence by female partners are often reluctant to seek help because they are afraid of not being taken seriously, not being believed, or being seen as the main perpetrator of violence (Hines and Douglas, 2010a; Nybergh, 2014). Social reluctance to see women as perpetrators of violence is also found in the way female perpetrators of intimate partner violence are sometimes explained and understood as victims of previous violence, in childhood or in relation to partners. Male perpetrators on the other hand, are generally not understood this way, even though they might also have been the victims of previous violence. Our perceptions of gender influence how we perceive male and female victims and perpetrators of violence (McHugh et al., 2005)

Gender permeates all levels of the ecological model and is important both in direct interaction between individuals and on a societal level. One example of this, which is specifically relevant to intimate partner violence, is how we organize intimate relationships. For example the average man is taller than the average woman but there is a considerable overlap between the sexes that we tend not to notice. This is because, as a way of doing gender, intimate heterosexual relationships are often organized so that the man is taller than the woman (Anderson, 2005; Connell, 2009; Baker et al., 2013). Likewise the individual man in specific relationships is likely to earn more money than the woman, partly as a consequence of the gendered division of labour. This means that many men have both a physical and financial advantage over their female intimate partners, leaving women more vulnerable to intimate partner violence than men (Anderson, 2005). On a societal level, power imbalances with gender norms supporting male dominance in families and in some cases even men's use of violence against their female intimate partners, facilitate intimate partner violence against women (Baker et al., 2013). Also, ignoring gender when considering violence ignores the impact violence have on also those not directly exposed, such as fear of rape among many women (Muehlenhard and Kimes, 1999).

1.4 METHODOLOGICAL CHALLENGES

As described in sections 1.1 and 1.2 the conceptualization and perspective used when researching violence will greatly affect the results. Also, there are considerable methodological challenges within the field. Differences in definition, assumptions and methodology have created a situation where a diversity of prevalence rates is given for what is called the same phenomenon. For example the life-time prevalence rate of physical and/or sexual intimate partner violence among women in Sweden has in different studies been reported to be as diverse as 15% (National Board of Health and Welfare, 2014b), 24% (Nybergh et al., 2013a) and 27% (Lovestad and Krantz, 2012). Among men, the figures have been reported to be 8% (National Board of Health and Welfare, 2014b), 14% (Nybergh et al., 2013a) and 21% (Lovestad and Krantz, 2012). In this thesis I report figures of 10% for women and 3% for men. I only mention these prevalence rates here to point out the importance of definition and methodology in researching interpersonal violence. None of these numbers are necessarily more right than the others; they only represent different perspectives, definitions and methodologies that all have value. However, it is important to try to understand what kinds of differences in methodology and definitions that produce such discrepancies in results. I will return to the prevalence rates in more depth in section 1.5 and especially in section 4.1.1-4.1.2 with the aim of understanding more about what produces the differences found. However, it is first necessary to consider some known methodological challenges within the research field. Also it is important to remember that the conceptualization and methodology used in research will naturally not only affect the prevalence of violence but also the estimation of the co-occurrence of violence. Likewise, the association between exposure to violence and other factors, such as background characteristics and different measurements of ill-health, will be affected.

1.4.1 DEFINING, LABELLING AND OPERATIONALIZING VIOLENCE

Again, how we label concepts will affect research results. Using single items or sensitive wording like 'abuse' or 'rape' may lead to lower prevalence rates than using a description of events, which is generally recommended (Woodin et al., 2013). But using too detailed descriptions can lead to the risk of some behaviours/events not being reported because they are not included in the description. Also, using too many questions can lead to 'reporting load', meaning that respondents avoid reporting incidents because they want the interview to finish faster (Hamby, 2005).

Different instruments intended to measure the same constructs can produce different results depending on how questions are worded and framed. For example, when comparing three different instruments intended to measure physical intimate partner violence among women, Hamby and colleagues found that every third woman was classified as a non-victim on one or two scales while simultaneously being classified as a victim on the remaining scales (Hamby, Poindexter and GrayLittle, 1996). Another example of how using different instruments affects prevalence rates that is of specific interest to this thesis comes from a comparison of NorAQ and the WHO Violence Against Women Instrument (VAWI) carried out in Sweden (Nybergh, Taft and Krantz, 2012, 2013b). Because the focus of those studies was intimate partner violence, NorAQ was modified so that questions were asked specifically about partner violence rather than using the unspecific wording of the original version. The items used to measure violence in VAWI can be found in table 2, page 28-29. In that study, lower prevalence rates were found for physical, sexual and emotional violence by a partner for both men and women when using NorAQ compared to VAWI. However, the differences were only significant for emotional violence, both among men (VAWI=30.6% and NorAQ =10.2%)

and women (VAWI=17.1%, NorAQ =2.6%). The differences could largely be attributed to two items concerning milder forms of emotional violence on VAWI that did not have any corresponding item in NorAQ (Nybergh et al., 2012, 2013b). The large discrepancy between prevalence rates serves to illustrate that prevalence rates are largely dependent on the definitions and measurements used. Hence, prevalence rates always need to be accompanied by a clear statement of the operationalization used.

1.4.2 BEHAVIOURAL CHECKLISTS

The field of intimate partner violence has struggled with challenges concerning content and construct validity of survey instruments for a long time (Hamby, 2005; Follingstad and Rogers, 2013; Follingstad and Ryan, 2013; Woodin et al., 2013; Hamby, 2014a). One fundamental challenge is what kind of instruments should be used. The most frequently used are so-called behavioural checklists. Both VAWI and the most commonly used instrument in the U.S., the revised Conflict Tactic Scale (CTS2) (Straus, Hamby, Boney - MacCoy and Sugarman, 1996), are examples of this. They use statements about the partner's behaviours and ask respondents to declare whether, and if so at what frequency the behaviour occurred during the previous 12 months and earlier in life (e.g., My partner slapped me…). Both instruments also include corresponding questions about the respondents' own behaviours (e.g., I slapped my partner…). In contrast to this, NorAQ uses non-partner-specific questions (e.g., have you ever experienced someone… ?) and do not ask about respondents own perpetration of violence. After each category of violent behaviour (physical, sexual, emotional) a follow-up question is used to find out who the perpetrator was. This difference can be perceived as small but recent research has shown that it can have major effects on results. Hamby compared prevalence rates found when using the standard version of CTS2 (with partner-specific wording) to a modified version where the only difference was that the statements were non-perpetrator-specific. While using the standard version the prevalence rate of intimate partner violence victimization was 40% for men and 33% for women (which is in line with previous studies using CTS2). In the non-specific version, prevalence rates dropped to 24% for males and increased to 39% for women (Hamby, 2014b). The reason for these shifts in prevalence rates is suggested to be that women experience the most severe form of violence in intimate partnerships while men experience more severe community violence. Hence when using non-perpetrator-specific wording women focus on intimate partner violence and men tend to remember violence in other kinds of relationships (Hamby, 2014b).

One problem that NorAQ has in common with behavioural checklists is that it largely lacks contextual factors. Studies suggest that many victims include playful violence and mock violence when answering CTS2. This can lead to misclassification of respondents as victims of violence (Fernandez-Gonzalez, O'Leary and Munoz-Rivas, 2013; Hamby, 2014b; Lehrner and Allen, 2014). In a study of youth, respondents were asked about the reasons for violence and about half of both men and women reported that violence had occurred in a joking context only (Fernandez-Gonzalez et al., 2013). In an effort to reduce such false positives, Hamby experimented with different qualifiers when measuring intimate partner violence using CTS2, including "Not including horseplay or joking around…" and "When my partner was angry…". Both qualifiers were intended to reduce the reporting of acts of violence occurring in a friendly, joking context, which were considered to be false positives. It was hypothesised that a gender asymmetry would be created, i.e., women would report more victimization than men when the qualifiers were used. The first qualifier (joking) led to higher prevalence rates among women and lower prevalence rates among men for intimate partner

victimization compared to the standard CTS2. Using the "angry" qualifier led to overall lower prevalence rates than the standard version but produced surprisingly higher levels of victimization for men than for women. This latter result was interpreted to mean that the angry qualifier had an overall dampening effect on reporting, not only on the false positives (Hamby, 2014b). It should be underlined that violence within a joking context may also be important, but the interpretation is likely to be different from when violence occurs in an aggressive context (Fernandez-Gonzalez et al., 2013).

As is evident from the examples about the use of partner specific language and qualifiers, even small changes in methodology and wording can have a great effect on results—effects that are sometimes surprising and difficult to understand.

Also, the same kind of behavioural checklists that are already limited when used for their original purpose—to measure acts of physical violence—become even more problematic when trying to measure emotional violence (Follingstad and Rogers, 2013). Focusing on perpetrators' behaviours rather than context, intention and/or consequence, as with behavioural checklists, is likely not adequate when trying to capture the complexity of emotional violence.

One alternative to using behavioural checklists would be to also make an assessment of victims' perceptions of the violent event. This has been done in the Women's Experience of Battering (WEB), an instrument constructed to measure experiences of battering (Smith, Smith and Earp, 1999). When developing the WEB the focus was on conceptualizing and measuring women's experiences of battering rather than on the specific acts of male batterers. The instrument uses a Likert-type scale where respondents endorse statements like "He makes me feel unsafe even in my own home" and "I feel like he keeps me prisoner" (Smith et al., 1999). However, this approach has been criticised for putting too much focus on the victim's experience, failing to recognize the actions of the perpetrator (Dutton, Kaltman, Goodman et al., 2005). The researchers that constructed the WEB suggest using it with other measurements, for example behavioural checklists, to capture both the experience of victims and the behaviour of the perpetrator (Smith et al., 1999; Smith et al., 2002).

1.4.3 FOCUSING ON A SPECIFIC KIND OF VIOLENCE

Because co-occurrence of violence is so common, it is reasonable to include different kinds of violence in research; doing so is simply closer to victims' experiences. Also, considering the large co-occurrence of different kinds of interpersonal violence, it is likely that only studying one kind of violence will introduce a bias in studies, where associations are misinterpreted. One example where such a possible misinterpretation can occur is a study focusing on intimate partner violence and its association with ill-health. In such studies respondents are generally classified as victims or non-victims of intimate partner violence. Differences concerning health status between the two groups are attributed to their differences on the basis of being victim or non-victims of intimate partner violence. However, considering that co-occurrence of violence is so common, the victim group is likely to include victims of several kinds of violence. Hence attributing the health status to experiences of intimate partner violence may be inaccurate; it is possible that they should instead be attributed to the cumulative effect of experiencing more than one kind of victimization.

Also, because exposure to different kinds of violence is common, participants in a comparison group may very well be individuals exposed to other kinds of violence than the violence focused upon in the study. For example, when comparing victims of intimate partner violence to non-victims, it is

likely that many of the 'non-victims' are actually victims of another kind of violence. If little or no difference regarding a risk factor or an outcome is found between the victim group and the ostensibly non-victim group the conclusion is that intimate partner violence is not associated with that risk factor or outcome. However, if the non-victimized comparison group includes victims subjected to violence that are associated with the same risk factors and consequences as intimate partner violence, than the conclusion of no association is likely to be erroneous (Hamby and Grych, 2013).

Studies concerning children and youths have found this kind of bias. Associations between a single kind of victimization and ill-health have been found to be overestimated if other kinds of victimization are not considered, i.e. when including poly-victimization in studies, the strength of the association between a single kind of violence and ill-health was reduced or eliminated (Finkelhor et al., 2007a).

1.4.4 GENDER IN RESEARCH ON INTERPERSONAL VIOLENCE

When researchers want to measure the prevalence and consequence of violence among both men and women they logically use the same instruments to measure violence among both sexes. As has been done in the studies included in the thesis, the only changes generally made are concerning sex-specific words such as vagina or penis. However, violence is a gendered phenomenon and interpersonal violence will be understood differently by victims, perpetrators and bystanders as a consequence of gender (Smith et al., 1999; Anderson, 2005). Gender needs to be considered when asserting the construct validity of an instrument measuring violence (Follingstad and Rogers, 2013). Concerning intimate partner violence, scales used often stem from research on experiences of women subjected to severe forms of intimate partner violence. Controlling behaviour is an important aspect of the experience of psychological violence for many women and has hence become one of the focuses in measurements of emotional violence. However, research indicates that the concept of psychological violence is gendered. For many men the concept seems to entail manipulative behaviours and gender role harassment, which are concepts often not included in instruments of intimate partner violence. An example of gender role harassments of men that are associated with anxiety, anger and shame among victims include emasculating comments about the man being feminine. Instruments measuring psychological violence towards women may hence be inadequate for measuring psychological violence against men (McHugh et al., 2013).

Items in violence surveys are dependent on respondents' interpretation of them. The understanding of items will be filtered through gender, class, ethnicity and other identity markers and there is a risk that this can introduce a systematic bias in studies (Baker et al., 2013).

That gender stereotypes portraying men as perpetrators and women as victims of violence inform research on violence can also be exemplified by the fact that one of the largest surveys conducted in the U.S. concerning both men and women is named the "National Violence Against Women Survey" (Tjaden and Thoennes, 2000a). Hence, male victims are made invisible. From a wider perspective, research concerning intimate partner violence has been accused of misrepresenting non-normative victims' experiences. The conceptualizations are often heteronormative (Baker et al., 2013; Woodin et al., 2013) and defined by female experiences (McHugh et al., 2013).

1.4.5 GENDER (A)SYMMETRY DEBATE

The methodological problems of measuring violence can be exemplified through the gender symmetry/asymmetry debate which has been ongoing and lively for more than thirty years now. Gender symmetry means that equally as many men and women are perpetrators and victims of intimate partner violence. The gender (a)symmetry debate started when researchers found equal rates of perpetration and victimization of physical violence for men and women in intimate partner relationships (Archer, 2000). However, the idea that men and women are equally violent in intimate relationships is controversial and remains heatedly debated among scholars.

Central to the controversy is the meaning and conceptualization of intimate partner violence. Some focus on the repeat finding that men and women report perpetration of acts of physical violence within an intimate partner relationship at similar rates (Straus, 2012). Others claim that it is not reasonable to decontextualize acts of violence from their gendered nature in such a way (Brush, 2005; Anderson, 2009). Most scholars agree that the consequences of violence are different for men and women. For example, men are generally found to be more likely to inflict physical injury on their female partners than the other way around (McHugh et al., 2005; Hamby, 2009; Langhinrichsen-Rohling, 2010). Even those arguing for gender symmetry by emphasising that equally as much violence is being perpetrated by men and women, often state that the consequences of violence are different between men and women (Straus, 2012). However, even though about two-thirds of injuries inflicted by intimate partners are reported to be male-perpetrated, about one-third are inflicted by women (Langhinrichsen-Rohling, 2010). It is also worth noting that even less severe violence and violence that is bidirectional in nature may have negative emotional implications for victims (Frieze, 2005).

It has been argued that one reason for the finding of gender symmetry concerning acts of physical violence is that many instruments measuring violence cannot discriminate between aggressive violence and violence in self-defence. The latter has been assumed to be more common among women than men. However, when motives for violence have been assessed, self-defence has been reported at equal levels for men and women (below 20%)(Hamby, 2009).

From a methodological point of view it is interesting that mainly research using behavioural checklist has found gender symmetry (Hamby, 2014a). Hamby has compared data obtained from studies using CTS2 (which she herself had a part in designing) to studies using other kinds of methodology, mainly large-scale data such as crime victim surveys, reports by witness, homicide data, and youth violence surveys (Hamby, 2005; Hamby, 2009, 2014a). She concluded that it is mainly data collected with behavioural checklists that has produced gender symmetry; in all other kinds of survey methodology, men are found to be the perpetrators of most violence. Of course it is possible that behavioural checklists are more reliable than all other measurements of interpersonal violence, but Hamby concludes: *"if a screening measure for a medical condition gave a different result than every other known test for that condition, people would question the validity of the screening test, not the condition "* (Hamby 2014a:154). American professor of sociology and principal constructer of CTS2 Murray Straus is one of the strong voices proclaiming gender symmetry. He argues that it is CTS2, rather than other studies that is valid. His main argument for this is the considerably higher percentage of violence found while using CTS2 compared to studies such as the American crime victimization survey (about 15% vs 1%). He claims that this is evidence of low sensitivity in the crime victimization survey (Straus, 2012). However, he does not seem to consider the possibility of over-

reporting in CTS2. It has been suggested that pushing and sometimes even hitting or kicking are not necessarily perceived as acts of violence by victims, and hence affirmative answers to such items could constitute false positives. Examples of this would be violence within a joking context as described previously (Hamby, 2009; Fernandez-Gonzalez et al., 2013). Likewise, as previously described, using partner-specific language or qualifiers had a large influence on results, also indicating the possibility of measurement errors (Hamby, 2014b).

Johnson has tried to settle the debate on gender symmetry by attributing the gender symmetry result to a sampling error (Johnson, 2006, 2008). He argues that the more severe and controlling form of violence, intimate terrorism, is perpetrated almost exclusively by men towards women and that this kind of violence can mainly be found in samples recruited from hospitals and shelters. Victims and perpetrators of intimate terrorism are not likely to participate in large-scale survey research while victims and perpetrators of situational couple violence will. Johnson argues that the latter is perpetrated equally as often by men and women which then explain the gender symmetry findings in survey research. The social understanding of intimate partner violence as a phenomenon however stems mainly from qualitative data collected at shelters, which is violence likely to be intimate terrorism. There is a risk that portrayals of intimate terrorism found in shelter studies are erroneously generalized to be accurate for all victims found in survey studies. He concludes that it is true that men and women are equally likely to perpetrate the less severe situational couple violence found in survey research, while men are much more likely to be the perpetrators and women the victims of the more severe intimate terrorism found in shelter and hospital samples (Johnson, 2006, 2008). However, arguments have been put forward against this theory as a way of solving the gender symmetry debate. Hamby argues that the sampling error might well exists but because the number of victims of intimate terrorism is considered to be small, even if all non-respondents in surveys that were in fact victims of intimate terrorism were included in survey research this would not change the gender symmetry substantially. Hence, there is still a discrepancy between findings concerning gender symmetry of violence in research using behavioural checklists and research using other formats (Hamby, 2014a).

It can also be pointed out that Johnson's conceptualization of intimate terrorism stems mainly from research concerning female victims. It is possible that severe intimate partner violence entails different behaviours when perpetrated by women against men. As previously described, psychological violence encompasses different behaviours among men and women (McHugh et al., 2013). Considering that the conceptualization of intimate partner violence against men is uncertain, it is also possible that many studies investigating the prevalence of intimate terrorism are as a matter of fact investigating behaviours that are irrelevant for male victims while failing to measure those behaviours that are relevant.

Though it is difficult to unravel every aspect of the gender (a)symmetry debate, it seems to me that a large part of the controversy lies in how intimate partner violence is conceptualized. Some scholars focus solely on the acts of physical violence against an intimate partner, and these scholars are also generally those who emphasise gender symmetry (Straus, 2012). Another way of conceptualizing partner violence is to include contextual factors, acts of sexual violence, infliction of injuries and other consequence of violence within the concept (Hamby, 2009). A central focus on the aspect of coercive control and the gendered nature of intimate partner violence have made some argue that intimate partner violence needs to be divided into types of violence (Johnson, 2008).

1.5 PREVIOUS RESEARCH

1.5.1 PREVALENCE OF VIOLENCE

As previously mentioned the definition and operationalization of violence, as well as the data collection methodology will greatly influence the prevalence rates found when researching violence. One method sometimes used is to study crime statistics. This will give a restricted prevalence rate, because it is well known that far from all crimes are reported to the police and not all acts of violence can be classified as crimes (National Council for Crime Prevention, 2014b). An alternative to this is to use crime victim surveys. In Sweden the National Council for Crime Prevention (BRÅ) carries out crime victim surveys yearly ("Nationella Trygghetsundersökningen, NTU). As is common in crime victim surveys the NTU is focused on events/acts of violence that can be classified as crimes according to Swedish law and is also restricted to events during the previous year. For the year 2012, 1.3% of women and 2.6% of men reported physical violence and 1.4% of women and 0.3% of men reported being the victim of sexual violence[1] (National Council for Crime Prevention, 2014b). Another source of knowledge about the prevalence of violence is the "Swedish Living Condition Surveys" (ULF/SILC) produced by Statistics Sweden (SCB) yearly and includes three questions about violence. These surveys have found that in 2012-2013, 2.9% of women and 3.5% of men, aged 16-84 were exposed to violence during the previous 12 months [2] (Statistics Sweden, 2014). One question about interpersonal violence is also included in the yearly public health survey ("Nationella folkhälsoenkäten – hälsa på lika villkor") produced by the Public Health Agency of Sweden (Folkhälsomyndigheten). This reports that 3% of both men and women were exposed to physical violence during 2014[3] (Public Health Agency of Sweden, 2015). These three large-scale, repeatedly conducted, country-wide surveys give an important perspective on victimization, but violence is not the primary focus of the studies. This limits the number of questions that can be used, and data is hence reported from 1-3 screening questions framed within a larger context of crime, living conditions, and public health. Using single general questions, especially if referring to 'assault' or 'rape' within larger surveys, is known to produce lower prevalence rates than if behaviour-specific questions are used in studies focusing on violence (Ellsberg, Heise, Pena et al., 2001). Also, the three surveys are restricted to estimating the prevalence of violence during the previous year.

In 2012, the National Centre for Knowledge on men's violence against women (NCK) conducted a large-scale survey focusing on violence and estimating the prevalence of physical, sexual and emotional violence by any perpetrator during victims' lifetime and within the past year. In that study 11% of women and 1% of men were reported to have been exposed to severe sexual violence in adulthood, defined as forced intercourse or a similar act (including an attempt). Ten percent of

[1] Violence in the NTU is defined as an affirmative answer to the following questions. Physical violence: In the previous year (2012) did someone hit, kick or subject you to other kinds of intentional physical violence, so that you were injured or so that it hurt? Sexual violence: Did someone harass you, force you or attack you sexually during the previous year (2012)? The question concerns both serious and less serious events, for example at home, at work, in school or in some public place. (My translation)

[2] Violence in the ULF/SILC is defined as an affirmative answer to one of three question asking if respondents have been subjected to violence during the previous 12 months that A) caused injuries that required health care or dental care, B) caused visible marks or physical injuries but did not require health care or dental care, C) did not cause any visible marks or physical injuries. (My translation)

[3] Violence in the public health survey is defined as an affirmative answer to the following question: Have you during the previous 12 months been subjected to physical violence? (My translation)

women and 15% of men reported experiences of severe physical violence in adulthood, defined as being hit with the fist/an object/kicked or exposed to violence, including weapons. Questions used to operationalize violence can be found in table 2, page 28-29.

Recognizing the limitations of large-scale surveys when researching violence, and with the goal of learning more about intimate partner violence a new section was added to the NTU in 2012 (henceforth referred to as 'extended NTU'). This new section covers exposure to physical, sexual and emotional violence perpetrated by an intimate partner during the previous year as well as during the respondents' life-time. In contrast to the usual NTU, the new section also has the specific goal of including not only acts of crime but also other kinds of violent behaviour by intimate partners. It includes more questions, and questions that are more behaviour-specific than the ordinary NTU. The definitions used in the extended NTU are presented in table 2, page 28-29. The broader approach is evident when looking at the results. In the new section, 1.9% of women and 1.8% of men reported being the victims of physical assault and 0.5% of both sexes reported aggravated assault by an intimate partner in 2012 (remember that 1.3% of women and 2.6% of men reported physical violence from *all* perpetrators, including partners in the ordinary NTU) (National Council for Crime Prevention, 2014b, a). Still, the estimates of intimate partner victimization in the extended NTU are low in comparison to two other recent studies of intimate partner violence conducted in Sweden. Using the WHO Violence against women instrument (WAVI), Nybergh and colleagues found that 8% of both men and women reported physical violence victimization by an intimate partner during the previous year (Nybergh et al., 2013a). Lövestad and Krantz used CTS2 and found that 8% of women and 11% of men reported being subjected to physical intimate partner violence during the previous year (Lovestad and Krantz, 2012). The definition used in each study is presented in Table 2, page 28-29. Not only do the definitions vary, there are also differences in methodology used; an overview of this is given in Table 3.

In the first sections of the discussion (4.1.1 and 4.1.2) I will return to the differences found in prevalence rates and examine them more closely in light of methodological differences and relate them to the results found in this thesis.

Table 2. Items that constitute exposure to violence in different Swedish studies.

Psychological/emotional violence and/or controlling behaviour	
NorAQ	Have you experienced 1) anybody systematically and for a long period trying to repress, degrade or humiliate you? 2) by threat or force trying to limit your contacts with others or totally control what you may and may not do? 3) living in fear because somebody systematically and for a long period has threatened you or somebody close to you?
NCK study:	**Before the age of 18:** 1) Has an adult… 2) Has someone your age done any of the following to you? Offended or oppressed you with words (for example belittled, insulted or degraded you)? **After the age of 18:** Has anybody done any of the following to you? Your partner systematically and repeatedly 1) belittled, insulted, degraded or in other ways offended or oppressed you with words? 2) dominated you or decided for you: whom you may see, how much money you may have, when you can go out, what clothes you should wear etcetera? 3) threatened to hurt himself/herself or your children or to take the children and leave you, or to break your valued possessions or share your secrets etcetera? 4) Someone systematically and repeatedly bullied, offended or harassed you (e.g., relatives, at your work, in your school or something similar)?
Extended NTU:	Has your partner: 1) systematically offended, insulted, belittled or humiliated you? 2) not allowed you to have contact with a specific person, stopped you from leaving your home or in similar ways tried to decide what you can do? 3) threatened you (e.g., threatened to hurt you or other persons or destroy objects) so that you felt scared? 4) on repeated occasions followed or harassed you (e.g., unwanted e-mail, text messages, phone calls, visits or similar)?
Lövestad study: (CBS)	My partner: 1) tried to restrict the time I spent with family/friends. 2) wanted to know where I went and who I spoke to when not together. 3) tried to limit my activities outside the relationship. 4) felt suspicious and jealous of me. 5) tried to control my activities.
Nybergh study: (VAWI)	My partner: 1) insulted me in a way that made me feel bad. 2) belittled and humiliated me in front of others. 3) tried to scare and terrorize me on purpose. 4) threatened to hurt me or someone I care about.
Physical violence	
NorAQ	Have you experienced anybody 1) hitting you, smacking your face or holding you firmly against your will? 2) hitting you with his/her fist(s) or with a hard object, kicking you, pushing you violently, giving you a beating, thrashing you or doing anything similar to you? 3) threatening your life by, for instance, trying to strangle you, showing a weapon or knife, or by any other similar act?
NCK study:	Has someone done any of the following to you? 1) hit you with an open palm, pulled your hair, pushed you or shook you so that it hurt? 2) hit you with his/her fist or a hard object, kicked you or grabbed you in a stranglehold? 3) hurt you with a knife or a firearm? 4) used other kinds of physical violence towards you?
Extended NTU:	Has your partner: 1) grabbed you in a violent way, pushed you, thrown something hard against you, slapped you or something similar? 2) hurt you with an object, hit you with his/her fist, kicked you or something similar?
Lövestad study: (CTS2)	My Partner: 1) threw something at me. 2) twisted my arm or hair. 3) pushed or shoved me. 4) used a knife or tool. 5) hit me with something that could hurt. 6) choked me. 7) slammed me against a wall. 8) beat me up. 9) grabbed me. 10) slapped me. 11) burned or scalded me. 12) kicked me.
Nybergh study: (VAWI)	My partner: 1) pushed or shoved me. 2) threw something that could have hurt me. 3) hit me with his/her fist or with some other object. 4) kicked and dragged me and beat me up. 5) choked me or burnt me on purpose. 6) hurt me with a knife, a gun or other weapon.

Sexual violence	
NorAQ	1) Have you been sexually humiliated; e.g. by being forced to watch a pornographic movie or similar against your will, forced to participate in a pornographic movie or similar, forced to show your body naked or forced to watch when somebody else showed his/her body naked? Has anybody against your will 2) touched parts of your body other than the genitals in a 'sexual way' or forced you to touch other parts of his or her body in a 'sexual way'? 3) touched your genitals, used your body to satisfy him/herself sexually or forced you to touch anybody else's genitals 4) put his penis into your vagina, mouth or rectum or tried any of this; put in or tried to put an object or other part of the body into your vagina, mouth or rectum?
NCK study:	**Before the age of 15:** Has an adult done any of the following to you? 1) made you pose naked? 2) touched you in a 'sexual way' 3) made you touch his or her body in a 'sexual way'? 4) tried to have intercourse with you (oral, vaginal or anal) that was not completed? 4) had intercourse with you (oral, vaginal or anal)? Afterwards the same questions are asked but the perpetrator is stipulated to be someone of your own age (+/-5 years) who did it against your will. **Between 15-17 years:** Same questions as for before the age of 15 but for both adults and same-age perpetrators the following prerequisite is added: by threat or force or because you could not defend yourself because you were for example sleeping, were ill or affected by drugs or alcohol. **After the age of 18:** Has someone done any of the following to you? 1) forced you or 2) tried to force you to have intercourse (oral, vaginal, anal) or perform any other similar sexual act (e.g., masturbation) by threatening to or actually using physical force? 3) forced or tried to force you to have some kind of sexual activity when you were defenceless because you were sleeping, sick or affected by drugs or alcohol? 4) against your will touched or tried to touch your body in a sexual way (for example caressed, held, hugged, kissed, groped) or made you touch him/her in a sexual way?
Extended NTU:	Has your partner: 1) subjected you to, or involved you in a sexual act against your will? 2) forced you to engage in some kind of sexual act by threatening you, grabbing you or taking advantage of you when you were drunk, or similar?
Lövestad study: (CTS2)	My partner: 1) made me have sex without a condom. 2) used force to have sex. 3) insisted on having sex. 4) used threats to have sex.
Nybergh study: (VAWI)	My partner: 1) demanded to have sex with me even though I did not want to. 2) forced me to have sex against my will by using his/her physical strength. 3) forced me to perform sexual acts that I experienced as degrading and/or humiliating.

Note: NTU, Lövestad and Nybergh are all studies focused on intimate partner while NorAQ and NCK also include other kinds of perpetrators. My translation of items in NCK and extended NTU. Original items and prevalence rates can be found in each original study (Lovestad and Krantz, 2012; Nybergh et al., 2013a; National Board of Health and Welfare, 2014b; NCK, 2014).

Table 3. Methodology used in different prevalence studies of violence in Sweden. All are random population samples.

	NorAQ	NCK study	Extended NTU	Lövestad study	Nybergh study
Sample and response rate	Women n=1168 (61%) Men n=2924 (50%)	Women n= 5681 (57%) Men n= 4654 (47%)	n= 12671 (64.2%)	Women n=282 (56.5%) Men n= 217 (43.5%)	Women n= 624 (62.0%) Men n=458 (45.5%)
Number included in analysis*			12534	Women n=251 Men n=173	Women n= 573 Men n=399
Age	18-65	18-74	16-79	18-65	18-65
Year	Women: 1999&2001 Men: 2007	2012	2013	2009	2009
Context of survey	Focus on violence. Not perpetrator-specific. Also includes questions about abuse in health care and questions about respondents' health.	Focus on violence. Not perpetrator-specific. Questions about health are included and register data concerning health is also used.	Last part of NTU which focuses on crime. In the section used, violence is framed as covering conflicts within an intimate partner relationship.	Focus on intimate partner violence (victimization, and perpetration).	Focus on intimate partner violence (victimization, and perpetration).
Data collection method	Postal questionnaire	Web survey and postal questionnaire	Telephone interview Postal questionnaire	Postal questionnaire	Postal questionnaire
Number of items	Psychological: 3 Physical: 3 Sexual: 4	Psychological: 8** Physical:20** Sexual:24**	Psychological:4 Physical:2 Sexual:2	Psychological:5 Physical:12 Sexual:4	Psychological: 4 Physical: 6 Sexual:3
Instrument	NorAQ. Validated in male and female sample using interviews as gold standard	Own instrument, peer reviewed and tested in a pilot survey. Interviews with respondents to test the format.	Own instrument, peer-reviewed. Interviews with respondents to test the format.	CTS2, for sexual and physical violence (validated in many countries) and CBS, the Controlling Behavioural Scale.	VAWI. Psychometric properties tested among men and women in Sweden

** Reported to be lower than the response rate in Lövestad's and Nybergh's study due to respondents not answering any of the violence item. In extended NTU the lower number is due to 137 individuals not responding to the question if they had been involved in a relationship*

*** In the NCK survey the same or similar questions are asked about experiences before the age of 15, between 15-17 years and after 18 years and concerning different kinds of perpetrators. For example, the same five items are used for sexual violence by an adult and someone the same age before 15, between 15-17. In addition to this come four items on sexual violence in adulthood, resulting in a total of 24 items covering sexual violence.*

1.5.2 CO-OCCURRENCE OF VIOLENCE

In the previously described recent Swedish study by NCK, 40% of women and 13% of men exposed to sexual violence in childhood also reported being victims of sexual violence in adulthood (for definitions used see table 2, page 28-29). This should be compared to 15% of women and 3% of men not exposed to childhood sexual violence reporting experiences of adult sexual victimization. Likewise, physical violence in adulthood was reported about three times as often among women exposed to physical violence in childhood and six times as often by men exposed to physical violence in childhood than those not exposed in childhood. For emotional violence the corresponding figure was 2-3 for women and 3-4 for men. The co-occurrence of violence by different kinds of perpetrators has so far not been reported (NCK, 2014). This pattern of re-victimization is well in line with international research. An example of this is the U.S. National Survey of Violence Against Women (NSVAW), in which both men and women who had been physically abused by a caregiver in childhood were reported to have been physically assaulted by any perpetrator in adulthood twice as often as those not abused by a caregiver (Tjaden and Thoennes, 2000b).

In the Nybergh study on intimate partner violence, almost every third female victim (32%) and every fourth male victim (24%) reported being exposed to more than one kind of intimate partner violence (sexual/physical/psychological) in the past year (Nybergh et al., 2013a). The extended NTU presented even higher estimates and stated that 85% of those reporting physical violence by an intimate partner also reported psychological violence by an intimate partner. Also, more than every fourth person reporting psychological violence by an intimate partner reported experiences of physical violence by an intimate partner in the past year (National Council for Crime Prevention, 2014a). Likewise, the majority of victims in another study concerning experiences of psychological, sexual and physical violence among women reported to have experienced more than one kind of violent behaviour (Samelius, Wijma, Wingren and Wijma, 2007).

In a study of Swedish youth (age 15-23 years old), Danielsson and colleagues found, using NorAQ, that 5.5% of men and 11% of women reported experiences of all kinds of violent behaviours (sexual, physical and emotional violence). Also, 29% of victims of both sexes had been exposed to emotional and physical violence (Danielsson, Blom, Nilses et al., 2009). The co-occurrence of violence by different kinds of perpetrators was not reported. Patterns of re-victimization were recently reported using the same data set: exposure to physical, emotional and/or sexual violence before the age of 15 was found to be a strong risk factor for reporting violence during the previous 12 months (Blom, Hogberg, Olofsson and Danielsson, 2014).

Naturally the magnitude of the co-occurrence of violence will be affected by the same methodological and conceptual difficulties as the estimated prevalence of violence. It can hence be expected that the reported level of co-occurrence of violence varies between studies. However, there is a consistency in studies reporting a large overlap between different kinds of victimization, though especially the co-occurrence of violence by different kinds of perpetrators has not been thoroughly examined among adult men and women in Sweden.

Internationally, the most well studied phenomenon concerning the co-occurrence of violence is probably re-victimization. Because the focus in studies of re-victimization is often violence across different developmental periods the focus is on the victim's age at the time of victimization, and the kind of perpetrator reported is not always specified, or analysis may not be separated by kind of

perpetrator (Coid et al., 2001; Desai et al., 2002; Widom et al., 2008; Cloitre, Stolbach, Herman et al., 2009; Parks et al., 2011). However, many studies have reported strong associations between women experiencing different kinds of childhood abuse and later being the victims of intimate partner violence (Coid et al., 2001; Desai et al., 2002; Whitfield et al., 2003; Rich et al., 2005; McKinney et al., 2009; Renner and Whitney, 2012). Also, the association has been reported to be graded so that reporting multiple kinds of violence in childhood increased the likelihood for both victimization by an intimate partner as an adult as well as adult rape by any perpetrator (Whitfield et al., 2003; Messman-Moore and Brown, 2004; Cloitre and Rosenberg, 2006). Also, among women, childhood abuse is linked to an increased risk of repeat victimization by different intimate partners as adult (Cole, Logan and Shannon, 2008; Alexander, 2009). For men, the association is not found to be as clear cut; some scholars report associations between childhood family violence and intimate partner violence (McKinney et al., 2009) while others do not (Desai et al., 2002).

Also both childhood sexual and physical abuse as well as neglect have been associated with victimization as an adult by non-partners for both sexes (Tjaden and Thoennes, 2000a; Tjaden and Thoennes, 2000b; Coid et al., 2001; Desai et al., 2002; Arias, 2004; Romito and Grassi, 2007; Widom et al., 2008).

Associations between being subjected to different kinds of violence in adulthood have not been as well investigated. However, intimate partner violence has been associated with violence from acquaintances, strangers or co-workers in youth and adulthood (Porcerelli, Cogan, West et al., 2003; Romito, Molzan Turan and De Marchi, 2005; Taylor, Boris, Heller et al., 2008; Montero, Ruiz-Perez, Martin-Baena et al., 2011). Also, college women have been found to report repeated sexual and physical victimization (Daigle, Fisher and Cullen, 2008).

1.5.3 VIOLENCE AND ILL-HEALTH

Different kinds of interpersonal violence (e.g., intimate partner violence, childhood abuse, peer victimization) have been associated with both poor physical and psychological health among both men and women (Felitti, Anda, Nordenberg et al., 1998b, a; Brokaw, Fullerton-Gleason, Olson et al., 2002; Campbell, 2002; Coker, Davis, Arias et al., 2002a; Plichta, 2004; Dube, Anda, Whitfield et al., 2005; Romito and Grassi, 2007; Samelius et al., 2007; Wijma, Samelius, Wingren and Wijma, 2007; Ellsberg, Jansen, Heise et al., 2008; Wuest, Merritt-Gray, Ford-Gilboe et al., 2008; Afifi, MacMillan, Cox et al., 2009; Samelius, Wijma, Wingren and Wijma, 2010; Hines and Douglas, 2011).

As much research is still conducted on different kind of violence separately, much knowledge about associations between violence and ill-health comes from separate fields of research. Data from the NCK study gives information about the association between sexual/physical/emotional violence and ill-health among men and women in Sweden. Among women, violence was strongly associated with symptoms of depression[4] and symptoms of Post-Traumatic Stress Disorder (PTSD)[5] and the

[4] Depression was estimated using the Hospital Anxiety and Depression scale (HADS) (Zigmond and Snaith, 1983). The scale includes 14 questions concerning symptoms of depression and anxiety. Answers were graded between 0 (no symptoms) and 3 (frequently occurring symptoms). What are referred to in the NCK study as symptoms of depression is score >11.

[5] To estimate symptoms of PTSD the PTSD checklist was used (McDonald and Calhoun, 2010). It includes 17 questions about present symptoms indicating PTSD and an individual answering 'yes' to at least nine of these was considered to have considerable symptoms of PTSD.

association did not vary markedly by type of violence (physical, sexual, emotional) or age at victimization (<18 or >18 years). About 20% of women reporting experiences of severe physical, sexual and/or emotional violence reported symptoms implying depression. That makes symptoms of depression twice as common among women exposed to violence as among non-victims. More than every fourth female victim reported symptoms of PTSD, which is 3-4 times as common as among non-victims.

Among men, the association between violence and ill-health was more dependent on kind of violence reported and age at victimization. Men exposed to severe sexual violence in adulthood reported an especially high level of PTSD symptomatology (27% among victims, 6% among non-victims) and symptoms of depression (23% among victims and 9% of non-victims). The weakest association was found for victims of physical violence in adulthood. About 11% of male victims reported symptoms of PTSD, while 5% of non-victims did so. For symptoms of depression, the corresponding figures were 14% of victims and 9% of non-victims.

Intimate partner violence and ill-health

In a multi-country study on intimate partner violence conducted by the WHO, women who reported any lifetime partner violence had poorer self-reported health compared to non-victims. They also reported more emotional distress such as suicidal thoughts and suicidal attempts as well as more specific health problems in the previous four weeks (i.e. difficulty walking, difficulty with daily activities, pain, memory loss, dizziness, and vaginal discharge) (Ellsberg et al., 2008). Intimate partner violence has also been associated with gynaecological disorders, adverse pregnancy outcomes, chronic-pain syndrome, post-traumatic stress syndrome, depression, and higher health care utilization (Brokaw et al., 2002; Campbell, 2002; Plichta, 2004; Wuest et al., 2008). Concerning male victims of intimate partner violence, there are greater discrepancies in studies for the association between exposure to violence and reporting ill-health. Depression, anxiety and PTSD, all established by means of a diagnostic interview, was associated with intimate partner violence against women but not men in one study (Ehrensaft, Moffitt and Caspi, 2006), while others found that both men and women exposed to intimate partner violence reported symptoms of depression (Coker et al., 2002a). It is often reported that women suffer more severe health consequences in the aftermath of victimization, which is sometimes taken as a sign that women are exposed to more severe forms of intimate partner violence (Carbone-Lopez, Kruttschnitt and Macmillan, 2006; Afifi et al., 2009).

Childhood abuse and ill-health

A recent meta-analysis found strong evidence for associations between emotional and physical childhood abuse as well as neglect and adverse mental health outcomes (e.g., depression and anxiety) in adulthood. By means of the Bradford Hill criteria (assessing the strength of the association, temporality, dose-response relationship, biological plausibility and alternate explanations) the authors suggest that the association is causal (Norman, Byambaa, De et al., 2012). The risks of suffering an adverse mental health outcome were approximately doubled among children suffering from childhood physical abuse, emotional abuse and neglect. Repeated, frequent or severe abuse as well as multiple types of abuse was found to be associated with a higher risk of poor health outcomes. That childhood abuse needs to be considered within its broader socioeconomic context is also emphasized. Lifestyle factors, access to care, neighbourhood characteristics, family dysfunction and other environmental factors as well as genetic factors are

hypothesised to influence the relationship between childhood abuse and ill-health (Norman et al., 2012).

Likewise, the Adverse Childhood Experience (ACE) study in the USA found strong associations between psychological, physical and sexual childhood abuse and ill-health as well as health risk behaviour in adulthood (Felitti et al., 1998a; Dube et al., 2005). Also in the ACE study a graded relationship was found so that those reporting exposure to more categories of childhood abuse were more likely to report adverse outcome in adulthood (Felitti et al., 1998a). A graded relationship have been found also in Swedish studies, where children experiencing co-occurrence of violence were more likely to suffer from poor health than those reporting single kinds of victimization (Annerback et al., 2012).

The co-occurrence of violence and ill-health

Both re-victimization and poly-victimization have been found to be more strongly associated with depression and anxiety than any single kind of victimization alone (Messman-Moore, Long and Siegfried, 2000; Schumm, Briggs-Phillips and Hobfoll, 2006; Turner, Finkelhor and Ormrod, 2006; Finkelhor et al., 2007a; Turner, Finkelhor and Ormrod, 2010). The associations between experiencing co-occurrence of violence in adulthood and ill-health have not been thoroughly investigated but have been reported to be associated with depression and anxiety in both sexes (Tubman, Montgomery, Gil and Wagner, 2004; Romito et al., 2005; Romito and Grassi, 2007; Margolin, Vickerman, Oliver and Gordis, 2010).

An indication of how important it is to consider the co-occurrence of violence when investigating associations between interpersonal violence and different kinds of ill-health comes from studies of poly-victimization. It has been found that when poly-victimization is not considered, this might lead to overestimation of how strong the association between a specific kind of violence and ill-health is. An example of this is a finding by Finkelhor and colleagues: experiencing sexual abuse in childhood was by itself significantly associated with symptoms of anxiety and depression but when also poly-victimization was included in analysis the association between symptoms and sexual victimization dropped below the significance level. Also, poly-victimization was the strongest predictor found for lifetime adversities in that study (Finkelhor et al., 2007a). Similar findings were reported from a Swedish study of children concerning the association between adverse childhood experiences (abuse and non-interpersonal traumatization) and adverse psychological symptoms. The association between symptoms and individual items covering abuse and trauma was diminished or dropped below significant levels when co-occurrence of adverse experiences was considered (Gustafsson, Nilsson and Svedin, 2009).

Finkelhor found boys to be more exposed to poly-victimization than girls, possible due to a greater volume of peer assault among boys (Finkelhor et al., 2007a). In a Swedish study, boys and girls did not differ in relation to the reported frequency of exposure to abuse and non-interpersonal trauma (Gustafsson et al., 2009). Among adults, American women have been reported to experience more kinds of violent behaviours within an intimate partner relationship than men (Carbone-Lopez et al., 2006). In an Italian study, men and women were found to report similar rates of family victimization and victimization by an intimate partner. However, women were more likely to report exposure to more than three kinds of violence and it was above that threshold that the risk of reporting mental suffering was found to be the highest (Romito and Grassi, 2007).

1.5.4 HEALTH CARE SYSTEM'S RESPONSE TO VICTIMS OF VIOLENCE

Due to the strong associations between violence and ill-health it is inevitable that health care professionals will come into contact with victims of different kinds of violence, both victims who disclose their experiences and victims who do not. Violence can be both an overt and a hidden reason for seeking health care. It can also be a complicating factor, overt or hidden, when seeking help for another condition.

In the NCK study referred to previously, only 5-10% of female victims, and about 1% of male victims of adult sexual violence had sought professional help from a councillor, psychologist or doctor. The equivalent numbers for childhood sexual abuse were even lower. Among men and women subjected to physical violence as adults about 20% of both men and women had sought professional help (NCK, 2014). In the extended NTU study it was reported that 12% of women and 3% of men who had experiences of violence within an intimate partnership had been in contact with the health care system. For severe physical assault the number was 29% for women and 2.4% for men. This is in line with international research findings that seeking help is more common among women and among victims of severe violence (Liang, Goodman, Tummala-Narra and Weintraub, 2005; Leone, Johnson and Cohan, 2007; Schreiber, Renneberg and Maercker, 2009; Ansara and Hindin, 2010; Sabina, Cuevas and Schally, 2012). Some of the gender differences found in help-seeking after intimate partner violence have been reported to disappear when the severity of violence is accounted for (Ansara and Hindin, 2010).

Reasons and obstacles for seeking help after exposure to violence have not been investigated among men to the same extent as among women. Female victims of intimate partner violence report a fear of escalating violence, shame, low self-esteem, cultural factors, obligations to family/partner, finances and a lack of knowledge about sources of help as reasons for not seeking medical help or withholding information about victimization to health care professionals (Rodriguez, Quiroga and Bauer, 1996; Hathaway, Willis and Zimmer, 2002; Liang et al., 2005; McCart, Smith and Sawyer, 2010; Sabina et al., 2012). In studies exploring what female victims of intimate partner violence want from their health care providers, a good patient-provider relationship characterized by trust, compassion, support and confidentiality is underlined. Also a non-judgmental attitude and an understanding of the complexity of intimate partner violence favours disclosure (Rodriguez et al., 1996; Hathaway et al., 2002; Chang, Decker, Moracco et al., 2005; Feder, Hutson, Ramsay and Taket, 2006a; Liebschutz, Battaglia, Finley and Averbuch, 2008). Both among victims and providers, time constraints and a lack of knowledge among health care professionals concerning violence are often given as reasons for not talking about violence within the health care system (Hathaway et al., 2002; Kapur and Windish, 2011).

Among men, constructs of masculinity have been found to influence the help-seeking process. Men who endorse views that men should be self-sufficient, should not be weak, and should control their emotions, have been found to have less favourable attitudes towards seeking psychological help than other men (Vogel, Heimerdinger-Edwards, Hammer and Hubbard, 2011; Johnson, Oliffe, Kelly et al., 2012). Also, due to normative beliefs about men as perpetrators and women as victims of intimate partner violence it may be difficult for health care professionals to identify men as victims and women as perpetrators of intimate partner violence (Douglas and Hines, 2011). Many male victims of intimate partner violence report negatively gendered experiences of the police, social services and the health care system. They report, for example, not being believed or being assumed

to be the perpetrator of violence because they were men. A large proportion of male victims have reported being referred to a batterers program when seeking help as victims at domestic violence agencies (Douglas and Hines, 2011). It should also be noted that the heteronormative view of intimate partner violence being perpetrated by a man against a women may obstruct help-seeking for victims in same-sex relationship (Kay and Jeffries, 2010).

Theories have been developed to better understand the help-seeking process of victims of interpersonal violence in general (Schreiber et al., 2009; Schreiber, Maercker and Renneberg, 2010) and more specifically female victims of intimate partner violence (Liang et al., 2005). Liang and colleagues suggest a process with three stages: a) problem recognition and definition, b) the decision to seek help, and c) selecting a source of support. All three stages are influenced by individual, interpersonal and sociocultural factors and the relationships between them are non-linear. Though the three stages may seem to be characterized by cognitive decisions it is also underlined that feelings such as shame, fear and guilt will influence what happens, as will norms in society and attitudes from people in the victims' surrounding (Liang et al., 2005). It has been suggested that using an ecological model can be beneficial for understanding the help-seeking process and placing it in its sociocultural context (Schreiber et al., 2010; Alaggia, Regehr and Jenney, 2012).

The low proportion of victims who have spoken to formal sources of support, in combination with the high prevalence of intimate partner violence and strong associations found between victimization and different kinds of ill-health has led to the suggestion of asking all women coming into contact with the health care system about exposure to intimate partner violence. For example, the American Medical Association encourages physicians to routinely enquire about the family violence history of their patients as a history of violence may affect a patient's health status and/or their ability to adhere to medical recommendations (American Medical Association, 2008). One argument for such an approach is that no patient history or specific symptoms have proved sensitive enough to detect experiences of violence (Muelleman, Lenaghan and Pakieser, 1998; McFarlane, Soeken and Wiist, 2000; Brokaw et al., 2002; McFarlane, Groff, O'Brien and Watson, 2006).

There is a controversy as to what term to use to describe routinely asking patients about a history of violence within the health care system. In many studies the term 'screening' is used. However, this has been criticised because the screening programs evaluated in studies do not generally live up to the normal criterion for a screening program. For example, violence per se cannot be considered a medical condition and enquiring about a history of violence is not a medical test that can be applied to achieve early detection and more effective treatment (Goodyear-Smith, 2002; Klevens and Saltzman, 2009). In Sweden, it is more common to talk about using 'routine enquiry' as a tool to identify victims of violence, with the purpose of giving proper counselling and support (Berglund, 2010). However, the distinction between 'screening' and 'routine enquiry' has been questioned as both terms are generally understood to mean the same in this specific context. That is, they both consist of health care professionals initiating a test (here asking about a history of violence) which will select some individuals (victims), from a larger population for possible further treatment (Juth and Munthe, 2012). This understanding of 'screening'/'routine enquiry' fits well with most research in the field and regardless of which term is used, the same main benefits and problems are applicable to what will be discussed in this thesis. Because of this I have chosen to use both terms, guided by the word chosen by the authors of different studies.

Some research has investigating expected beneficial outcomes of screening for intimate partner violence against women. They have however not been able to show an effect of screening in reducing exposure to violence or improving health (MacMillan, Wathen, Jamieson et al., 2009; Hegarty, O'Doherty, Taft et al., 2013; WHO, 2013; O'Doherty, Taft, Hegarty et al., 2014). It should be noted that though support for general screening of all women has not been found, it might very well be beneficial to use routine enquiry within specific subgroups of patients, for example within antenatal care (MacMillan et al., 2009; Hegarty et al., 2013; Taft, O'Doherty, Hegarty et al., 2013). It should also be noted that it is difficult to design studies that could prove the effects of screening. One difficulty is for example to design a controlled study where the study in itself does not become a way of screening or even an intervention (McFarlane et al., 2000; Spangaro, Zwi and Poulos, 2009).

As in many other countries, the debate about screening women for intimate partner violence is also ongoing in Sweden. Arguments for and against routine enquiry about victimization in antenatal care were heatedly debated a few years back (Högberg and Edin, 2008; Rådestad, Rubertsson and Hildingsson, 2008c, b, a; Stenson, Öberg, Witkowski and Heimer, 2008; Stenson, Öberg, Witkowski et al., 2008). The most recent contribution to the debate is a report on the ethical aspects of implementing routine enquiry about intimate partner violence within the health care system. The authors were concerned about the low evidence for beneficial outcomes of a general program concerning routine enquiry and recommended that such a program should not be implemented until evidence for its benefits could be presented (Juth and Munthe, 2012; Munthe and Juth, 2014). Critics argued that the negative effects of not asking and thereby not finding out about victimization, had not been considered enough in the analysis (Beausang, Berg, Carlsson et al., 2014). During 2014 the National Board of Health and Welfare issued a recommendation that all women should be routinely asked about intimate partner violence in antenatal care and in adult psychiatric care. It has also been recommended that the issue of witnessing interparental violence should be addressed with children in child psychiatric care (National Board of Health and Welfare, 2014b, a). Recommendations to ask about other kinds of violence or to ask men have not been made.

AIMS

STUDY I:
To estimate the self-reported prevalence of emotional, physical, sexual violence and abuse in health care in a random male population sample.

To compare the prevalence rates found in the population sample with those found in a previous clinical male sample and consider whether the different sampling methods and response rates affected the prevalence rates found.

STUDY II:
To examine the co-occurrence of self-reported lifetime exposure to different kinds of violent behaviours (sexual, physical, and emotional) among both sexes in both clinical and random population samples.

To examine the co-occurrence of self-reported lifetime exposure to violence perpetrated by different kinds of perpetrators (family member, intimate partner and acquaintances/strangers) among both sexes in both clinical and random population samples.

STUDY III:
To investigate how self-reported lifetime exposure to cumulative violence (i.e., being subjected to more than one kind of violent behaviour and/or violence by more than one perpetrator) was associated with self-reported symptoms of psychological ill-health.

To investigate if the association between life-time self-reported exposure to each single kind of violent behaviour/kind of perpetrator and self-reported symptoms of psychological ill-health would be affected when information about experiences of also other kinds of violence/violence from other kinds of perpetrators was included in analysis.

STUDY IV:
To develop a theoretical model concerning male victims' processes of disclosing experiences of being exposed to interpersonal violence to health care professionals in Sweden.

MATERIAL AND METHOD

In this section I briefly describe the material, method and procedure used for generating and analysing data. More complete descriptions are provided in each article.

2.1 PARTICIPANTS AND PROCEDURES

Studies I-III are quantitative studies of self-reported exposure to physical, sexual and emotional violence among men and women in Sweden. In study I, experiences of abuse in health care are also included but will not be discussed further, considering that such abuse is not the focus of this thesis.

Studies I-III: Altogether four different samples have been used in studies I-III. The original purpose of each data collection was to estimate the self-reported prevalence of exposure to interpersonal violence in each sample: A) Female clinical sample (Wijma et al., 2003), B) Female population sample (Swahnberg et al., 2004) C) Male clinical sample (Swahnberg et al., 2009), D) Male population sample (collected for study I of this thesis) (Swahnberg, Davidsson-Simmons, Hearn and Wijma, 2012). Table 4 gives an overview of the different data collections. Study I in this thesis is built on original data from the male population sample and secondary analysis of data collected in the male clinical sample. Studies II and III are based on secondary analysis of all four data collections.

Respondents in the population samples were randomly selected and NorAQ was sent to them by post. The clinical samples were recruited consecutively among patients at gynaecology clinics (women) and six different somatic clinics (men). Patients were invited verbally to participate and NorAQ was sent to everyone who did not decline. Two reminders were used, except for the male population sample where three reminders were used. Detailed description of the procedure is published in each original article.

Study IV: The aim was to develop a theoretical model concerning the process of disclosing experiences of being exposed to violence to health care professionals for male victims, a research question that could better be answered by using qualitative than quantitative methodology. Grounded theory is suitable for investigating actions and social processes with the aim of creating theory (Polit and Beck, 2008). Originally, grounded theory was created by Glaser and Straus and the idea was to discover theory that emerges from the data (Glaser and Strauss, 1967/1999). In contrast to the positivistic assumptions of the original version, Kathy Charmaz has developed constructivist grounded theory which was used in study IV of this thesis (Charmaz, 2006). Though the method of analysis is much the same between the original and the constructivist grounded theory, Charmaz emphasizes that we construct rather than discover theory and that theory is an interpretation, not an exact picture of the studied phenomena. Focus is also not so much on finding one core category; rather the resulting theory can consist of several theoretical concepts (Charmaz, 2006).

Twelve men were interviewed. All were recruited from respondents in a quantitative study concerning experiences of interpersonal violence, ill-health and help-seeking conducted in 2012 (unpublished). For the quantitative study, respondents were collected at random from the population (n=1510, response rate 37%) as well as consecutively from two primary health care clinics (n=129, response rate 70%). The men interviewed for study IV were recruited by means of theoretical sampling among male respondents in the quantitative study and had all answered

NorAQ. Eligible were men who had reported exposure to sexual, physical and/or emotional violence by any perpetrator and reported that they had either talked to, or wanted to talk to a health care professional about their victimization. Experiences of disclosing victimization to professionals who work within health care services, as well as therapists and councilors who work within social services were included. After each interview the data was analysed using the constant comparative method and the next informant was chosen with the aim of elaborating the categories. After nine interviews, no new categories were constructed. Three more interviews were conducted to stabilize and refine the categories.

Table 4. The different samples and data collections used in the different studies in this thesis.

	Female		Male		
Kind of sample	Clinical	Population	Clinical	Population	Clinical (n=1) Population (n=11)
Method of recruitment	Consecutive patients at three gynaecology clinics	Random population	Consecutive patients at six somatic clinics at one hospital	Random population	Theoretical sampling from respondents in a quantitative study
Year	1999-2000	1999 & 2001	2005	2007	2012
n	2439	1168	1767	2924	12
Response rate	81%	61%	74%	50%	
Included in					
Study I			x	x	
Study II	x	X	x	x	
Study III	x	X	x	x	
Study IV					x
Original publication	Wijma et al., 2003	Swahnberg et al., 2004	Swahnberg 2009	Swahnberg et al., 2012 Study I in this thesis	Study IV in this thesis. Quantitative data unpublished.

2.2 MEASURES

As stated previously, NorAQ was used to operationalize experiences of exposure to interpersonal violence in this thesis. The instrument is briefly described in section 1.2.2 and the items that constitute the different kinds of violence are found in table 1.

In NorAQ the answer to each kind of question about exposure to violence is “no”, “yes, as child (before the age of 18)”, “yes, as an adult (18 years of older)” and “yes both as a child and as an adult”. After the questions about each kind of violence have been asked there is one question about who the perpetrator was. This means that NorAQ only makes it possible to relate the reported perpetrator to the kind of violence reported, not to the severity of violent behaviour or to the age at victimization.

Because the main focus of study II and III was to investigate the co-occurrence of violence the different degrees of severity of violence were merged and coded into one variable with the following categories: 1) no violence 2) emotional 3) physical 4) sexual 5) emotional and physical 6) emotional and sexual 7) physical and sexual 8) emotional, physical and sexual.

Concerning the perpetrator, respondents are given a list of possible alternatives in NorAQ. For the purpose of the studies in this thesis the possible answers were grouped into three categories: 1) family (parents, stepparents, siblings), 2) partner (former or present partner), 3) acquaintance/stranger ("same age playmate, schoolmate or other person under 18", "a known person who doesn't belong to your family", "a person totally unknown to you" and "other"). Finally, the answers were grouped into one variable with the following mutually exclusive categories describing the kind of perpetrator reported: 1) no violence, 2) family, 3) partner, 4) acquaintances/strangers, 5) family and partner, 6) family and acquaintance/stranger, 7) partner and acquaintance/stranger, 8) family, partner and acquaintance/stranger.

After the questions about exposure to each kind of violence, the respondents are also asked to estimate to what extent he or she currently suffers from the violence reported. The answer is given on an 11-point scale (0=no suffering, 10= suffers terribly).

To measure symptoms of psychological ill-health, six items found in NorAQ were used. The first three items asked if respondents during the previous 12 months, and to such an extent that they found it difficult to cope with their daily life, had suffered from 1) anxiety, 2) depression, and 3) insomnia. The next three items related to symptoms of PTSD and asked if respondents during the previous 12 months had 4) experienced intrusive recollections that disturbed them, 5) avoided situations that might lead to unpleasant recollections of feelings, and whether this had interfered with what they wanted to do, 6) felt as if their feelings were numb for a long period. To all questions respondents could answer a) "no", b)" yes, but rarely", c) "yes sometimes", d) "yes, often". Each answer was given a score ranging from zero for "no" to three for "yes, often". A resulting sum score was created and divided into the following categories: 1) 0 points; 2) 1-3 points; 3) 4-6 points; 4) 7-18 points.

2.3 ANALYSES

2.3.1 STATISTICAL ANALYSES

SPSS software was used for all statistical analysis and the significance level was set to $p<0.05$ for all analysis in all studies. Pearson's chi-square analysis was used to investigate differences concerning background characteristics between the different samples in studies I-III. In the few cases where the expected frequency was below five, Fischer's exact test was used instead.

Study-specific analyses

Study I: Descriptive statistics were used to explore the prevalence of self-reported exposure to each kind of violent behaviour. To investigate associations between background characteristics and lifetime exposure to emotional, sexual, physical violence and abuse in health care, binary logistic regression analysis was used. Age-stratified Pearson's chi-square tests were used to compare the reported prevalence of violence in the population and clinical samples.

Study II: Descriptive statistics were used to examine the co-occurrence of violence. To test for associations between reporting violence from different kinds of perpetrators, a two-step hierarchal binary logistic regression analysis was used for each kind of perpetrator and in each sample. In the first step, socio-demographic variables were put as the explanatory variable while the reported kind of perpetrator was put as the response variable. In the next step information about the co-occurrence of violence by different kinds of perpetrators was added as explanatory variable.

Study III: Ordinal regression analysis was used to investigate both aims and the ordinal measure of symptoms of psychological ill-health was used as the response variable in all analysis. To explore the association between cumulative violence and symptoms of psychological ill-health, the variable including information about the co-occurrence of different kinds of violent behaviour/violence from different kinds of perpetrators was entered as explanatory variable. The resulting odds ratios (OR) for reporting symptoms of psychological ill-health were compared between those reporting a single kind of victimization and those reporting experiences of cumulative violence.

To investigate if adding information about cumulative violence would affect the association found between each kind of violence and symptoms of psychological ill-health, one model for each kind of violent behaviour/violence from each kind of perpetrator alone was first created. As a second step information about experiences of other kinds of violent behaviours/violence from other kinds of perpetrators was also included in analysis. The OR gained in the first and second models were then compared to see if adding information about cumulative violence had a significant influence on the results.

2.3.2 QUALITATIVE ANALYSIS

All interviews were recorded and transcribed verbatim. Analysis was performed as described by Charmaz (Charmaz, 2006) and started with me performing line-by-line coding after each interview. The co-authors of study IV also performed line-by-line coding of two interviews each to ensure that the interpretation was consistent between all the authors. Constant comparative method was used for analysis, meaning that codes were compared to each other both within one interview and between interviews. The next step was focused coding, a more interpretive level of coding where the most frequent or significant codes were used to categorize data. Afterwards, I and the second author met to discuss how codes and categories were related to each other, i.e., performing what is referred to as theoretical coding. Afterwards I started to work on writing a first draft of the manuscript using the theoretical codes as well as memos that I had written during the whole process. As a final step I evaluated the theoretical model we had constructed against each man's individual process of disclosure as described in the interviews.

2.4 ETHICS

Asking questions about experiences of violence might elicit feelings of distress, anxiety, suffering, flashbacks etcetera among participants. This might have happened both while using written questions in studies I-III as well as during the interviews in study IV. The contact information of the research team as well as to an independent therapist was included in all quantitative data collections and also given to the men interviewed in study IV. The participants were encouraged to reach out if they felt a need to talk about their experiences. This opportunity was taken by very few.

Efforts were made to ensure privacy and confidentiality for participants. When reaching out to the men in study IV, I contacted them by phone and invited them to participate in the interview held at two different private locations at the university. After they had agreed to the interview I sent an e-mail to the participants explaining again what the main topic of the interview should be, so that they had time to prepare themselves and decide what information they wanted to share. At this stage, one man regretted his choice to be included and decided not to participate after all. All men signed a written consent form and were carefully informed that they could withdraw their participation and stop the interview at any time and without explanation if they wanted to. Care was taken that we could not be overheard during the interview in order to ensure confidentiality. All names of individuals or places that could lead to the identification of the informant were excluded from the transcripts of the interviews.

The regional ethical review board in Linköping approved all studies included in this thesis (registration number 37-07 and 194-31).

RESULTS

In this section I briefly describe the results of the four different studies of this thesis and show how they are related to each other. More complete descriptions are provided in each article.

It is again important to remember that there is no single interpretation of what constitutes violence. The reported numbers here are estimates constructed by the researchers and the respondents together. The respondents decided if their experiences of victimization applied to the questions in NorAQ as constructed by the researchers. Hence, it is not certain that a bystander would define the acts as violent, even if they are reported as such here by the victims. Also, the results have been filtered through the categorizations and interpretations made by me and the rest of the research team. This means that the results would probably not have been exactly the same had we asked the reported perpetrators to define if violence had occurred, or used a legal definition as a prerequisite for defining exposure to violence. These assumptions apply to all results presented here, i.e., prevalence rates of violence, symptoms of psychological ill-health, and victim's experiences when meeting health care professionals.

3.1 PREVALENCE AND CO-OCCURRENCE OF VICTIMIZATION

The reported level of exposure to different kinds of violence was high. Among the men in the random population sample, 49% reported experiences of physical violence from any perpetrator. The corresponding figure for emotional violence was 17%, sexual violence 5% and Abuse in health care 7%. Most victims of physical, sexual and emotional violence reported victimization in childhood while abuse in health care was more commonly reported in adulthood (Study I). That experiences of physical violence are frequent was also found in study IV. Some of the interviewed men said that physical violence was so prevalent that it was sometimes normalized by both male victims and health care professionals (Study IV).

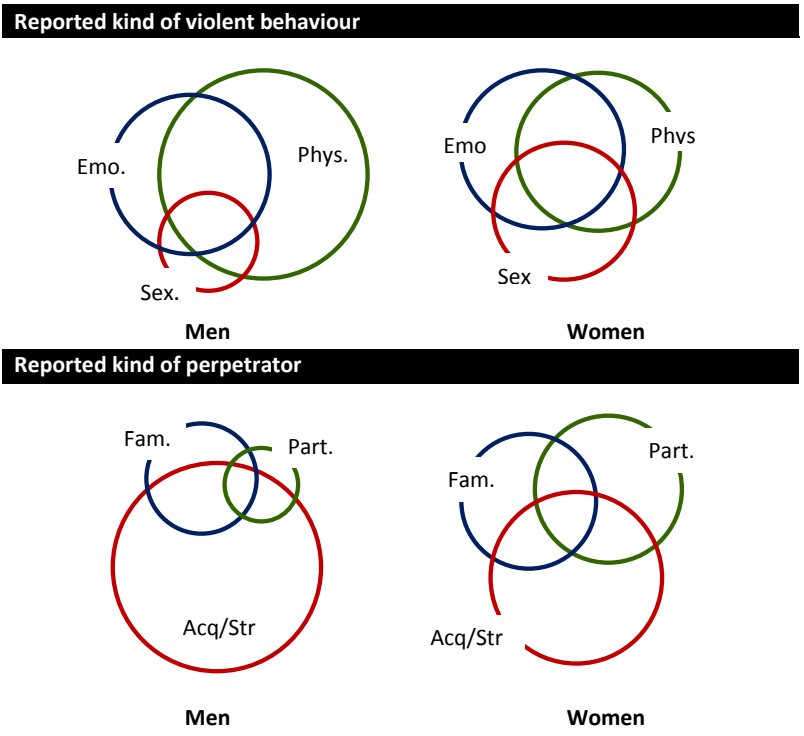
Among men in the population sample, reporting life-time experience of physical victimization was associated with younger age and higher education. Reporting emotional violence was associated with several of the variables that could potentially indicate a more vulnerable socioeconomic status: younger age, being single, low annual income and being on sick-leave. Reporting emotional violence however was also associated with high education. Reporting sexual victimization was not associated with any of the background characteristics in the male population sample.

As elaborated on in section 1.2.2. men and women who reported experiences of mild physical violence in NorAQ, but not moderate or severe physical violence were considered as non-victims of physical violence in study II-IV. Hence the prevalence rates are lower for physical violence in study II compared to study I. In study II more men than women reported experiences of some kind of interpersonal violence (Population sample: Men 42%, women 36%; Clinical sample: men 35%, women 33%). Men reported more physical violence (women 20-21%, men 29-35%) but more women than men reported sexual violence (women: 17% in both samples, men 4-5%) as well as experiences of all three kinds of violent behaviour (women 6-7%, men 1-2%). Acquaintance/stranger was most commonly reported as perpetrator for any life-time experience of violence for both men and women (women: 18-22%, men: 29-37%). However, women reported violence by an intimate

partner more often than men (women: 15-16%, men 3-5%), as well as violence by all three kinds of perpetrators (women 3%, men 1% in both samples) (Study II).

As illustrated in the Venn diagram (figure 3), co-occurrence of victimization was common. Among female victims, 33-37% reported being exposed to violence from more than one kind of perpetrator and 47-48% reported being exposed to more than one kind of violent behaviour. Violence by more than one perpetrator was reported by 22-23% of male victims and 29-31% reported exposure to more than one kind of violent behaviour (study II). Prevalence rates for each kind of violence/violence by each kind of perpetrator and all possible combinations of violent behaviours/kind of perpetrators can be found in Figure 1 in paper II, page 159-161.

Figure 3. Proportional Venn diagram illustrating the co-occurrence of violence in the male and female population samples respectively.



Note: The Venn diagrams are not proportional to each other. Emo=emotional, Phys=physical, Sex= Sexual, Acq/Str=Acquaintances/strangers, Fam= family, Part= partner

Reporting victimization by one kind of perpetrator was associated with also reporting victimization by another kind of perpetrator. For example: in the male population sample the odds of reporting victimization by a partner were five times greater among men also reporting victimization by family perpetrator (OR=5.1; 95% CI 2.5-10.5) and ten times greater among men reporting victimization by family and acquaintance/stranger perpetrator (OR=9.7; 95% CI = 5.9-16.1) compared to those

reporting no other kind of perpetrator. Likewise, in the female population sample, the OR for reporting victimization by a partner was higher for those reporting also other kinds of perpetrators: among those also reporting violence by a family perpetrator, the OR for reporting victimization by a partner was 4.4 (95% CI 2.6-7.3), and if reporting experiences of violence perpetrated by both a family perpetrator and an acquaintance/stranger the OR was 6.1 (95% CI 3.6-10.2) (Study II). Odds for reporting violence by each kind of perpetrator depending on experiences of victimization by the other kinds of perpetrators can be found in paper II, table 3, page 163.

3.2 VIOLENCE AND SYMPTOMS OF PSYCHOLOGICAL ILL-HEALTH

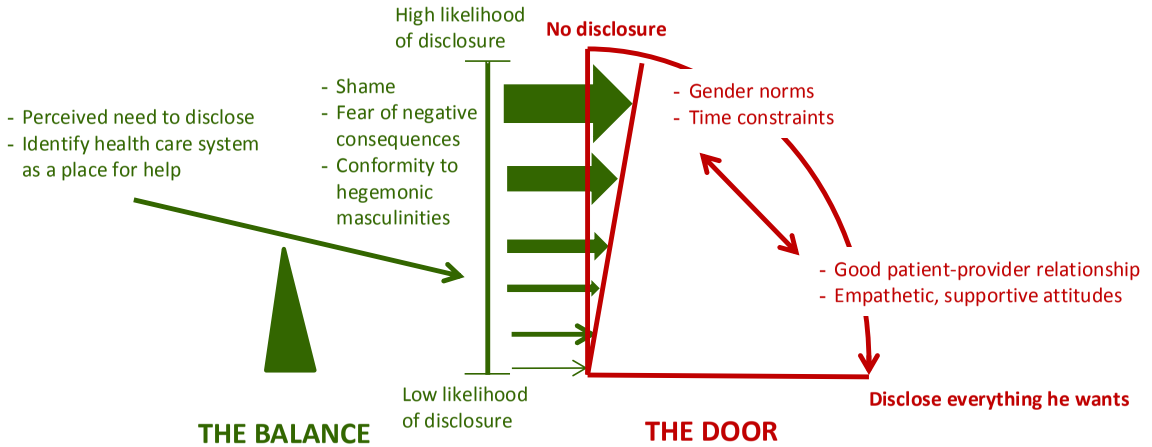
Among victims in the male population sample, 66% reported they were still suffering from exposure to emotional violence, 59% reported still suffering from exposure to abuse in health care, 47% from exposure to sexual violence and 25% from exposure to physical violence (Study I). Another finding indicating that physical victimization may have the least negative impact on victims was also found in study IV. In that study, we found that physical violence had the potential to cause suffering that could be difficult to talk about with health care professionals, but it did not seem to be as stigmatizing for victims as other types of violence, for example sexual violence (Study IV).

Co-occurrence of violence was associated with symptoms of psychological ill-health, i.e. both men and women reporting all kinds of violent behaviours/all kinds of perpetrators had with a few exceptions significantly higher odds of reporting a higher level on the measure of symptoms indicating psychological ill-health than those reporting each kind of victimization alone (Study III). For example: in the female population sample, reporting violence perpetrated by all three kinds of perpetrators (family, partner and acquaintance stranger) increased the odds of reporting a higher level on the measure of symptoms indicating psychological ill-health more than 14 times compared to those not reporting any experiences of violence (OR= 14.3; 95% CI 7.4-27.9). Corresponding figures for those reporting only partner victimization were OR=4.0 (95% CI=2.6-6.3), only family victimization OR=3.2 (95% CI = 2.0-5.1) and violence perpetrated by only an acquaintance stranger OR= 3.1 (95% CI= 2.2-4.3) (study III). A detailed description of the association between cumulative violence and symptoms of psychological ill-health can be found in paper III, table 3, page 11.

3.3 DISCLOSING VICTIMIZATION TO HEALTH CARE PROFESSIONALS

Though not all victims of violence need health care some of the men in study IV described disclosing victimization to health care professionals as an unmet need. However, disclosing was not easy. The process of disclosing could be described by using two metaphors: the balance and the door. The balance was used to illustrate that it was a dynamic process where a range of factors balanced against each other within the men. Among other things not knowing where to seek help, feelings of shame and fear of negative consequences of disclosing could tip the balance towards a low likelihood of disclosing, while a strong need for help could tip it towards a high likelihood. The door metaphor illustrates the dynamics during the health care encounter where the opening represents how much and what the victims disclose. Health care professionals took the role of door-keeper and had a strong influence on if and what the men disclosed. Among other things an emphatic and caring attitude helped open the door while time constraints pushed the door shut (Study IV).

Figure 4. An illustration of the theoretical model of disclosing experiences of interpersonal violence to health care professional (study IV).



"The balance" illustrates that the men's likelihood of disclosing experiences of violence to health care professionals was dependent on a variety of factors balanced against one another. "The door" illustrates the dynamics during the actual disclosure, where the door's opening represents if, how much, and what the men disclose. The balance and the door are intertwined and arrows in the model symbolise that the men's likelihood of disclosure translates to the force with which they try to open "the door". The health care professionals acted as doorkeepers and had a strong influence on how much and what the men disclosed. Hence, if a man had a low likelihood of disclosing, due to for example shame, disclosure could still occur if health care professionals opened the door by being empathetic and supportive. It was also possible for a man to have a high likelihood of disclosure due to a strong perceived need, but disclosure could still be hindered by for examples professionals time constraints or adherence to gender norms.

Gender norms strongly influenced the process of disclosing experiences of victimization to health care professionals. The men's own practices of hegemonic masculinity lay a heavy weight on the balance. An example of this was that despite acknowledging suffering from their experiences, the men were reluctant to seek help; some men even had a breakdown and still did not seek help. Instead women in their vicinity had to help them contact health care professionals. Some men, especially those who had sustained violence from a female intimate partner, expressed a fear of not being taken seriously or not being believed when disclosing experiences of victimization. This was mirrored in professionals' strong adherence to gender norms, as narrated by the interviewed men, which had a very negative influence on "the door" in the theoretical model. One man had for example been laughed at when telling health care professionals about his victimization by a woman. The men also said that their psychological suffering was not acknowledged by health care professionals, which they interpreted to be because they were men (Study IV) (Figure 4).

3.4 METHODOLOGY WHEN RESEARCHING VIOLENCE

In study I, the prevalence of self-reported exposure to interpersonal violence did not differ between the two samples (male clinical and population samples) despite differences in sampling method and response rates. We also found that the reported co-occurrence of different kinds of violent behaviours as well as different kinds of perpetrators were similar in the population and clinical samples (but different between the sexes) (Study II).

In study III we found that the reported co-occurrence of violence had a strong impact on the association between kind of violent behaviour/kind of perpetrator and symptoms of psychological ill-health. Associations between each kind of violent behaviour/violence from each kind of perpetrator and symptoms of psychological ill-health were generally overestimated if the co-occurrence of violence was not considered in the analysis. For example, when analysing the association between reporting physical violence and symptoms of psychological ill-health alone in the male clinical sample the OR was found to be 2.3 (95% CI=1.9-2.8). When also including information about the co-occurrence of violent behaviour and the reported perpetrator the association with symptoms of psychological ill-health was no longer significant for physical violence alone, OR=1.1 (95% CI=0.7-1.7). Likewise, the association between violence from each kind of perpetrator alone and symptoms of psychological ill-health was overestimated if co-occurrence of violence by different kinds of perpetrators and kind of violent behaviour was not included in analyses. For example, when analysing the association between reporting violence perpetrated by a partner and symptoms of psychological ill-health alone among women in the clinical sample, a strong association was found, OR= 4.6 (95% CI= 3.7-5.6). When information about experiences of violence from other kinds of perpetrators as well as the kind of reported violent behaviours were included in analyses the OR dropped significantly, OR= 1.6 (95% CI=1.02-2.5) (Study III). A more detailed description of how the association between each kind of violent behaviour/violence from each kind of perpetrator was overestimated if cumulative violence was not considered can be found in paper III, table 4, page 13.

There seems to be a considerable risk of overestimating the association between symptoms of psychological ill-health and each single kind of victimization if the co-occurrence of victimization is not considered in analysis. The effect of reporting more than one kind of victimization remains hidden in the other categories (Study III).

DISCUSSION

4.1 MAIN RESULTS

As has been described in the background (section 1.4) different studies concerning interpersonal violence tend to yield different prevalence rates. To illustrate this and try to understand the findings of this thesis, as well as why the differences in prevalence rates emerges I have compared the results found in this thesis with the results in the Swedish studies concerning exposure to interpersonal violence, presented in section 1.5.1 I start by comparing data from the NCK study (2014), with NorAQ data (Section 4.1.1). Both of those studies include data on the self-reported prevalence of exposure to sexual, physical and emotional violence by any perpetrator. In the next section (4.1.2) I will examine differences concerning intimate partner violence found in NCK, extended NTU (National Council for Crime Prevention, 2014a), as well as the studies by Lövestad (2012) and Nybergh (2013a). Because the comparison studies all consist of random population samples, only the NorAQ population samples (male and female) (Swahnberg et al., 2004; Swahnberg et al., 2012) are included in the comparison. To make as reasonable comparisons as possible I have, whenever possible, excluded behaviours obviously not included in all studies. For example, NCK present prevalence rates of emotional violence bot including and excluding experiences of witnessing parental violence. As no such item exists in NorAQ, I'm using NCK prevalence rates without that specific item. Also, it should be noted that in study II, the item concerning mild physical violence was excluded from analysis. After some consideration, I have chosen to include this item in the comparison made here (both section 4.1.1 and 4.1.2). The reason for this is that all the other instruments include one or several items concerning physical violence of a similar, less severe nature.

At the end of section 4.1.2 I will finish the comparison of prevalence rates by giving a short concluding remark concerning the differences found in all comparisons made. In section 4.1.3 the co-occurrence of violence is discussed and some potential explanations for the phenomenon are presented. After that I will discuss the results of study III, and the association between cumulative violence and symptoms of psychological ill-health (section 4.1.4). Some theories for why cumulative violence would be more strongly associated with psychological ill-health than single kinds of victimization will also be outlined. This will be followed by a discussion concerning the health care system's response to interpersonal violence (section 4.1.5).

4.1.1 PREVALENCE OF VIOLENCE BY ANY PERPETRATOR

NorAQ and the NCK study both estimate exposure to violence by all kinds of perpetrators. However, the prevalence rates found in respective study differ considerably (table 4). For example, the prevalence of any sexual, physical or emotional violence in childhood is reported to be 75% among women and 77% among men in the NCK study. Using NorAQ we found the prevalence to be 33% among women and 44% among men.

Different items

When looking at the different items used in NorAQ and NCK (table 2, page 28-29) some differences in prevalence rates seem logical. One example is emotional violence in childhood: NCK, unlike NorAQ, does not include any signifier that the violence had to be systematic or repeated. Also, NCK

Table 4. Comparison of prevalence rates (%) of sexual, physical and emotional violence between NCK and NorAQ. Data consist of merged data for the mild to severe items as well as data concerning all perpetrators.

	Women		Men	
	NorAQ n=1168	**NCK** n=5681	**NorAQ** n=2924	**NCK** n=4654
Before age 18				
Any kind of violence	33	75	44	77
Sexual	11	27	3	11
Physical	26	39	36	59
Emotional	14	54	12	58
After the age of 18				
Any kind of violence	25	55	23	36
Sexual	7	28	2	6
Physical	17	19	17	20
Emotional	13	22	8	9
Lifetime				
Any kind of violence	45	81	52	80
Sexual	16	42	5	15
Physical	36	46	49	62
Emotional	21	37	17	29
Last 12 months				
Any kind of violence	6	20	6	11
Sexual	1.0	5.8	0.5	1.7
Physical	1.5	3.0	3.0	3.2
Emotional	4.6	6.2	3.4	3.2

uses the word “kränka” (offend, insult) which can be very widely applied. Hence a prevalence of more than 50% is not surprising.

When measuring emotional violence in adulthood NCK uses a more specific language than NorAQ. More examples of specific behaviours are given. NCK asks for threats to hurt oneself or to take children away while NorAQ focuses on threats to hurt the respondent or someone close to him/her.

Concerning exposure to emotional violence in adulthood (as opposed to in childhood), NCK uses the prerequisite of systematic violence as is also done in NorAQ. This is likely to be an important reason why the prevalence rates for emotional violence in adulthood are considerably more alike between the two studies than concerning emotional violence in childhood. It is noteworthy that there is virtually no difference in prevalence of emotional violence in adulthood for men (NorAQ : 8% and NCK: 9%) but almost twice as many women report emotional violence in NCK (22%) compared to NorAQ (13%). Emotional violence is the only concept for which NCK uses perpetrator-specific questions. As noted previously, recent studies have found such wording to yield higher prevalence rates for women than for men concerning intimate partner violence (Hamby, 2014b). However, it was not reported in that study how prevalence rates of violence by other perpetrators were affected by changing the wording, and it is therefore difficult to speculate on how using perpetrator-specific language would affect overall prevalence rates.

Another possible reason for the sex differences found is the gendered nature of emotional violence. As discussed previously (section 1.4.4), emotional violence between intimate partners has been found to be gendered and may need reconceptualization to be applicable to men. Emotional violence seem to, at least to some extent, be perpetrated in accordance with stereotypical male and female behaviour and involve gender role harassments (McHugh et al., 2013). NCK includes more explicit examples of behaviours than does NorAQ and it is possible that some of these are more consistent with stereotypical male to female than female to male behaviour[6]. If so, this could explain the higher prevalence rates found among women, but not among men, in NCK compared to NorAQ. For example, controlling financial expenditure is an example given in NCK that could be considered to be consistent with male gender norms, potentially leading to a higher proportion of female victims. On the other hand, threats to take children away or to take control over child custody have been reported to be used by women against men (McHugh et al., 2013), which would instead lead to a greater gender symmetry, contrary to findings in the NCK study.

Concerning sexual violence among adults it is difficult to discern why it is reported four times as often among women and three times as often among men in the NCK study compared to among men and women in NorAQ. It seems the items used include much the same kind of behaviours. Both instruments asks respondents if they have been touched 'in a sexual way', however NCK gives concrete examples of behaviours that this may entail (for example caressed, holed, kissed and groped). It is possible that 'in a sexual way' is more restrictively interpreted by respondents than the concrete examples, which could explain some of the differences.

Concerning physical violence, a great discrepancy is found for childhood abuse but not victimization in adulthood. The items used are very similar and not likely alone to account for the differences found, especially considering that the same items are used for victimization in childhood and adulthood, while differences in prevalence rates are mainly found concerning childhood abuse.

Instrument design

One possible reason that prevalence rates are generally found to be higher in the NCK study, compared to NorAQ, is that the NCK study includes questions about each kind of violence five times: first for violence committed by a parent or other adult before 15 years, then for same age perpetrators before 15 years, which is followed by adult and same age perpetrators respectively between the ages of 15 and 17, and then questions concerning experiences after 18 years. NorAQ asks the questions only once and then asks if the violence occurred in childhood (< 18 years), adulthood (≥ 18 years) or both and does not use separate questions for adult and same-age perpetrator. It is likely that when questions are asked about specific time frames and separately for adult and same-age perpetrators this will prompt respondents to recall more events of violence. Using several items that are specific concerning perpetrators' behaviour rather than asking general questions such as "have you ever been abused" is generally recommended in the field of intimate partner violence (Ellsberg et al., 2001; Hamby, 2014a). The main reason given for this is usually that general questions often force respondents to identify with categories that may be stigmatizing, such as "battered" or "rape victim" (Ellsberg et al., 2001). Many respondents who acknowledge having

[6] Violence also occurs in same-sex relationships but in NorAQ we found that 92% of male and 99% female victims reported the perpetrator of intimate partner violence to be of the opposite sex (data not published). This is why the reasoning here assumes heterosexuality.

been exposed to acts of violence, reject such labelling (Hamby and Gray-Little, 2000). Also, asking several questions and questions about a specific behaviour is said to help victims recall experiences of violence. Several questions concerning specific behaviours that are seemingly closely related are used in NorAQ and the NCK study. Rather, the main difference lies in NCK asking repeat questions about exposure to violence at different time periods. If indeed respondents are prompted to recall more episodes of violence when specific time frames are used as in the NCK study, it is reasonable that the discrepancies would be greatest for the time frame where more questions are used. This is also the case concerning rates of physical violence between the NCK and NorAQ study. In childhood (where NCK asks the same questions four times) the differences for women are: 26% vs 39%, men: 36% vs 59%. For reporting physical violence in adulthood the differences between the two studies are considerably lower: women: 17% vs 19%, men: 17% vs 20% (table 4).

4.1.2 PREVALENCE OF INTIMATE PARTNER VIOLENCE

The overall prevalence rates for male and female victimization by an intimate partner found in NorAQ are presented in study II. However, analysis of intimate partner violence by kind of violent behaviour (sexual, physical, emotional) has not been presented before. The differences between studies are even more pronounced in this comparison than when only NCK and NorAQ data was compared in the previous section. Generally NorAQ produces low prevalence rates compared to other instruments. For example the prevalence of life-time emotional violence by an intimate partner among women is reported to be 10% in NorAQ and 37% in the Nybergh study which uses VAWI. Likewise the life-time prevalence of sexual and/or physical violence by an intimate partner is 3% for men in NorAQ which can be compared to 8% in the extended NTU, 14% in the Nybergh study and 21% in the Lövestad study using CTS2 (Table 5).

Different items

Items used in the different studies can be found in table 2, page 28-29. Some of the differences found in prevalence in the different studies are not surprising. For example emotional/psychological violence is conceptualized very differently in the instruments. NorAQ, NCK and extended NTU all include both humiliating and degrading behaviours as well as controlling behaviours in emotional/psychological violence. In the Lövestad study the CBS was used, which is an instrument developed to measure only controlling behaviours while VAWI, used in the Nybergh study, does not include items that are explicitly named controlling behaviour at all. Likely even more importantly, in NorAQ, it is a prerequisite for emotional violence that it has been going on “systematically and for a long period of time”. Systematically is included in some of the questions in NCK and extended NTU but not at all in CBS (used in the Lövestad study) and VAWI (used in the Nybergh study). “For a long time” is included only in NorAQ. Considering this, it is not surprising that NorAQ gives the lowest estimate of emotional violence (women 10%, men 3%) followed by NCK (women 20%, men 8%) and extended NTU (women 24%, men 15%) while both Nybergh (women 37%, men 31%) and Lövestad report considerably higher prevalence rates (women 41% men 37%). In the Lövestad study the highest prevalence rates given for emotional violence (controlling behaviour) are for the items entitled: “wanted to know where I went and who I spoke to when not together” (women 28.3%, men 26.0%) and “felt suspicious and jealous of me” (women 27.1% men 27.2%) (Lovestad and Krantz, 2012). Even in a healthy relationship it is not unreasonable to experience such feelings occasionally. Considering that the prevalence rates are given for ever experiencing such feelings it would not have been surprising if the prevalence rates were even higher. It is not clear from the article how the items

Table 5. Estimated prevalence (%) of different kinds of intimate partner violence in five different Swedish surveys

	Women					Men				
	NorAQ	**NCK**	**NTU**	**Lövestad**	**Nybergh**	**NorAQ**	**NCK**	**NTU**	**Lövestad**	**Nybergh**
Instrument used	NorAQ	Original	Original	CTS2/CBS	VAWI	NorAQ	Original	Original	CTS2/CBS	VAWI
Prevalence of self-reported lifetime exposure to intimate partner violence										
Any violent behaviour	18	N/A	26	N/A	N/A	5	N/A	17	N/A	N/A
Emotional/psychological	10	20	24	41	37	3	8	15	37	31
Sexual	5	7	N/A	N/A	N/A	1	1	N/A	N/A	N/A
Physical	13	14	N/A	N/A	N/A	2	5		N/A	N/A
Sexual and/or physical	15	N/A	15	27	24	3	N/A	8	21	14
12-month prevalence of self-reported exposure to intimate partner violence										
Any violent behaviour	N/A	N/A	7	N/A	23	N/A	N/A	7	N/A	26
Emotional	N/A	5	7	N/A	24	N/A	3	6	N/A	24
Sexual	N/A	1	N/A	3	3	N/A	N/A	N/A	1	2
Physical	N/A	2	N/A	8	8	N/A	1	N/A	11	8
Sexual and/or physical	N/A	N/A	2	N/A	N/A	N/A	N/A	2	N/A	N/A

Notes: N/A = Not Applicable, data was not presented in the respective studies.

- *The 12-month prevalence for sexual and physical violence by an intimate partner is not given in the NCK report as a percentage. Values reported here are calculated from the proportion of victims that in the NCK study were reported to have been victimized by a partner. For example 25% out of the 3.4% of women that reported sexual victimization reported a partner perpetrator: 0.25x3.4% is 0.9%, which is round off to 1% in the table.*
- *The lifetime prevalence rates for violence in the Lövestad as well as the Nybergh studies are calculated values from numbers given in table 5 in Lövestad & Krantz (2012) and table 3 and 4 in Nybergh (2013a).*
- *Concerning the NCK data, perpetration by an intimate partner was reported separately before and after 18 years. Here data concerning victimization after the age of 18 is presented. Also, in this table, NCK data on threats of physical violence are included as physical violence because the prevalence rate for partner violence without threats was not possible to discern.*
- *In the Lövestad study, emotional/psychological violence pertains only to controlling behaviour as measured by the CBS.*

were introduced in the study. However, as previously mentioned, some respondents include behaviours not occurring in an aggressive context when reporting physical violence (Fernandez-Gonzalez et al., 2013; Hamby, 2014b). This could also be the case concerning controlling behaviours.

Also considering sexual and physical intimate partner violence, both Lövestad and Nybergh present considerably higher prevalence rates than the other studies, especially compared to NorAQ data. Lövestad reports the life-time prevalence of sexual and/or physical violence by an intimate partner to be 27% among women and 21% among men. Nybergh reports 24% for women and 14% for men while corresponding figures in the extended NTU are 15% for women and 8% for men. This can be compared to 15% for women and 3% for men in NorAQ. These differences are difficult to understand, considering that the items used seem to overlap considerably. They may in part be explained by the number and specificity of items used. CTS2 (used in the Lövestad study) includes the most items concerning physical violence: 12 compared to NorAQ (3), NCK (5), extended NTU (2) and VAWI (used in the Nybergh study) (6). However, the items measuring behaviours that are not specified at all in NorAQ did not yield very high prevalence rates in the Lövestad study, either for past year or earlier in life. For example in the male sample: twisted arm or pulled hair (past year 1.7, earlier in life 1.7), slammed against a wall (past year 0%, earlier in life 0.6%) and burned or scalded (past year 0%, earlier in life 0.6%). Because Lövestad and Nybergh both report a combined prevalence rate for physical and sexual lifetime victimization, it is not possibly to know if the considerably higher prevalence found is for both physical *and* sexual violence or only one of the two. Compared to NCK and extended NTU data, both Lövestad and Nyberg present considerably higher 12-month rates for both sexual and physical violence. Concerning sexual violence, this is somewhat surprising considering that CTS2 (used in the Lövestad study) only focuses on "sex"," which could be interpreted as intercourse, rather than the different sexual activities exemplified in NCK.

NorAQ has previously been compared to VAWI as a measurement of intimate partner violence in both a male and female sample by Nybergh and colleagues. The questions in NorAQ were in that study re-written to be partner-specific (Nybergh et al., 2012, 2013b). The two instruments were filled out by 77 women and 50 men. Nybergh found the prevalence of emotional violence to be considerably lower when using NorAQ compared to the VAWI, which is in accordance with the results presented here. However, though NorAQ produced lower prevalence rates also for physical and sexual violence in Nybergh's studies the differences for those two items were not statistically significant. In the comparison above, the lifetime prevalence of sexual and/or physical violence is reported 4.5 times more often among men and 1.5 times more often by women in VAWI compared to NorAQ. One explanation of why the differences in Nybergh's studies were smaller can be that partner-specific wording was used also in NorAQ in those studies. As discussed previously, Hamby found that whether or not partner-specific questions were used had a great influence on prevalence rates (Hamby, 2014b).

Other methodological differences

Some differences, besides definitions and wordings of questions are worth mentioning. In the NCK and extended NTU, weighted data was used. This means that the reported prevalence rates were adjusted for socio-demographic factors of non-respondents. For example, the response rate is often found to be lower among young people while at the same time young people tend to report a higher prevalence of violence. If this was the case and data is weight, prevalence rates are adjusted for the higher non-response among young people compared to older people and the reported prevalence

rate will be reported to be slightly higher than the one actually found. In study I we found response rates to be lower among men and young people, which are two groups generally found to report higher prevalence rates of violence than others. The same was found in the Nybergh studies, which also do not use weighted data. Therefore, it is possible that both NorAQ and the Nybergh study under-estimate the prevalence of violence, while the NCK and extended NTU do not, due to the weighted data. However considering that the Nybergh study yields comparably high prevalence rates and NorAQ the lowest, using weighted data does not seem to have any major influence.

How the survey is introduced can potentially affect results. In NorAQ the questionnaire was framed as being about women and men's health and living condition while the Nybergh study introduced the questions as concerning health, conflicts and relationships. The extended NTU is included as the last section of the ordinary NTU, which is a crime survey. However, the influence of introducing questions by saying they concern crime, health or family has been reported to be modest (Hamby, 2009). In NorAQ, a heading introduced the questions as about "emotional/physical/sexual abuse" and it was explicitly stated that if answering affirmatively to one or more of the questions the individual would be considered, in this study, to be a victim of sexual/physical/emotional abuse. In the Nybergh study, the questions specifically about violence were framed as being about anger, threats and violence that can exist in a relationship. Many people exposed to violence reject labels such as 'abused' or 'battered' (Hamby and Gray-Little, 2000). Hence, specifying that the respondent would be labelled "exposed to abuse" as was done in NorAQ, might have made some informants refrain from answering affirmatively in NorAQ. This could in part explain the comparably lower prevalence rates of intimate partner violence in NorAQ compared to the Nybergh study. Also, both the Nybergh and Lövestad studies ask about both victimization and perpetration of intimate partner violence. It is possible that when perpetration of violence is included, victimization becomes less stigmatizing and respondents are more likely to answer affirmably than when only victimization is included.

In the NTU, interviews have been reported to sometimes last for 1h or more and the questions concerning intimate partner violence are in the last section. This might increase the risk for reporting load which means that respondents try to shorten the interview by omitting incidents that would otherwise have been reported (Hamby, 2005). In accordance with this, extended NTU generally reports lower prevalence rates than Lövestad and Nybergh, but on the other hand higher than NorAQ, so reporting load does not seem to have any major effect.

Another difference is the mode of collecting data. NorAQ, Lövestad and Nybergh all used paper while NCK used a web form as the primary source of data collections and a printed instrument for those who did not want to respond online. NTU uses telephone interviews (87%) as the primary mode of enquiry and a paper version as the second choice (13%). However, using telephone, computer-based or paper-pencil format have previously not been found to affect prevalence rates of violence at significant levels (Hamby, Sugarman and Boney-McCoy, 2006; Rosenbaum, Rabenhorst, Reddy et al., 2006). Extended NTU is, as I understand it, the only survey which offers participants the opportunity to answer in languages beside Swedish (Interview: English; Paper: English, Arabic, Persian, Bosnian/Croatian/Serb) which could potentially influence prevalence rates, but again, extended NTU reports prevalence in the mid-range so the effect does not seem to be considerable.

Gender discrepancies in prevalence rates

The discrepancies in prevalence rates between the surveys concerning intimate partner violence are larger for male than female victims and also greater for emotional violence than for physical or sexual violence (Table 5). The conceptualization of intimate partner violence stems largely from female victims, and emotional violence has as previously discussed, been found to be a gendered experience (McHugh et al., 2013). The larger discrepancies concerning prevalence rates for men may indicate that the instruments are less precise when investigating male than female victimization and that there is a need to conceptualize what intimate partner violence against men is.

Concerning gender symmetry in research on intimate partner violence: Nybergh, Lövestad and extended NTU present gender symmetry for the last 12 months but not for life-time prevalence rates. Nybergh hypothesises that this differences is because men are generally found to report less severe violence than women and they may not consider it salient enough to remember later in life (Nybergh et al., 2013a). Due to the design of NorAQ it is not possible to discern only partner violence during the previous 12 months but for lifetime prevalence there is no gender symmetry and the differences in prevalence between the sexes are also larger than was found by Nybergh, Lövestad as well as in the extended NTU. NCK does not produce gender symmetry, either for the past 12 months or for life-time prevalence. This result is in accordance with Hamby's study that using non-partner specific language produces gender asymmetry (Hamby, 2014b).

False positives

As seen in tables 4 and 5, NorAQ produces lower prevalence rates of violence than the instruments it has been compared to. This can be interpreted as a sign that violence is under-reported in NorAQ. In the extended NTU and NCK studies, as in much research about intimate partner violence, it is presumed that under-reporting is one of the major threats to validity (e.g., M Ellsberg et al., 2001; National Council for Crime Prevention, 2014a; NCK 2014). This is argued to be because the nature of the topic is sensitive and respondents are expected to be reluctant to report experiences of violence. However, as mentioned in section 1.4.2 the possibilities of false positives are seldom considered. For example findings indicate that a small number or respondents include entirely playful episodes such as pillow fights when responding to CTS2 and potentially also being pushed or shoved in rush hour traffic (Hamby, 2005). Also, as previously discussed (section1.4.2), efforts to exclude violence occurring in a joking context in a survey of youth had a significant impact on the prevalence rates found (Fernandez-Gonzalez et al., 2013). What is considered a false positive is naturally dependent on how violence is conceptualized and what acts are understood as violent. However, there is a cognitive inconsistency between what is measured by instruments such as CTS2 and the public idea of what intimate partner violence is (Straus, 2012). For example, not including violence occurring in a joking context is likely to be a prerequisite that many would think to be already considered in the concept of intimate partner violence.

Another sign of potential over-reporting is that some researchers have found high prevalence rates of intimate partner violence but yet also high levels of relationship satisfaction. In fact, if the level of violence is low, this does not seem to lead to dissolution of the relationship or even to a lower level of relationship satisfaction (Frieze, 2005). This can be interpreted as a sign of denial of the seriousness of violence. However, it can also be a sign that not all violence captured in surveys is of great importance or consequence to the respondents. This is in line with the previously mentioned speculation that gender symmetry is reported for the past year but not for earlier in life because

respondents tend to forget acts of violence they did not find to be of serious consequence. It is important to learn more about what kind of violent experiences respondents report in different instruments, so that this can be considered in study designs and an informed decision can be taken as to whether or not such violence is of interest to the particular study.

In light of this I interpret the generally lower prevalence rates found in NorAQ, compared to the other instruments, not as a sign of under-reporting but rather as a sign that the researchers constructing NorAQ achieved their goal of not including violence of a very low magnitude.

Concluding remarks about the differences in prevalence rates (sections 4.1.1 and 4.1.2)
As discussed, some of the difference in prevalence rates found could be easily explained or at least reasonable suggestions for the differences found could be made. However, large discrepancies remain unaccounted for. The same problem is found in other countries. Hamby reports that prevalence rates concerning intimate partner violence ranging from 2% to 60% are often found in studies from the US, and that little is known about what produces this imprecision (Hamby, 2014a). Because there is no true definition or conceptualization of violence it is reasonable to find discrepancies between studies. However, it is not reasonable that so little is known about what produces these differences. The Hamby study concerning the significant fluctuations of prevalence rates of intimate partner violence when using partner-specific language or different qualifiers is an illustration of the problem (Hamby, 2014b). That study should be considered a call for more empirical research concerning methods to investigate intimate partner violence.

4.1.3 CO-OCCURRENCE OF INTERPERSONAL VIOLENCE

One of the most important findings of this thesis is that so many victims report experiences of more than one kind of violence and/or violence by more than one kind of perpetrator (study II). The estimated co-occurrence of violence found in study II is likely to be rather restrictive considering that NorAQ seems to produce rather low prevalence rates compared to other instruments and that only the kind of perpetrator, not the number of perpetrators was investigated. Likewise, only the kind of violence and not the frequency or duration of violent acts was considered in the analysis.

One question concerning the co-occurrence of violence that cannot be answered using data collected with NorAQ is to what extent victims have reported experiences of different kinds of violence/violence by different kinds of perpetrators simultaneously or at different times. For example, reporting physical and sexual violence in NorAQ can mean one experience consisting of both physical and sexual violence (e.g., rape including physical violence) or physical violence on one occasion and sexual violence on another. It is possible that also violence by different kinds of perpetrators co-occurs at the same time. However, that is likely to be less prevalent than the simultaneous co-occurrence of different kinds of violent behaviours. It is likely that multiple perpetrators are included in bullying and it is also quite possible to experience violence perpetrated by several family members. However, we have made our analysis according *to* the *kind of* perpetrator and it is more difficult to imagine that a substantial proportion of violence is perpetrated by family members, partners and/or acquaintances/strangers *at the same time*. Hence, I consider it likely that a large proportion of victims have been victimized at different times in their life. This is likely to be important for the consequences of violence. Ideally an experience of violence would be followed by recovery and support from people in the victim's vicinity. However, when victimization is reported at different time periods and by different perpetrators this might lead to an aggravated

trauma response as well as less protective factors in the form of social support. I will return to this in section 4.1.4.

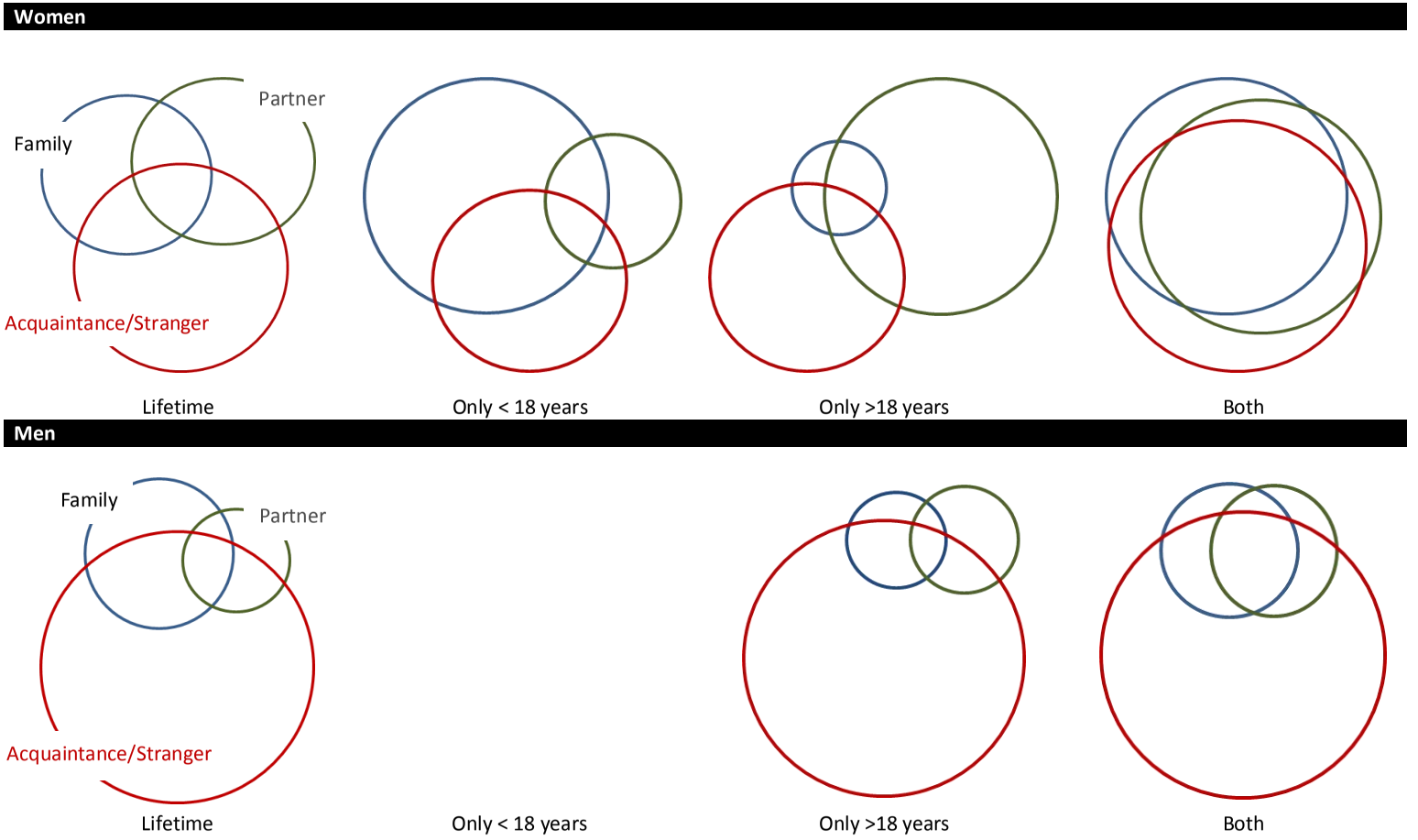
That experiences of violence tend to co-occur has become increasingly well-known in recent years, especially internationally. Not considering previous experiences of violence might hamper our understanding of both the origin and consequences of different kinds of victimization. However, many studies concerning interpersonal violence are still conducted in isolation from each other and the knowledge about the co-occurrence of violence among adult men and women in Sweden is limited. In the recent NCK study, re-victimization between childhood and adulthood was found to be extensive (see section 1.5.2). However, the co-occurrence by kind of perpetrator was not reported. Both in the extended NTU and Nybergh studies the co-occurrence of emotional, physical and sexual violence in intimate partner relationships was substantial. However, the focus of those studies was intimate partner violence, and consequently the co-occurrence of violence by different perpetrators was not reported.

It is often reported that men are primarily exposed to violence by acquaintances and strangers while women are primarily the victims of violence from intimate partners. One study reporting such a pattern is the National Violence Against Women Survey (NVAWS) from the US where 64% of female and 16% of male victims of rape, physical assault and/or stalking reported an intimate partner as the perpetrator (Tjaden and Thoennes, 2000a). Study II gives quite a different picture (figure 3): we report that the most common kind of perpetrator of violence against both men and women is an acquaintance/stranger. However, in the NVAWS as in some other studies, the perpetrator is reported for violence occurring in adulthood (> 18 years) while we present life-time data. This is likely to account for the discrepancy in perpetrator pattern between study II and previous studies. Violence from an intimate partner is likely to primarily be reported in adulthood. Hence if life-time prevalence is reported, as in study II, the proportion of victims reporting an intimate partner as the perpetrator is likely to be lower than if only adult victimization is considered.

In NorAQ, the kind of perpetrator can be related to victimization in childhood, adulthood or both. This means that if a respondent reports victimization both in childhood and adulthood and both by a partner and acquaintance/stranger it is not possible to know if he/she was victimized by both perpetrators in both childhood and adulthood or for example by a partner in adulthood and an acquaintance/stranger in childhood. Hence, the pattern of reported perpetrators cannot be discerned for the two categories exposed to violence in childhood and adulthood. It can however be discerned for the three categories exposed to violence only in childhood, only in adulthood, or in both childhood and adulthood.

In Figure 5, Venn diagrams are presented that illustrate the reported perpetrator pattern among victims in the male and female population sample separated for violence reported only in childhood, only in adulthood, as well as both in childhood and in adulthood. No male victim reported only partner violence in childhood and hence no Venn diagram could be constructed for childhood violence among men. However, most male victims reporting only violence in childhood reported an acquaintance/stranger as the perpetrator (62%) followed by 20% reporting family and an acquaintance/stranger and 14% reporting only family violence. Only one per cent of victims reported having been subjected to violence by all three kinds of perpetrators.

Figure 5. Proportional Venn diagram for the reported perpetrator in the population samples, depending on age at victimization.



As expected the differences concerning perpetrator pattern were highly dependent on age at victimization, especially for women. Among women reporting violence only in adulthood, 64% reported only a partner or a combination of perpetrators including a partner as the perpetrator while 46% reported only an acquaintance/stranger or any combination including an acquaintance/stranger as the perpetrator. For men, the corresponding number was 15% for a partner and 91% for an acquaintance/stranger. This reported perpetrator pattern is hence more in line with the NVAWS (Tjaden and Thoennes, 2000a) as well as in some other studies where a similar perpetrator pattern has been reported.

Why interpersonal violence occurs and co-occurs

Understanding how and why different kinds of violence overlap is important for both prevention of and response to interpersonal violence. However, to investigate the roots of violence and the co-occurrence of violence is beyond the scope of this thesis and not possible with the current data set. Even so I will give some brief theories, reported by others, as to why violence occurs and co-occurs. The reported risk factors are far from comprehensive.

Many forms of violence share the same risk and protective factors (Hamby and Grych, 2013; Wilkins, Tsao, Marci et al., 2014). They are here considered within the ecological framework. It is important to remember that risk factors are not causal factors and violence is an interpersonal process. Victims become victims in interaction with perpetrators. Also, as previously discussed, it is not always easy to make a distinction between victim and perpetrator (Langhinrichsen-Rohling, 2010; Hamby and Grych, 2013).

Individual level: Many of the theories concerning why victims are exposed to more than one kind of violence have a developmental perspective and concern why children exposed to violence later become the victims of violence again. It has been proposed that children may learn to consider violence as normative and justifiable (McHugh et al., 2005; Hamby and Grych, 2013). Cognitive schemata have been proposed to be important. Children exposed to violence may start to anticipate hostility and threat from others which may lead them to enter into social interactions expecting to be treated negatively. Similar thoughts come from attachment theory, where unsecure attachment is believed to lead to views of others as unreliable, indifferent or rejecting and oneself as inadequate or unloved. Victims may start to expect and accept violence. If violence is considered normative or acceptable it may lead victims to tolerate violence, from an intimate partner or another perpetrator. Victims may also be seen as an “easy target” because they are unlikely to defend themselves (Cloitre and Rosenberg, 2006; Alexander, 2009; Cloitre et al., 2009; Hamby and Grych, 2013). It should be emphasized that these cognitive reactions generally act on an automatic level rather than as conscious intentional processes (Hamby and Grych, 2013).

Relational level: The specific relationship between perpetrators and victims affects the likelihood of violence occurring. For example, a serious of behaviours between two intimate partners that become increasingly more hostile can culminate in violence (Hamby and Grych, 2013). Also, the closeness of the relationship is important, for example the risk of violence may increase within an intimate partnership as the relationship becomes more intimate. When the investment in a relationship increases, the stakes are higher and threats to the relationship may evoke controlling or abusive behaviours. In line with this, the breakup of a relationship is found to be a high risk time for violence to occur (Langhinrichsen-Rohling, 2010; Hamby and Grych, 2013). However, none of these

relationship-specific factors explain why some victims are exposed to violence in more than one kind of relationship. One explanation for the co-occurrence of violence could be that different kinds of interpersonal violence share the same risk factors on the relational level, such as economic stress and associating with delinquent peers (Hamby and Grych, 2013).

Community level: Vulnerabilities such as unsafe neighbourhoods and dysfunctional families increase the risk for many kinds of violence (Hamby and Grych, 2013; Wilkins et al., 2014). For example, individuals with a low income tend to live in a more dangerous neighbourhood and be exposed to chronic stressors which may increase the risk of violence. Situational factors, as well as personal factors, may serve as triggers, promote or inhibiting violence. Even environmental factors such as temperature, crowding and houses starting to fall apart may promote aggression (Hamby and Grych, 2013).

Societal level: How gender, especially masculinity, is constructed is also important. It is often emphasized when considering why intimate partner violence by men towards women occurs but other kinds of violence are also gendered (Connell, 1995; Anderson, 2005; Gottzén, 2014). For example, the vast majority of exposure to community violence reported by men is perpetrated by other men (Gottzén, 2014).

4.1.4 INTERPERSONAL VIOLENCE AND SYMPTOMS OF PSYCHOLOGICAL ILL-HEALTH

Violence has previously been associated with both psychological and physical ill-health, but because only psychological ill-health was considered in this thesis I will not discuss associations with physical ill-health here. It should also be noted that the items used to measure symptoms of psychological ill-health in this thesis (study III) have limitations that will be further discussed in section 4.2.2. However, it needs to be emphasized that the outcome variable referred to in study III are not measures of depression, PTSD or any other psychiatric diagnoses, but rather a measure of symptoms indicating psychological ill-health.

As hypothesized in study III we found strong associations between being subjected to different kinds of interpersonal violence and symptoms of psychological ill-health. The association was stronger for both men and women who reported cumulative violence than among other victims. This is in line with previous research (Messman-Moore et al., 2000; Tubman et al., 2004; Schumm et al., 2006; Turner et al., 2006; Romito and Grassi, 2007; Margolin et al., 2010). Also, the association between each kind of victimization and symptoms of psychological ill-health was overestimated if cumulative violence was not considered. This is also in line with previous research, mainly studies of poly-victimization among children (Finkelhor et al., 2007a). Our results supported by previous research imply that some of the influence a particular kind of victimization seems to have on the outcome variable may in fact be due to the underling constructs of experiencing more than one kind of violence or violence from more than one kind of perpetrator. Not considering the co-occurrence of violence might hence lead to the impact of a single kind of victimization being overestimated. This underlines the importance of considering the co-occurrence of violence in research. Of the previously described Swedish studies only the NCK study included estimates of violence by different perpetrator as well as measurements of different kinds of ill-health. NCK has however not (yet) reported on the co-occurrence of violence by different perpetrators.

Why co-occurrence of violence is important for the associations between violence and psychological ill-health goes beyond the scope of this thesis and would need another research design to

investigate. Also, the mechanism leading from violence to psychological ill-health is multifactorial and not completely understood. However, some possible explanations are outlined here:

The co-occurrence of violence may lead to an aggravated trauma response. For victims developing PTSD after a trauma the risk of developing PTSD also after a subsequent trauma is heightened (Briere and Jordan, 2004; Breslau, Peterson and Schultz, 2008). Some researchers have also suggested that prior merely stressful life events may have a sensitizing effect, making victims of a trauma more prone to develop PTSD (Lloyd and Turner, 2003; Hedtke, Ruggiero, Fitzgerald et al., 2008). Experiencing high level of community violence has been associated with increased severity of symptoms of PTSD above and beyond the trauma that was used as the reference for reporting PTSD symptoms. Childhood abuse has been associated with symptoms of posttraumatic stress in adulthood. The effect has been found to be direct but also mediated by greater exposure to adult interpersonal violence (Stevens, Gerhart, Goldsmith et al., 2013).

Childhood abuse has been associated with changes in the neuroendocrine stress response and alterations in the Hypothalamic Pituitary Adrenal axis (HPA axis) (Crofford, 2007; Heim, Newport, Mletzko et al., 2008; Keeshin, Cronholm and Strawn, 2012). Changes in the neuroendocrine stress system among adult men and women in response to childhood trauma have been found to resemble changes that occur in depression and PTSD (Heim et al., 2008). It has been hypothesized that early-life stressors, such as childhood abuse, may lead to alterations in the biological stress response, which, in turn, leads to an increased risk of developing depression in adulthood in response to a stressor (Heim et al., 2008). Violence may serve as such a stressor, in part explaining why victims of cumulative violence would be more likely to report psychological ill-health than victims of a single act of violence. It should, however, be noted that because many diseases, in themselves, are associated with changes in the biological stress response, the link between violence, derangements in the stress response and ill-health remains somewhat unclear (Keeshin et al., 2012).

The ecological framework can also be used to understand the association between the co-occurrence of violence and symptoms of psychological ill-health. Within the ecological framework, the importance of victims' sociocultural context is emphasized. It may be that experiences of violence in different relational contexts do not only lead to an aggravated trauma response but may also impede recovery. As previously mentioned, Finkelhor suggests concerning poly-victims, that because more people and more environments are involved children may for example have more difficulties in resisting negative self-attribution (Finkelhor et al., 2007a).

If victimized in several kinds of relationship it is likely that the social support is lower. For example, women who have been victimized both in childhood and adulthood are found to be at a higher risk of living with low social support than are women victimized only as children, or only as adults (Schumm et al., 2006). Positive social support after trauma has been found to be associated with less somatic symptoms as well as better perceived health among female victims of sexual violence (Ullman, 2007). Likewise, among female victims of intimate partner violence, perceived high levels of social support have been associated with reporting less symptoms of depression (Coker, Smith, Thompson et al., 2002b; Mburia-Mwalili, Clements-Nolle, Lee et al., 2010), and social support has been found to be a protective factor against self-reported posttraumatic stress symptoms among adult victims of childhood abuse (Stevens et al., 2013). Support from family and friends is found to be an important resilience factor among children (Boxer and Sloan-Power, 2013), and high perceived

social support predicted decreased symptoms of PTSD among victims of community violence (Scarpa, Haden and Hurley, 2006). In the latter study, the protective effect of social support was less significant at higher levels of community violence victimization. Community violence was defined as including violence in or near homes, schools and surrounding neighbourhoods and included violence both within and outside the family (Scarpa et al., 2006). This is an indication that the protective effect of social support on PTSD symptoms is lower for victims of cumulative violence than for those reporting single victimization.

A gender perspective on the association between violence and ill-health

We found an association between exposure to interpersonal violence and symptoms of psychological ill-health for both sexes. The association was particularly strong concerning experiences of intimate partner violence for both men and women. As previously mentioned other studies have reported different results concerning the association between intimate partner violence and psychological ill-health among men. It has been reported to be associated with symptoms of depression in both sexes (Coker et al., 2002a), but it has also been reported that depression, anxiety and PTSD were associated with intimate partner violence in women but not men (Ehrensaft et al., 2006). Depression has been argued to be socially constructed as feminine, and men have been found to express it differently than women. For example, acting out in anger attacks can be an expression of suppressed emotion among men suffering from depression. It has been suggested that the social construction of depression as feminine may lead to diagnosis criteria not being sensitive enough to male expressions of depression (Oliffe and Phillips, 2008). Likewise, it is possible that constructs of masculinity and femininity affect how men and women interpret and answer the questions about symptoms of psychological ill-health in NorAQ. It is, hence, questionable whether we used questions that were sensitive enough to capture symptoms of men's psychological ill-health.

4.1.5 HEALTH CARE SYSTEM'S RESPONSE TO VICTIMS OF INTERPERSONAL VIOLENCE

Study IV was conducted to learn more about why male victims of violence disclose or do not disclose a history of victimization to health care professionals. We chose to include male victims reporting experiences of sexual, physical and/or emotional violence by all kinds of perpetrator. The experience of disclosing was found to be somewhat related to the kind of victimization, for example sexual violence seemed to be more difficult to disclose than physical violence. However, the theoretical model presented in Figure 4 is applicable to all the interviewed men, and the similarities in experience between the men, regardless of kind of victimization, were striking. Previously, adults experiences of disclosing a history of exposure to violence to health care professionals has primarily been studied among female victims of intimate partner violence. Many of the findings in study IV are recognizable from those studies. The major exception to this is the effect male gender norms had on the process of disclosing. Also, research is often restricted to victims' help-seeking process or restricted to how to make health care professionals screen for experiences of violence. One important finding of study IV is that the process of disclosing was complex, and to understand it, it was important to consider the men's own perceptions and considerations beforehand (e.g., perceived need for help, feelings of shame and fear of negative consequences of disclosing), as well as the dynamics during the actual health encounter (e.g., quality of the patient-provider relationship and time constraints).

Female victims of intimate partner violence have been reported to be reluctant to offer their stories of victimization spontaneously but to be positive about being asked questions about victimization within the health care system (Rodriguez et al., 1996; Hathaway et al., 2002; Dienemann, Glass and Hyman, 2005; Feder et al., 2006a). In line with this, several of the men in study IV reported that they had been reluctant to seek help and that it had been difficult to disclose their victimization but when they did, it was a relief. Another similarity with previous studies involving female victims of intimate partner violence was that shame and fear of negative consequences were often reported as strong factors tipping the balance towards not disclosing (Hathaway et al., 2002; Liang et al., 2005; Schreiber et al., 2009; Fanslow and Robinson, 2010).

Sometimes both in research and public debate about the health care system's response to violence the question is limited to whether or not professionals should routinely enquire about a history of violence. Also, public debate is often limited to issues concern female victims of intimate partner violence. Study IV did not evaluate an effort to implement routine enquiry and does not give clarity to the general benefits or harm of such an approach. However, though we found that health care professionals had a strong influence on the disclosing process, we also found other factors to be important. Some of these factors can be targeted during an intervention in health care. It might be beneficial to broaden the perspective and not focus so much on whether or not to routinely ask female patients about intimate partner violence. First of all, there was a lack of knowledge among the men about available help within the health care system. A lack of knowledge about available resources has also been found in studies concerning female victims of intimate partner violence (Hathaway et al., 2002; Liang et al., 2005; Postmus, Severson, Berry and Yoo, 2009) and should be possible to target in an intervention. Several of the men had serious concerns about the patient-provider confidentiality, not least due to a lack of privacy. This has also been reported by female victims of intimate partner violence (Rodriguez et al., 1996; Hathaway et al., 2002; Feder et al., 2006a). Improving physical conditions for privacy in health care settings as well as assuring patients of confidentiality during the encounter with professionals should without doubt be beneficial for all patients, including those not suffering from experiences of violence.

A wish for a supportive and individually tailored meeting with health care professionals was expressed by the men in study IV, which has also been expressed by female victims of intimate partner violence (Dienemann et al., 2005; Feder, Hutson, Ramsay and Taket, 2006b). As in our study, the importance of a good physician-patient relationship for disclosure of violence is emphasized in most studies of female victims (Chang et al., 2005; Dienemann et al., 2005; Feder et al., 2006b) and is suggested to be more important than the actual wording of questions (Fogarty, Burge and McCord, 2002). Hence the relevance of only testing different wordings of questions or the mode of screening (face-to-face, written, computer based) as is sometimes done in research (Fogarty et al., 2002; MacMillan, Wathen, Jamieson et al., 2006; McCord-Duncan, Floyd, Kemp et al., 2006; Chen, Rovi, Washington et al., 2007) can be questioned . Though it may be beneficial to continue working with potential ways of asking about violence it should be acknowledged that not only have screening programs not been proven to have a significant effect on health outcomes or reduced levels of victimization, but screening is also a difficult strategy to implement. For example in one study about possible ways of screening for intimate partner violence in a primary health care setting in the U.S. it was reported that during the study only 12% of male and 38% of female patients were asked questions about violence. The low screening rate came about even though professionals had been educated about intimate partner violence, generally found it to be important to ask

patients about violence, and during the study period were reminded that they should ask their patients about violence (Kapur and Windish, 2011). Likewise, one study from Canada used a written screening tool to identify victims of intimate partner violence. The idea was that physicians should talk about violence with those screening positive. In that study, only 44% of those screening positive were later asked about their history of violence by their physician (MacMillan et al., 2009). Some of the benefits of screening for intimate partner violence among women have been said to be that it is a way to communicate compassion and also gives victims a sense of control because they have a choice about whether to talk about their victimization. It has also been argued that when somebody asks questions about violence he or she forwards the idea that violence is not normal and that help is available. If a woman decides to disclose the violence, her experience can be validated and help-seeking is legitimized (McFarlane et al., 2006). This might all be true. However, such arguments for implementing a screening program become substantially weaker in the light of the Canadian study. If more than half of the women giving positive answers to the written screening tool were not followed up by their physician, what does that risk signalling to victims? That victimization is not of importance to the health care provider? That victimization is normal? That help is not available and help-seeking is not legitimate?

It also seems there is a need to improve the health care system's preparedness to care for victims of violence. Screening within the health care system is sometimes said to be a way of identifying victims and referring them to community services. One Cochrane review has evaluated the benefits of such referrals, called advocacy interventions, which was defined as at least one of the following activities: 1) providing legal, housing and financial advice 2) facilitating access to and use of community resources and 3) providing advice for safety planning. No evidence that advocacy generally leads to cessation of violence was found, however. Intensive advocacy (12h or more) was found to potentially improve women's quality of life and reduce levels of depression, but the effects were not statistically significant. The conclusion was that advocacy may improve a wide range of outcomes but that the benefits are uncertain (Ramsay, Carter, Davidson et al., 2009).

Also, in a study from Australia 40% of female victims of intimate partner violence did not think that they had received the help they needed in the health care system (Fanslow and Robinson, 2010). Studies of female victims of sexual violence also indicate that though help services may be helpful they may also be harmful (Ullman, 2007). For example, victim-blaming attitudes by professionals have been associated with worse PTSD symptoms after sexual violence (Campbell, Sefl, Barnes et al., 1999). Male victims of intimate partner violence who classified their own experience of seeking help with domestic violence agencies, the police and/or medical providers as not at all helpful have been found to have increased odds for reporting more symptoms of PTSD (Douglas and Hines, 2011). In a study from the US about help-seeking among male victims of intimate partner violence a majority of those seeking help from mental and physical health resources report telling the provider about their victimization. However only 14% report receiving information from the medical provider about how to get help for intimate partner violence (Douglas and Hines, 2011). In a qualitative study of female victims of intimate partner violence in Sweden, victims reported experiencing retraumatization, uncaring behaviour and suffering in meetings with health care professionals (Pratt-Eriksson, Bergbom and Lyckhage, 2014). One study of Swedish emergency departments found that very few had routines for identifying victims of violence, and none were prepared to care for male victims of violence (Linnarsson, Benzein, Arestedt and Erlingsson, 2013). A need for structural improvements both inside and outside the health care system to improve professionals' knowledge about resources

for victims of intimate partner violence was pointed out in another Swedish study (Lawoko, Sanz, Helstrom and Castren, 2011). All these identified shortcomings in the health care system's response to victims of violence raises ethical concerns about the focus on implementing screening programs before structures for handling a positive answer are in place. Such structures needs to be in place regardless of whether a screening program is implemented or not. Another important ethical concern seldom articulated in the debate about screening for intimate partner violence is how to help health care professionals who are themselves victims of violence.

In health care for adults the question of screening has mainly been raised in regard to intimate partner violence against women. However, some men are victims of intimate partner violence, other kinds of violence can have detrimental health effects and not all experiences of intimate partner violence are associated with poor health. Hence, one important question in the debate about health care response to victims of violence needs to be how to identify clinically relevant interpersonal violence and how to best help those victims who need it. It is also important for health care professionals to be aware that co-occurrence of violence is common so that victims, without being blamed for their victimization, can be helped to reduce the risk of further victimization. Also, considering that intimate partner violence and child abuse are strongly associated, an important part of improving the health care response to intimate partner violence is to also care for the children of victims, who may or may not be abused themselves (Janson, 2010).

Gender and the health care response

In previous studies of help-seeking many men have been found to endorse believes that men should be reluctant to seek medical help, especially for psychological ill-health such as depression (O'Brien, Hunt and Hart, 2005; Oliffe and Phillips, 2008; Vogel et al., 2011; Johnson et al., 2012). One exception to this is if help-seeking is perceived as something that can preserve or restore masculinity (O'Brien et al., 2005; Vogel et al., 2011). Seeking help for being the victim of violence is not likely to be seen as preserving or restoring masculinity. In study IV the men's reluctance to seek help and other ways of conforming to hegemonic constructs of masculinity was a strong factor tipping the balance towards not disclosing violence to health care professionals.

The social construction of men as perpetrators of violence does not only affect male victims' own help-seeking but also how male victims of violence are perceived and treated by different support systems, including health care professionals. Female violence may not be perceived or accepted to be as serious as male violence (Anderson, 2005; Langhinrichsen-Rohling, 2010; McHugh et al., 2013). An example of how gender affects bystanders' perception of violence comes from a study using vignettes to describe different psychologically abusive behaviours. The aim was to investigate if context and gender would influence how the behaviours were classified by study participants. One vignette portrayed threats of physical violence and was viewed as considerably more abusive when described as perpetrated by a male. The effect was not related to the study participants' sex (DeHart, Follingstad and Fields, 2010). In study IV, professionals' adherence to gender norms, as understood through the interviewed men's narratives, was a strong factor counteracting disclosure of victimization. The most disturbing example was the man who said that health care professionals at the emergency room had laughed at him in disbelief when he told them that his female partner was the perpetrator of the severe physical violence he had been subjected to. Similarly, in a survey of the help-seeking process of approximately 300 male victims of intimate partner violence in the U.S., a large proportion of the men reported not being listened to or taken seriously. Also, many

men reported that domestic violence agencies and the police assumed they were the perpetrator of violence (Douglas and Hines, 2011). Langhinrichsen-Rohling identified a need to question some of the foundations that support programs for intimate partner violence often rely on, namely that men are the sole perpetrators of violence, whereas women are victims and that violence is always an expression of male power and control (Langhinrichsen-Rohling, 2010).

Another finding of study IV is that the sex of the professional seemed important to some of the interviewed men. They found it easier to disclose to a woman than to a man and had only actively turned to women for help. It was also expressed by some of the men during the interviews that they would not have agreed to the interview had I, the interviewer, been a man. This can be theorized to be related to male homosociality. It has been suggested that behaving in a way that challenges constructs of hegemonic masculinity (in this case disclosing victimization), within a group of men (in this case a male health care professional or interviewer) can lead to the man being denied status as masculine (Bird, 1996). Also, constructs of femininity and women as caring and easier to talk to may explain why the men turned to women. Similar to this, Terry Arendell, a female U.S. researcher who has interviewed men, found that the men related to her on the basis of their expectations of her as a woman rather than to her as a person (Arendell, 1997).

The risk of medicalization

Naturally not all victims of violence, especially when broad definitions of victimization are used, have the need to seek professional help. It is impossible from our data to estimate the proportion of victims who need help from the health care system. However, the large proportion of men reporting current suffering due to violence (study I) as well as the strong associations found between victimization and symptoms of psychological ill-health (study III) imply that more victims need help then are receiving it. This underlines the need for greater attention to interpersonal violence within the health care system.

As previously reported from the NCK study, many victims never seek help or tell formal sources of support about their victimization. Considerably more victims report telling informal sources of support about their experiences. The same pattern has been reported among both men and women in international research (Ullman, 2007; Postmus et al., 2009; Ansara and Hindin, 2010; Fanslow and Robinson, 2010; McCart et al., 2010). In accordance with this a need to talk to professionals about their victimization was expressed by some of the men in study IV, some also said that the support they received from family and friends was enough. For many victims, talking with informal sources of support is likely to be what they need.

There is a need for greater evaluation of services used and of what services are preferred by victims. Some victims report that informal sources of support are equally as good as or better than formal sources (McCart et al., 2010). Social support is important for the recovery of victims and most people are likely to know victims of violence, whether they are aware of it or not (Coker et al., 2002b). Perhaps strengthening friends and family members of victims and guiding them in helping the victims themselves or in helping victims to find health care resources/social services, can be an important improvement of the community response to victims of interpersonal violence. From a community point of view, interventions can be designed to help victims or prevent violence on all levels of the ecological model.

It is important to avoid medicalization of all negative life-events and to acknowledge that the need for professional help depends on the experience of victimization as well as on other life-circumstances and personal vulnerability. A shifting need for help, depending on factors unrelated to their victimization was one of the findings in study IV. Again, exploring ways to identify clinically relevant experience of violence is one way forward. However, it should be remembered that it is difficult both for victims and professionals to identify a history of violence as a contributing factor for many of the conditions that have been associated with a history of violence. The importance of education, training and routines for taking care of women identified as victims is often emphasized in research and public debate about routinely asking female patients about intimate partner violence (Lawoko et al., 2011; Berglund and Witkowski, 2014). However, to be able to give good health care, training and education about interpersonal violence and its health effects are necessary for professionals, regardless of whether or not a screening program should be implemented.

4.2 METHODOLOGICAL STRENGTHS AND WEAKNESSES

4.2.1 CONCEPTUALIZATION OF VIOLENCE

As repeatedly stated throughout this thesis, the conceptualization and operationalization of violence will heavily influence the prevalence rates found. The validity of the prevalence rates found when using NorAQ is the foundation for the validity of study I-III. As could be seen in section 4.1.1 and 4.1.2 the prevalence rates found in this thesis were restrictive compared to some of the other measurements. Hence, the question is whether the estimates found when using NorAQ are to be considered to be more or less precise than the results from the previously discussed studies? I find the answer to that question to be that none of the instruments have an obvious advantage; rather, they offer different perspectives. Considering that there is no universal truth as to what constitutes violence, using different perspectives to gain knowledge is valuable. I consider the statement of Maureen McHugh and colleagues to be relevant for all kinds of interpersonal violence: *"We argue against the conceptualization of intimate violence as a single truth or as a debate between polarized positions, and we reject either/or dichotomies as simplistic and not helpful"* (M.C. McHugh et al., 2005:323). In the end, the main question has to be what the focus of the study is. How violence is conceptualized will affect research results and there is no single measure that is suitable for all purposes (Woodin et al., 2013). For example, aggressive play has been associated with an increased risk for violence in a dating relationship (Gonzalez-Mendez and Hernandez-Cabrera, 2009). Hence, if the focus of a study is primary prevention of intimate partner violence it might be interesting also to include joking violence in studies, but if the aim is to estimate the prevalence of the more severe kinds of violence such as intimate terrorism or coercive control, it is reasonable to make an effort not to include episodes of joking violence. With the latter focus it might be reasonable to leave behavioural checklists behind altogether or combine those with other kinds of instrument focusing on experiences of victimization and the consequences that violence have on victims. This is done in some instruments, for example the Women's' Experiences with Battering (WEB) (Smith, Earp and DeVellis, 1995).

From my perspective as a physician I would have found it most interesting to learn about the prevalence of clinically relevant cases of interpersonal violence. NorAQ gives restrictive estimate compared to other instruments, and hence probably excludes some cases where victims did not find the violence to be relevant. However, in this study only current suffering of victimization and a measure of symptoms indicating psychological ill-health was used. From these measures it was not possible to know the impact the violence captured by NorAQ had on victims.

4.2.2 STUDY DESIGN AND PROBLEMS WITH USING SECONDARY ANALYSES OF DATA

One of the main methodological problems of this thesis is that secondary analysis of previously collected data is used in studies II and III. Data was originally collected to measure the prevalence of violence. Both the co-occurrence of violence and the association with psychological (and physical) ill-health should hence be investigated in new studies, with methodologies more suitable for investigating the research questions. Study III in particular needs to be replicated, using better measures of different kinds of ill-health.

NorAQ was not constructed to capture the co-occurrence of violence. Hence, some aspects of this phenomenon could unfortunately not be evaluated in studies II and III. It would have been beneficial if the severity as well as age at victimization could have been linked with the perpetrator of violence.

It would also have been interesting to know the number of perpetrators, not only the kind of perpetrator. The frequency and duration of victimization, which could have contributed to the understanding of the results, are also not included in NorAQ. In addition to this, as mentioned already in section 1.1, a large number of potentially important kinds of violence are not included in NorAQ, nor are other kinds of traumatic events included which also could have proven beneficial. However, taken together these shortcomings in the measurement of violence only emphasize the main result of study II, that co-occurrence of violence is common. It is likely that had we used a different instrument, we would have seen an even greater co-occurrence of violence.

Another methodological problem of this thesis is the poor measurement of symptoms indicating psychological ill-health in study III. This is also a consequence of secondary analysis being used; data was not collected with the main purpose of measuring any kind of ill-health. Considering the great number of existing instruments to measure different aspects of psychological ill-health it would no doubt have been better to use one of these instruments. Our questions about symptoms of psychological ill-health have not been validated by other means than re-test, which is a weak form of validation considering that it is perfectly possible for an instrument to be reliable and yet not valid.

It is also important to remember that studies I-III have a cross-sectional study design. This means that only associations can be accounted for and causality cannot be proven. Also, the data is retrospective in nature which leads to potential recollection bias. In this thesis, as in previous studies, the reported prevalence of violence is found to be higher among young people than among older. However, this should not necessarily be considered a sign that experiences of violence have become more prevalent. Rather, most violence occurs during adolescence and young adulthood. As respondents grow older they may forget and/or redefine violence they have been exposed to as not relevant. Hence, it is not surprising that young people report higher levels of exposure to violence.

4.2.3 GENERALIZABILITY AND TRANSFERABILITY

Generalizability is the term used in quantitative studies to refer to the extent to which the findings from a study conducted on a sample population can be extended to the population at large. In qualitative studies, focus is not on making findings generalizable but rather transferable. Broad claims are not made; the goal is to present data and conclusions in such a way that readers can make sound judgments on whether the results are applicable to a similar group in a similar setting (Polit and Beck, 2008).

Generalizability is rooted in logical positivistic epistemology where the aim is to look for an objective truth and to understand whether the study is a representation of that truth. However, as elaborated in section 1.1, I concur with Haraway that all knowledge is situated (Haraway, 2008). Hence, the discussion concerning generalizability below does not pertain to how well my results represent the truth; rather, it is carried out to offer an understanding of who has been included and who has been excluded in the process of constructing the result.

Generalizability can be enhanced by using sound research methods and assuring a representative and sufficiently large sample. As has previously been elaborated, there are considerable uncertainties and threats to validity in research on interpersonal violence. Keeping that in mind, my evaluation is that the results of study I and II about the prevalence of interpersonal violence (defined as in NorAQ) in the population sample are a good representation of the prevalence of interpersonal violence in the population of Östergötland (which the sample was drawn from) and can likely be

transferred to the general Swedish population. The main argument for this is that data was collected at random from the population and that a large sample was used. However, the response rate was only 50%, which is far from satisfying and a threat to the generalizability of the results. In study I, young and foreign born men were under-sampled compared to the representation of this group in the general population. Considering that young men tend to report a high levels of exposure to violence, this might have led to an underestimation of prevalence rates. Also, it is possible that victimized men and women are underrepresented in studies, because it is too painful to remember violent experiences, and if violence is ongoing, answering can also be dangerous. It is not possible to know for certain how response rates affect prevalence rates. However, in study I of this thesis, we did not find differences in prevalence rates despite differences in sampling method and response rates. Naturally, other factors could have affected the prevalence rates and concealed a true difference dependent on response rate. However, additional findings from a new data collection, using NorAQ in a random population sample in 2012, support our finding that the prevalence rate is not heavily dependent on the response rate. In that data collection, response rates were even lower, around 40% for both men and women. The prevalence rates did not, however, differ significantly between the different data collections—with one exception: young women reported a significantly higher prevalence of mild sexual violence in the 2012 year data collection (data not published).

In research on interpersonal violence, it has been hypothesized that men and women who are subjected to severe violence (e.g., intimate terrorism or coercive control), are less likely to respond to survey research, but that this group is rather small (Johnson, 2008; Hines and Douglas, 2010b). If this is true for other kinds of interpersonal violence as well, one possibility concerning the effects of the response rate could be that the sensitivity of the subject will affect some respondents, causing victims to refrain from answering questions, but these respondents are rather few and are mainly found among people who will never answer a survey of this kind. This would, theoretically, mean that no difference will be found in prevalence rates when the response rate is 40%, 60%, 80% or even 90%, but that the result will be affected and prevalence rates will be slightly higher if also the last few percentiles answered and the response rate was 100%.

One important factor limiting the generalizability of the results in study I-III, as well as the transferability of results from study IV, is that the data collection was only conducted in Swedish. This is a likely reason for the generally lower response rates found among foreign-born men (study I) and an indication of the deficient representative function of our study sample compared to the general population.

We did not find any differences in the prevalence of violence between the male population and the clinical sample. The same was found for the female samples in a previous comparison (Swahnberg et al., 2004). This was surprising, considering the strong association between violence and ill-health found in some previous studies. Concerning the generalizability of this result, it is important to remember that data for the clinical sample was collected at six different somatic clinics at a universal hospital where many of the patients would be expected to suffer from physical complaints, which was not assessed in the current thesis. It is possible that differences would have been found had data for the clinical sample been collected at a psychiatric ward or in primary care. Effects on mental health and emotional functioning but not physical well-being (all estimated using the SF36v2) has previously been reported among men reporting victimization by an intimate partner (Reid, Bonomi, Rivara et al., 2008).

The transferability of a qualitative study is judged by the reader, who decides if the results and conclusion can be transferred to another setting. To enhance transferability, it is important that sufficient descriptive data is given so that readers may evaluate whether the results can be applied to a similar group in a similar setting (Polit and Beck, 2008). In study IV, both a clear example of a man's process of disclosure, as well as quotes from other men's, have been included to illustrate the results. I believe that the men's experiences, as well as the theoretical model constructed, are relevant to other samples and in similar settings, but it is important to remember that the results are based on the experiences of 12 informants. Hence, more studies are needed to see if the theoretical model holds true for other male victims in a similar setting.

4.2.4 STATISTICS

Had we used a different instrument to measure psychological ill-health, preferably one resulting in a normally distributed continuous variable, we would also have had the opportunity to use more reliable statistical methods such as linear regression models to evaluate the association between cumulative violence and psychological ill-health. There are considerable problems with the ordinal regression model used in study III, especially in the male population sample, where the assumption of parallel lines was not met. Also, except for age, we could not include the few background factors we had access to in any of the models because they did not meet the assumption of parallel lines. I have argued here that violence needs to be conceptualized within an ecological framework and that many of the different kinds of violence share the same risk factors. Hence, it is possible that the co-occurrence of violence is associated with some of the socio-demographic factors and that one or more of these acts as a confounding factor, i.e., it might be that there is no true link between cumulative violence and symptoms of psychological ill-health, rather socio-demographic factors unmeasured or unaccounted for explain both the co-occurrence of violence and symptoms of psychological ill-health. However, the same general pattern concerning the association between cumulative violence and symptoms of psychological ill-health was found in all four samples, despite significant differences in socio-demographic factors between the samples. This is interpreted as an indication that socio-demographic factors do not influence the pattern of association in a major way.

One alternative to using the ordinal regression model would have been to use multinomial regression models. I tried this, and could then include socio-demographic factors in analyses, and found the results to be much the same: i.e., the co-occurrence of violence was associated with reporting more symptoms of psychological ill-health (data not shown). However, multinomial regression does not consider the ordinal nature of the measure indicating symptoms of psychological ill-health, which is unfortunate. Yet another alternative would have been to dichotomize the outcome variable and use binary logistic regression modelling. However, the measure of symptoms indicating psychological ill-health was weak to begin with and we do not know how to evaluate if there is a threshold where the level of reported symptoms is clinically relevant, or indicates an important level of suffering for the individual. For these reasons I did not want to lose any more variety in the variable by dichotomizing it.

When comparing the prevalence rates of violence between the population and clinical sample in study I, two kinds of analysis were performed: age stratified analysis using chi-square analysis and a binary logistic regression analysis where the kind of sample was used as an independent variable. However, it is questionable to consider the kind of sample as an independent factor in an analysis and it is also problematic that stratified analyses were only made for age when the samples also

differed on other background characteristics. There is a possibility that other differences between the samples act as confounding factor, hiding a true difference in prevalence rates between the samples.

4.2.5 LACK OF CONTEXT

NorAQ does not give us any possibility to understand why violence occurs. It does not investigate the motives or context of the violence explored. To gain a better understanding of interpersonal violence in general and the co-occurrence of violence specifically such information would be interesting. But again, this was beyond the scope of the primary data collections.

Not considering context has been argued to be both a strength and problem with instruments measuring intimate partner violence. Asking for behaviours is considered to be more reliable than using questions labelling victims (for example battered) or experiences (for example rape). However, context makes all the difference. For a severely victimized individual a gaze can be devastating and every push counts. On the other hand, between partners with poor conflict resolving skills a push and perhaps even a slap might be negative but not necessarily devastating. CTS2 is often criticised for not considering context and not being able to differentiate between different kinds of intimate partner violence that are conceptually different. One of the creators of CTS2, Murray Straus argues that this is one of the strengths of the instrument. He argues for the validity of CTS2 by pointing out that others have found the phenomenology of violence, but not the perpetration of physical acts, to be different between men and women. This means that the subjective experience of intimate partner violence is different for men and women but that they perpetrate similar acts of physical violence (Straus, 2012). Likewise, when investigating the psychometric properties of the VAWI among men and women, Nybergh found that the conceptual map for VAWI was different between the sexes (Nybergh et al., 2012; Nybergh et al., 2013a; Nybergh et al., 2013b). It was not as easy to see clear boundaries between the concepts of sexual, physical and emotional violence for men as for women. The authors suggest that even though similar acts are reported, the underlying constructs might be different between men and women (Nybergh et al., 2013a). If, as Straus concludes, the phenomenology is different between the sexes, is it then at all relevant to, as also I have done, compare prevalence rates of intimate partner violence between the sexes? Perhaps it is time to question if we need to take a few steps back, learn more about what intimate partner violence against men is, and develop new instruments to measure male victimization?

4.2.6 MEASURING GENDER

We found differences in both the kind of violent behaviour and kind of perpetrator reported by men and women in study II. Also, gender was an important construct in study IV. Together with gender theories this underlines the need to learn more about how victimization, perpetration, consequences and perceptions of interpersonal violence are gendered. However, making an analysis based on respondents' sex in survey research (such as studies I-III in this thesis) does not capture the complexity of the relationship between violence and gender. It is common to use the variable "sex" as a proxy for constructs of masculinity and femininity, indicating social and economic power as well as physical strength and training in using violence (Baker et al., 2013). However, though patriarchal norms in society promote male power and may present male violence as acceptable to resolve disputes on a cultural level this cannot be passed on to every individual relationship where violence occurs (McHugh et al., 2005; Baker et al., 2013). It should also be noted that it might be erroneous to assume that all respondents of a survey fit into the binary boxes of male or female (Baker et al.,

2013). In addition to this, weight, size and fighting skills are often assumed to be an important aspect of male violence towards female intimate partners. They have however seldom been investigated in studies. For example, it would be possible to investigate if the level of injury sustained or fear induced by an intimate partner is related to differences in size and strength between the partners (Baker et al., 2013). Using sex as a proxy for power and conceptualizing intimate partner violence as a problem of male dominance is obviously problematic for understanding male victims in heterosexual relationships but it is also inadequate for explaining violence within same-sex relationships (McHugh et al., 2005; Baker et al., 2013). However, though both men and women can be both perpetrators and victims of intimate partner violence, it does not mean that intimate partner violence is gender-neutral. Rather, it is important to understand more about the way violence is gendered and the complex interaction between system level factors and individual actions (Baker et al., 2013). An example of this is psychological violence, found to be imbued by gendered expressions and gendered harassments (McHugh et al., 2013).

Also, gender is not the only power relation. Not all differences in the prevalence and consequences of violence are dependent on gender; there are also within-groups differences, and differences in relation to other identity categories such as age and sexual orientation (Hester and Donovan, 2009). There is a need to pay attention to intersectionality and consider how different power relations intertwine to create different experiences (Baker et al., 2013). NorAQ includes very limited information about different identity categories and to find relevant markers of that is a challenging task. To better capture the complexity of constructs of masculinity and femininity in relation to interpersonal violence as well as the meaning and expressions of violence in relation to gender and other identity markers, other kinds of methodologies are needed. More qualitative research would be valuable, perhaps in conjunction with quantitative measurements in studies using mixed methods.

4.2.7 SITUATED KNOWLEDGE

In accordance with my epistemological assumptions, I find it important to reflect on the perspective and position I have in relation to my research, to strengthen the validity of my results,

The most obvious way that my study is situated is perhaps in its geographic location and the language used. As previously mentioned, speaking Swedish was an inclusion criterion for all studies which is a limitation. It is likely that there are relevant cultural differences between habitants in Sweden that we have missed when not specifically paying attention to this. Likewise, the studies in this thesis were blind to different types of identity status. For example, in study IV none of the men shared stories about being subjected to racist or homophobic violence. It is possible that experiences of such violence will lead to other difficulties in disclosing victimization to health care professionals. Also, when not considering the impact of ethnicity, class and other identity statuses there is a risk that the white middle class individual's experiences are normalized (McHugh et al., 2005).

The knowledge gained in this thesis is also situated in the sense that my interests and perspectives have affected the choices I have made during the research process. One example of this is that in the explorative phase of this research project we found that the severity of the violence reported was strongly associated with the co-occurrence of violence. I interpret this as another sign of the importance of co-occurrence of violence. However, it can also be interpreted to mean that the

severity of violence is the main reason for the strong associations found between co-occurrence of violence and symptoms of psychological ill-health. At that time I had already started to get interested in the co-occurrence of violence and so my main focus was there. This is one example of when different theories could fit the data equally well and choices made by the researcher becomes increasingly clear (Grasswick, 2013).

Also, in this thesis I have investigated the co-occurrence of violence. When choosing this perspective it is not possible to at the same time keep focus on details. I believe that an integrated approach is important but I also find focused studies to be valuable. When advocating the use of an integrated approach this does not mean that all researchers have to learn everything about all kinds of violence. Both focused, detailed perspectives as well as more comprehensive perspectives are valuable. However, the co-occurrence of violence needs to be considered to a greater extent.

Naturally I, as a researcher, have not only affected the quantitative data but also the qualitative study (IV). In addition to what I personally bring to the table in the interviews and analysis my gender may also be important for what I found. Other female researchers have experiences of men constructing masculinity in interviews by trying to take control of the situation. Some have been subjected to sexists and even misogynistic remarks as well as sexual invitations from the informants (Arendell, 1997; Pini, 2005). This has been most extremely articulated by researchers investigating topics concerning sex (Gailey and Prohaska, 2011). Perhaps the topic is the reason why I did not encounter this in any obvious way. The men I interviewed were all there to talk about when they had been in a vulnerable situation, both as victims of violence but also in encounters with health care professionals. To understand how gender is constructed in the interview, it is important to consider the topic of the interview as well as the individuals and the context of the interview (Pini, 2005). Some of the men said that my gender was important in the interview context. Women's role in conversations is stereotypically to be the emphatic listener and facilitate the man's narrative (Pini, 2005). Because this is also the role of the researcher, the fact that I am a woman might have been advantageous in the interview process. Other constructions of gender during the interview situation were not obvious. However, the interviews have not been analysed with this purpose, which would be interesting to do in the future.

My position as a physician might naturally also have affected the research results. For example in study IV, I signed the e-mail and letter with my name followed by my title. Though my profession was not underlined in any other way the men were hence probably aware of my profession. This might have made them see me as a representative of the health care system, which in turn might have affected the informants' decision to participate and what they chose to tell me. Likewise, my profession might have affected what I found interesting and important in the interviews, and what I chose to follow up on.

4.2.8 ETHICS

An important responsibility in research is to avoid harming participants. As previously mentioned (section 2.4) answering questions about violence may cause some suffering among respondents. However, participation was voluntary and it was easy to decline answering NorAQ. Only very few individuals took the opportunity to reach out to either the research team or an independent therapist. In study IV informants were selected from those who in NorAQ stated that they were willing to participate in an interview. The subject of the interview was clearly stated beforehand so

that participants could prepare themselves and choose what they wanted to share. Before the interview started, the men were again informed that they could stop the interview whenever they wanted, without giving a reason. This opportunity was not taken by anyone. Several of the men said during the interview that is was difficult to talk about what had happened to them though they wanted to do it. One man had never told anybody about his victimization and it was obvious during the interview that it was hard for him to do so. However, he clearly stated that he found the topic to be essential and that it was important for him to share his story. Several of the men also said during the interview, or afterwards, that they appreciated the opportunity to share what had happened to them.

As stated previously (section 1.1), ethics in research does not only concerns avoiding harming participants it is also a about which phenomena are deemed important enough to study, what questions are asked, and how the answers are interpreted (Skeggs, 1997; Grasswick, 2013). How violence is conceptualized can also be considered an ethical issue. In NorAQ, the perspective of the victims was seen as the gold standard during the validation process. As previously mentioned it was found that many respondents did not classify acts of mild physical violence to be abusive and that questions was therefore excluded from analyses in study II and III. I prefer this perspective over those finding it important that every act of violence should be included when trying to measure the prevalence of violence. I acknowledge that using the victim's perspective can be problematic because some victims of even severe violence tend to deny or minimize their experiences. It is for example possible that denying is the reason why 2/3 of women exposed to some kind of violence by an intimate partner did not want to label themselves as 'victims', 'abused' or 'battered' in one study. However the authors of that study suggests that context is important for the interpretation of the act (Hamby and Gray-Little, 2000). It is possible to experience acts of violence and aggression without necessarily being a person who can be labelled as a victim or as being abused. Also, even for severely victimized individuals, avoiding labelling may be a sign of a positive coping mechanism rather than denial. Intimate partner violence is often described as a process of entrapment where someone else takes control of the victim's life. I find it ethically questionable that I as a researcher should also take control by forcing a label such as 'victim' or 'abused' onto an individual who does not acknowledge it.

When the same label, in this thesis 'victim', is used for all kinds of experiences of violence this may also lead to all kinds of violence being understood in the same way which also raises ethical concerns. The gender (a)symmetry debate can serve as an example of this. Intimate partner violence was first conceptualized by feminists as men's violence against women and understood more or less entirely within a patriarchal system (Muehlenhard and Kimes, 1999; Frieze, 2005). The social conceptualization of intimate partner violence became a man who used severe violence and control over a female partner who could not leave due to economic and emotional dependency. However, as time has passed it has become evident that this conceptualization is not true for all relationships in which violence occurs. It has repeatedly been found that women use violence with male partners. However, as has been found repeatedly, this does not mean that the meaning or consequences of violence is similar between the sexes. Women more often suffer from injury following violence and more often report fear. Despite gender differences and different typologies of violence being found, intimate partner violence is still often understood within the same conceptual framework. This can have very real consequences. For example, findings of gender symmetry in the United States were used by politicians as an excuse to decrease funding for shelters for battered women in Chicago and

New Hampshire. The argument was that if women are as violent as men, there is no justification for shelters for battered women. A shelter for men was instead opened in New Hampshire, but this later closed due to the lack of men seeking help (Muehlenhard and Kimes, 1999). Hence, the labels we use and how violence and gender are conceptualized and understood within research as well as in media have very real consequences for victims. In this study I have used the label 'victim' for everyone reporting experience of at least one kind of violence. It is a sincere weakness of this study that I have not been able to make distinctions between different types of violence. It would have been beneficial had we been able to analyse and understand different types of intimate partner violence as well as violence prompted by racist or religious motives, which might very well have particular consequences for victims. Though different kinds of violence need to be understood differently, it is also important not to dismiss less severe kinds of violence, for example situational coupled intimate partner violence as not important. That might ignore forms of violence that have a significantly negative effect on society (Woodin et al., 2013).

IMPLICATIONS & FUTURE DIRECTIONS

5.1 CLINICAL IMPLICATIONS

The importance of the main finding of this thesis, that different kinds of violent behaviour and violence by different kinds of perpetrators co-occur, has in this thesis been considered mainly from a researcher's perspective. However, this is also an important finding for professionals both within the health care system and the social services, and may be valuable both in work to prevent violence and to care for victims. The realization that different kinds of violence often co-occur and that victims hence are at risk for subsequent victimization may affect both prevention efforts and treatment programs. Considering the possibility of co-occurrence of violence in therapy/treatment with victims could increase the understanding of the victim's health status, help mapping his/her resources for recovery, and perhaps help him/her find strategies to decrease the risk of future victimization.

There is also a need for health care professionals to be more aware of male victimization. Though men are the most common perpetrator of interpersonal violence some men are victims of violence and some women are perpetrators. This includes victims of severe intimate partner violence both in opposite-sex and same-sex relationships. Stereotypical beliefs portraying men only as perpetrators and women as victims of violence need to be broken down. Study IV indicated that both the men's own construction of masculinity and professionals' adherence to gender norms had negative influences on the process of disclosing victimization.

Study IV, like previous research concerning female victims of intimate partner violence, revealed that disclosing victimization to health care professionals is a complex process. Focus needs to broaden from how and when to ask questions about victimization to also include strategies about other ways to improve health care for victims of violence. This involves for example strategies to improve confidentiality in the health care setting and improve information about available resources. In many settings, structured programs to care for victims are also likely to be needed.

5.2 IMPLICATIONS FOR RESEARCH AND FUTURE DIRECTIONS

One of the main challenges for future research lies in how to simultaneously differentiate between different types of violence and integrate them in the same conceptual framework. Every aspect of interpersonal violence does not need to be included in every study. Detailed perspectives are also valuable, but due to the high co-occurrence of violence, an integrated approach in research on interpersonal violence needs to be more frequently occurring.

As in previous studies, we found that men and women are subjected to different kinds of violence and violence from different kinds of perpetrators. In the future however, the gendered nature of violence needs to be considered in more depth. It is not enough to only consider sex differences concerning the prevalence rate of different kinds of violent behaviours. Rather there is a need to learn more about the gendered construction of violence. How violence is differentially experienced and expressed by men and women should impact the way we study interpersonal violence. In addition to this there is a need to understand more about how violence is understood in relation to other identity categories such as sexual orientation and ethnicity.

There are great discrepancies in findings on the prevalence of different kinds of violence between different studies. This have led to many suggesting the need for developing a gold standard in research about violence (Follingstad and Bush, 2014). Though this intuitively may be appealing it raises serious questions as to who should be given priority when conceptualizing violence in such a standard. It is necessary to ask: *"Who benefits, who loses and what is implied through the questions they choose to ask and the way they define terms"* (Muehlenhard & Kimes, 1999:243). I find it necessary to accept that there is no true definition of what violence is. Rather what constitutes violence is dependent on the perspective taken. However, this is not an excuse for accepting the large discrepancies found when comparing prevalence rates in different surveys (table 4 & 5). Rather, more research into the methodologies used to measure violence is needed. When we understand more about what methods produced the different kinds of results, we also have the possibility to make a more informed decision about the methodology to be used in a study, based on its aim.

Also, though behavioural checklists may have a future in research about interpersonal violence in general and intimate partner violence specifically, we need to move past the idea that they represent the only way of investigating exposure to intimate partner violence. New, innovative ways of investigating different kinds of violence need to be explored. One potential way is suggested by Winstok, who proposes investigating dyads of actions rather than single behaviours. For example, if one partner engages in emotional aggression with the other partner, how does he/she respond to that? Does the response increase or decrease the level of aggression, and what happens in the next step? In this way Winstok suggests that we can learn more about why violence occurs and learn to intervene (Winstok, 2013). This kind of approach is likely to be valuable in researching types of violence that are mutual, as in for example situational couple violence. It is less likely to be valuable when researching unidirectional violence, such as coercive control.

Another approach is to measure the "clinically relevant" prevalence of violence, which has been suggested by Woodin and colleagues. They compare using self-reports of behaviours of violence to using scales measuring depression and other aspects of psychological ill-health. Such scales can give us an indication of how common a symptom is, but it cannot say anything about the impact the

symptoms have on victims' functioning or on the clinical relevance of the violence experienced. Therefore, they suggest an approach to measuring intimate partner violence that I believe could also be valuable for other kinds of interpersonal violence: start with a self-report such as CTS2 or NorAQ and use structured or semi-structured interviews as a follow-up among those giving positive answers to assess meaning, frequency, motives, impact and so on (Woodin et al., 2013). Such an approach would be more costly, both in time and money, but has the potential of accounting for more of the complexity of interpersonal violence, which is necessary if we want to advance research within the field.

CONCLUSION

The main finding in this thesis is that there are strong associations between different kinds of interpersonal violence. Almost half of female victims and a third of male victims reported exposure to more than one kind of violent behaviour (sexual, physical and/or emotional), while every third female and every fifth male victim reported being victimized by more than one kind of perpetrator (family, partner and/or acquaintance/stranger). Also, reporting having experienced more than one kind of violent behaviour/violence from more than one kind of perpetrator was more strongly associated with self-reported symptoms of psychological ill-health than any one kind of victimization alone.

In the qualitative study (IV), we found that conformity to hegemonic masculinity among male victims and adherence to gender norms among health care professionals had negative effects on the process of disclosing experiences of being exposed to interpersonal violence for men. Additionally, the disclosure processes could only be understood if the men's own perceptions and considerations beforehand (e.g., perceived need for help, fear of negative consequences of disclosing and feelings of shame) as well as the dynamics of the actual health encounter (e.g., the patient provider relationship), were considered.

What was mainly perceived as small differences in definitions and research methodology between this study and previous studies concerning interpersonal violence were found to have a large impact on the prevalence rate reported. This indicates that there is a need for methodology development in the field, and important aspects that need to be taken more into consideration are the gendered nature of violence and the co-occurrence of different kinds of violence.

ACKNOWLEDGEMENT

I want to express my sincere and heartfelt gratitude to everyone who made this journey possible and (most of the time) enjoyable.

First of all I want to thank the twelve men interviewed for study IV. I am so grateful to you for sharing stories from your life with me, stories that sometimes was very difficult to tell. You gave me a lot to think about and made me both a better researcher and a better physician.

I also feel gratitude towards all the men and women who took time to answer NorAQ, making this research project possible.

More specifically I want to thank:

Professor *Katarina Swahnberg*, my main supervisor, where can I start? Perhaps at the very beginning: thank you for taking me on all those years ago when I was a confused medical student who met NorAQ and the mysteries of SPSS for the first time. Eleven years has passed since we first met and I am now even more confused. However, it has been fun and I cannot imagine what it would have been like to walk this road without your constant enthusiasm. Thank you for all the support, all the laughter, for everything you taught me, for believing in me and for always being accessible. Well except for when you were in Nepal, but then on the other hand you gave me something to dream about, so thank you for that as well (and for sending me to Nepal of course).

Professor emerita *Barbro Wijma*, my co-supervisor. I do not known the number of times I have said or thought "good enough" about a text, but you continued to push by giving me more remarks to work on. It was not always fun, but in the end it was always worth it. Thank you for helping me doing the best I can and for being supportive. I am sorry for making you read and re-read so many times during weekends and evenings.

Jelmer Brüggemann, first of all, I am sorry for constantly interrupting your work and I am sorry that I went skiing and left you to finish my grants proposal. Thank you for helping me to see things from a new perspective and "to kill my darlings". Especially thank you for all the fun we had when working on study IV. In addition to this, thank you for letting me have the window seat and more often than not choose the music.

Sabina Brohede, you are an invaluable friend and have been so for many years now. I have truly enjoyed also working alongside you from time to time. Thank you for listening to my frustration concerning poor research methodology both at work, at the playground and at home. Thank you for all the support, all the discussions and all the fun.

Anke Zbikowski, Anneli Frostell, Birgitta Salomonsson, Goldina Smirthwaite, Katri Nieminen, Klaas Wijma, Lena Hanberger, Lotta Samelius and Maria Nygren, thank you for all the help in writing this thesis. Thank you for reading, for commenting and for participating in discussions and seminaries about my work as wells as letting me read your work. Your remarks and thoughts along the way were invaluable.

Anna-Karin Rehn Bjurströmer, Humlan Svensson, Ulla Svensson Bater, everyone previously mentioned and everyone else who over the years have passed by the coffee table in Hälsans hus for a short or long period of time. Thank you for so enthusiastically embracing 'måndagsfika' and for being who you are so that the coffee breaks have been so enjoyable. A special thanks to Humlan who have helped out with so many practical things and from time to time seemed to be the heart of the division of gender and medicine.

Gabriella Karlsson, if it wasn't for you laughing and crying with me those first hours spent with SPSS I do not think I would have continued on this journey, so for that I am grateful.

My parents, *Gertrud* and *Ingemar Davidsson,* for all the love and support through the years. Without it I would never have gotten to this point in my life. A special thank you to my mother for travelling back and forth so much to take care of Alfred and Oscar.

My in-laws *Monica* and *Bengt Simmons* for taking an interest in what I do and for being supportive. Also, thank you for your help in taking care of Alfred and Oscar, this book would not have included half as much without your help baby-sitting.

*Gustav, t*hank you for loving me, supporting me and believing in me. Thank you for talking about concrete, tools and other totally uninteresting things (as well as a lot of interesting things) so that I did not get caught up in my own world all the time. Thank you for not being too frustrated with me (or at least putting up a good face) when 50% work turned into 80%, that turned into 100%, that turned into 120%. It is over (for) now. I love you.

Alfred and *Oscar* thank you for waking me up in the morning and thank you for greeting me with smiles hugs and kisses when I get home. You are what is dearest to me, thank you for reminding me of that from time to time.

Last but not least I want to thank *Karolina Widerström*, *Ada Nilsson, Ellen Fries* and all the other heroines for building the road that I had the privilege of walking on.

P.S. MEA here I come! ☺

REFERENCES

Afifi, T. O., H. MacMillan, B. J. Cox, G. J. Asmundson, M. B. Stein and J. Sareen (2009). "Mental health correlates of intimate partner violence in marital relationships in a nationally representative sample of males and females." J Interpers Violence 24(8): 1398-1417.

Alaggia, R., C. Regehr and A. Jenney (2012). "Risky Business: An Ecological Analysis of Intimate Partner Violence Disclosure." Research on Social Work Practice 22(3): 301-312.

Alexander, P. C. (2009). "Childhood Trauma, Attachment, and Abuse by Multiple Partners." Psychological Trauma: Theory, Reserach, Practice and Policy 1(1): 78-88.

Ambjörnsson, F. (2004). I en klass för sig. Stockholm, Ordfront förlag.

American Medical Association (2008). Opinion 2.02: Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion202.page accesed on 2015-01-13

Anderson, E. (2011). Feminist Epistemology and Philosophy of Science. Stanford Encyclopedia of Philosophy. E. N. Zalta. Stanford, CA, USA, The metaphysics Reserach Lab. Center for the Study of Language and Information, Stanford University.

Anderson, K. L. (2005). "Theorizing Gender in Intimate Partner Violence Reserach." Sex Roles 52(11/12): 853-865.

Anderson, K. L. (2009). "Gendering Coercive Control." Violence Against Women 15(12): 1444-1457.

Annerback, E. M., L. Sahlqvist, C. G. Svedin, G. Wingren and P. A. Gustafsson (2012). "Child physical abuse and concurrence of other types of child abuse in Sweden-Associations with health and risk behaviors." Child Abuse Negl 36(7-8): 585-595.

Ansara, D. L. and M. J. Hindin (2010). "Formal and informal help-seeking associated with women's and men's experiences of intimate partner violence in Canada." Social Science Medicine 70(7): 1011-1018.

Aosved, A. C., P. J. Long and E. K. Voller (2011). "Sexual revictimzation and adjustment in college men." Psychology of Men & Masculinity 12(3): 285-296.

Arata, C. M. (2000). "From child victim to adult victim: a model for predicting sexual revictimization." Child Maltreat 5(1): 28-38.

Archer, J. (2000). "Sex differences in aggression between heterosexual partners: a meta-analytic review." Psychol Bull 126(5): 651-680.

Arendell, T. (1997). "Reflections on the Researcher-Researched Relationship: A Woman Interviewing Men." Qualitative Sociology 20(3): 341-368.

Arias, I. (2004). "The legacy of child maltreatment: long-term health consequences for women." J Womens Health (Larchmt) 13(5): 468-473.

Baker, N. L., J. D. Buick, S. R. Kim, S. Moniz and K. L. Nava (2013). "Lessons from Examining Same-Sex Intimate Partner Violence." Sex Roles 69(3-4): 182-192.

Beausang, A., L. Berg, N. Carlsson, D. Cederberg, I. Danielsson, K. Edin, M. Eliasson, V. Enander, m. Eriksson, K. Jigmo, G. Krantz, A. Kruse, C. Holmberg, U. Lehtinen, M. Mannheimer, P.-O. Michel, A. Norlen, E. Sundborg, C. G. Svedin, K. Swahnberg, B. Tingberg, C. Ohlsson, E. Wendt, A. Westerståhl, I. Wiklund and A. Åhlund (2014). Möjligheten att rädda några av dessa kvinnors liv har inte vägts in. Dagens Medicion.

Berglund, A. (2010). Hur hanteras frågor om våldsutsatthet inom hälso- och sjukvården internationellt? En litteraturöversikt. Att fråga om våldsutsatthet som en del av anamnesen. A. Berglund. Uppsala

Berglund, A. and Å. Witkowski (2014). Hälso- och sjukvårdens ansvar. Våldsutsatta kvinnor - Samhällets ansvar. G. Heimer, A. Björck and C. Kunosson. Lund, Studentlitteratur: 127-152.

Bird, S. R. (1996). "Welcome to the men's club - Homosociality and the maintenance of hegemonic masculinity." Gender & Society 10(2): 120-132.

Birkler, J. (2008). Vetenskapsteori. En grundbok. Stockholm, Liber.

Blom, H., U. Hogberg, N. Olofsson and I. Danielsson (2014). "Strong association between earlier abuse and revictimization in youth." BMC Public Health 14: 715.

Boxer, P. and E. Sloan-Power (2013). "Coping with violence: a comprehensive framework and implications for understanding resilience." Trauma Violence Abuse 14(3): 209-221.

Brah, A. and A. Phoenix (2004). "Ain't I a women? Revisiting intersectionality." Journal of International Women Studies 5(3): 75-86.

Breslau, N., E. L. Peterson and L. R. Schultz (2008). "A second look at prior trauma and the posttraumatic stress disorder effects of subsequent trauma: a prospective epidemiological study." Arch Gen Psychiatry 65(4): 431-437.

Briere, J. and C. E. Jordan (2004). "Violence against women: outcome complexity and implications for assessment and treatment." J Interpers Violence 19(11): 1252-1276.

Brokaw, J., L. Fullerton-Gleason, L. Olson, C. Crandall, S. McLaughlin and D. Sklar (2002). "Health status and intimate partner violence: a cross-sectional study." Ann Emerg Med 39(1): 31-38.

Bronfenbrenner, U. (1986). "Ecology of the Family as a Context for Human-Development - Research Perspectives." Developmental Psychology 22(6): 723-742.

Brush, L. D. (2005). "Philosophical and political issues in research on women's violence and aggression." Sex Roles 52(11-12): 867-873.

Brüggemann, A. J. (2012). Toward an Understanding of Abuse in Health Care A Female Patient Perspective, http://urn.kb.se/resolve?urn=urn:nbn:se:liu:diva-79334. Doctoral Thesis, Linköping University.

Campbell, J. C. (2002). "Health consequences of intimate partner violence." Lancet 359: 1331-1336.

Campbell, R., T. Sefl, H. E. Barnes, C. E. Ahrens, S. M. Wasco and Y. Zaragoza-Diesfeld (1999). "Community services for rape survivors: Enhancing psychological well-being or increasing trauma?" Journal of Consulting and Clinical Psychology 67(6): 847-858.

Carbone-Lopez, K., C. Kruttschnitt and R. Macmillan (2006). "Patterns of intimate partner violence and their associations with physical health, psychological distress, and substance use." Public Health Rep 121(4): 382-392.

Chang, J. C., M. R. Decker, K. E. Moracco, S. L. Martin, R. Petersen and P. Y. Frasier (2005). "Asking about intimate partner violence: advice from female survivors to health care providers." Patient Education and Counseling 59(2): 141-147.

Charmaz, K. (2006). Constructing Grounded Theory. A practical Guide Through Qualitative Analysis. London, SAGE Publications Ltd.

Chen, P. H., S. Rovi, J. Washington, A. Jacobs, M. Vega, K. Y. Pan and M. S. Johnson (2007). "Randomized comparison of 3 methods to screen for domestic violence in family practice." Ann Fam Med 5(5): 430-435.

Cloitre, M. and A. Rosenberg (2006). Sexual revictimization. Risk factors and prevention. Cognitive-Behavioral Therapies for Trauma. V. C. Follette and J. I. Ruzek. New York, The Guilford Press: 321-361.

Cloitre, M., B. C. Stolbach, J. L. Herman, B. van der Kolk, R. Pynoos, J. Wang and E. Petkova (2009). "A developmental approach to complex PTSD: childhood and adult cumulative trauma as predictors of symptom complexity." J Trauma Stress 22(5): 399-408.

Coid, J., A. Petruckevitch, G. Feder, W.-S. Chung, J. Richardson and S. Moorey (2001). "Relation between childhood sexual and physical abuse and risk of revictimisation in women: A cross-sectional survey." Lancet 358: 450-454.

Coker, A. L., K. E. Davis, I. Arias, S. Desai, M. Sanderson, B. HM and P. H. Smith (2002a). "Physical and mental health effects of intimate partner violence for men and women." American Journal of Preventive Medicine 23(4): 260-268.

Coker, A. L., P. H. Smith, M. P. Thompson, R. E. McKeown, L. Bethea and K. E. Davis (2002b). "Social support protects against the negative effects of partner violence on mental health." J Womens Health Gend Based Med 11(5): 465-476.

Cole, J., T. K. Logan and L. Shannon (2008). "Women's risk for revictimization by a new abusive partner: for what should we be looking?" Violence Vict 23(3): 315-330.

Connell, R. (2009). Om genus [Gender In World Perspective]. Göteborg, Daidalos AB in corporation with Polity Press Ltd.

Connell, R. W. (1995). Masculinities. Cambridge, Polity press.

Connell, R. W. and J. W. Messerschmidt (2005). "Hegemonic masculinity - Rethinking the concept." Gender & Society 19(6): 829-859.

Crofford, L. J. (2007). "Violence, stress, and somatic syndromes." Trauma Violence Abuse 8(3): 299-313.

Daigle, L. E., B. S. Fisher and F. T. Cullen (2008). "The violent and sexual victimization of college women: is repeat victimization a problem?" J Interpers Violence 23(9): 1296-1313.

Danielsson, I., H. Blom, C. Nilses, G. Heimer and U. Hogberg (2009). "Gendered patterns of high violence exposure among Swedish youth." Acta Obstet Gynecol Scand 88(5): 528-535.

DeHart, D. D., D. R. Follingstad and A. M. Fields (2010). "Does Context Matter in Determining Psychological Abuse? Effects of Pattern, Harm, Relationship, and Norms." Journal of Family Violence 25(5): 461-474.

Desai, S., I. Arias, M. P. Thompson and K. C. Basile (2002). "Childhood victimization and subsequent adult revictimization assessed in a nationally representative sample of women and men." Violence Vict 17(6): 639-653.

Dienemann, J., N. Glass and R. Hyman (2005). "Survivor preferences for response to IPV disclosure." Clin Nurs Res 14(3): 215-233; discussion 234-217.

Douglas, E. M. and D. A. Hines (2011). "The Helpseeking Experiences of Men Who Sustain Intimate Partner Violence: An Overlooked Population and Implications for Practice." Journal of Family Violence 26(6): 473-485.

Dube, S. R., R. F. Anda, C. L. Whitfield, D. W. Brown, V. J. Felitti, M. Dong and W. H. Giles (2005). "Long-term consequences of childhood sexual abuse by gender of victim." Am J Prev Med 28(5): 430-438.

Dutton, M. A., S. Kaltman, L. A. Goodman, K. Weinfurt and N. Vankos (2005). "Patterns of intimate partner violence: correlates and outcomes." Violence Vict 20(5): 483-497.

Ehrensaft, M. K., P. Cohen, J. Brown, E. Smailes, H. Chen and J. G. Johnson (2003). "Intergenerational transmission of partner violence: a 20-year prospective study." J Consult Clin Psychol 71(4): 741-753.

Ehrensaft, M. K., T. E. Moffitt and A. Caspi (2006). "Is domestic violence followed by an increased risk of psychiatric disorders among women but not among men? A longitudinal cohort study." Am J Psychiatry 163(5): 885-892.

Ellsberg, M., L. Heise, R. Pena, S. Agurto and A. Winkvist (2001). "Researching domestic violence against women: methodological and ethical considerations." Stud Fam Plan 32(1): 1-16.

Ellsberg, M., H. A. Jansen, L. Heise, C. H. Watts and C. Garcia-Moreno (2008). "Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study." Lancet 371(9619): 1165-1172.

Fanslow, J. L. and E. M. Robinson (2010). "Help-seeking behaviors and reasons for help seeking reported by a representative sample of women victims of intimate partner violence in New Zealand." Journal of Interpersonal Violence 25(5): 929-951.

Feder, G. S., M. Hutson, J. Ramsay and A. R. Taket (2006a). "Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies." Archives of Internal Medicine 166(1): 22-37.

Feder, G. S., M. Hutson, J. Ramsay and A. R. Taket (2006b). "Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies." Arch Intern Med 166(1): 22-37.

Felitti, V. J., R. F. Anda, D. Nordenberg, D. F. Williamson, A. M. Spitz, V. Edwards, M. P. Koss and J. S. Marks (1998a). "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study." American Journal of Preventive Medicine 14(4): 245-258.

Felitti, V. J., R. F. Anda, D. Nordenberg, D. F. Williamson, A. M. Spitz, V. Edwards, M. P. Koss and J. S. Marks (1998b). "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study." Am J Prev Med 14(4): 245-258.

Fernandez-Gonzalez, L., K. D. O'Leary and M. J. Munoz-Rivas (2013). "We Are Not Joking: Need for Controls in Reports of Dating Violence." Journal of Interpersonal Violence 28(3): 602-620.

Finkelhor, D., R. Ormrod, H. Turner and M. Holt (2009). "Pathways to poly-victimization." Child Maltreat 14(4): 316-329.

Finkelhor, D., R. K. Ormrod and H. A. Turner (2007a). "Poly-victimization: a neglected component in child victimization." Child Abuse Negl 31(1): 7-26.

Finkelhor, D., R. K. Ormrod and H. A. Turner (2007b). "Re-victimization patterns in a national longitudinal sample of children and youth." Child Abuse Negl 31(5): 479-502.

Finkelhor, D., H. Turner, R. Ormrod and S. L. Hamby (2009). "Violence, abuse, and crime exposure in a national sample of children and youth." Pediatrics 124(5): 1411-1423.

Fogarty, C. T., S. Burge and E. C. McCord (2002). "Communicating with patients about intimate partner violence: screening and interviewing approaches." Fam Med 34(5): 369-375.

Follingstad, D. R. and H. m. Bush (2014). "Measurement of Intimate Partner Violence: A Model for Developing the Gold Standard." Psychology of Violence 4(4): 369-393.

Follingstad, D. R. and M. J. Rogers (2013). "Validity Concerns in the Measurement of Women's and Men's Report of Intimate Partner Violence." Sex Roles 69(3-4): 149-167.

Follingstad, D. R. and K. M. Ryan (2013). "Contemporary Issues in the Measurement of Partner Violence." Sex Roles 69(3-4): 115-119.

Frieze, I. H. (2005). "Female violence against intimate partners: An introduction." Psychology of Women Quarterly 29(3): 229-237.

Gailey, J. A. and A. Prohaska (2011). "Power and gender negotiations during interviews with men about sex and sexually degrading practices." Qualitative Research 11(4): 365-380.

García-Moreno, C., H. A. F. M. Jansen, M. Ellsberg, L. Heise and C. Watts (2005). WHO multi-country study on women's health and domestic violence against women. Initial results on prevalence, health outcomes and women's responses. Geneva, World Health Organization.

Gemzöe, L. (2013). Feminism [Feminisim]. Falun, Sweden, Bilda Förlag & idé.

Gilbert, R., C. S. Widom, K. Browne, D. Fergusson, E. Webb and S. Janson (2009). "Burden and consequences of child maltreatment in high-income countries." Lancet 373(9657): 68-81.

Glaser, B. and A. Strauss (1967/1999). The discovery of grounded theory: Strategies for qualitative research. New York, Aldine de Gruyter.

Gonzalez-Mendez, R. and J. A. Hernandez-Cabrera (2009). "Play Context, Commitment, and Dating Violence A Structural Equation Model." Journal of Interpersonal Violence 24(9): 1518-1535.

Goodyear-Smith, F. (2002). "National screening policies in general practice: a case study of routine screening for partner abuse." Appl Health Econ Health Policy 1(4): 197-209.

Gottzén, L. (2014). Maskulinitet och mäns våld mot kvinnor. Våldsutsatta kvinnor - samhällets ansvar. G. Heimer, A. Björck and C. Kunosson. Lund, Studentlitteratur.

Graham-Kevan, N. and J. Archer (2003). "Intimate terrorism and common couple violence - A test of Johnson's predictions in four British samples." Journal of Interpersonal Violence 18(11): 1247-1270.

Grasswick, H. (2013). Feminist Social Epistemology. Stanford Ecnyclopedia of Philosophy. E. N. Zalta. Stanford, CA, USA, The Metaphysics Resrach Lab, Center for the study of Language and Information, Stanford University.

Grych, J. and S. Swan (2012). "Toward a More Comprehensive Understanding of Interpersonal Violence: Introduction to the Special Issue on Interconnections Among Different Types of Violence." Psychology of Violence 2(2): 105-110.

Gustafsson, P. E., D. Nilsson and C. G. Svedin (2009). "Polytraumatization and psychological symptoms in children and adolescents." Eur Child Adolesc Psychiatry 18(5): 274-283.

Hamby, S. (2009). "The Gender Debate About Intimate Partner Violence: Solutions and Dead Ends." Psychological Trauma-Theory Research Practice and Policy 1(1): 24-34.

Hamby, S. (2014a). "Intimate Partner and Sexual Violence Research: Scientific Progress, Scientific Challenges, and Gender." Trauma Violence & Abuse 15(3): 149-158.

Hamby, S. (2014b). "Self-Report Measures That Do Not Produce Gender Parity in Intimate Partner Violence: A Multi-Study Investigation." Psychology of Violence(Advance online publication October 27).

Hamby, S. and J. Grych (2013). The Web of Violence. Exploring Connections Among Different Forms of Interpersonal Violence and Abuse. New York, Springer.

Hamby, S., D. B. Sugarman and S. Boney-McCoy (2006). "Does questionnaire format impact reported partner violence rates?: An experimental study." Violence and Victims 21(4): 507-518.

Hamby, S. L. (2005). "Measuring gender differences in partner violence: Implications from research on other forms of violent and socially undesirable behavior." Sex Roles 52(11-12): 725-742.

Hamby, S. L. and B. Gray-Little (2000). "Labeling partner violence: when do victims differentiate among acts?" Violence Vict 15(2): 173-186.

Hamby, S. L., V. C. Poindexter and B. GrayLittle (1996). "Four measures of partner violence: Construct similarity and classification differences." Journal of Marriage and the Family 58(1): 127-139.

Haraway, D. (1988). "Situated knowledges: The science question in feminism and the privilege of partial perspective." Feminist studies 14: 575-599.

Haraway, D. (2008). Apor, cyborger och kvinnor. Att återuppfinna naturen Stockholm, Östlings Bokförlag Symposion.

Hathaway, J. E., G. Willis and B. Zimmer (2002). "Listening to survivors' voices - Addressing partner abuse in the health care setting." Violence Against Women 8(6): 687-719.

Hedtke, K. A., K. J. Ruggiero, M. M. Fitzgerald, H. M. Zinzow, B. E. Saunders, H. S. Resnick and D. G. Kilpatrick (2008). "A longitudinal investigation of interpersonal violence in relation to mental health and substance use." J Consult Clin Psychol 76(4): 633-647.

Hegarty, K., L. O'Doherty, A. Taft, P. Chondros, S. Brown, J. Valpied, J. Astbury, A. Taket, L. Gold, G. Feder and J. Gunn (2013). "Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial." Lancet 382(9888): 249-258.

Heim, C., D. J. Newport, T. Mletzko, A. H. Miller and C. B. Hemeroff (2008). "The link between childhood trauma and depression: Insights from HPA axis studies in humans." Psychoneuroendocrinology 33(6): 693-710.

Heise, L. L. (1998). "Violence against women: an integrated, ecological framework." Violence Against Women 4(3): 262-290.

Hester, M. and C. Donovan (2009). "Researching domestic violence in same-sex relationships--a feminist epistemological approach to survey development." J Lesbian Stud 13(2): 161-173.

Hines, D. A. and E. M. Douglas (2010a). "A Closer Look at Men Who Sustain Intimate Terrorism by Women." Partner Abuse 1(3): 286-313.

Hines, D. A. and E. M. Douglas (2010b). "Intimate Terrorism by Women Towards Men: Does it Exist?" Journal of Aggression, Conflict and Peace Research 2(3): 36-56.

Hines, D. A. and E. M. Douglas (2011). "Symptoms of Posttraumatic Stress Disorder in Men Who Sustain Intimate Partner Violence: A Study of Helpseeking and Community Samples." Psychol Men Masc 12(2): 112-127.

Högberg, U. and K. Edin (2008). "Fråga om våld i mödravården - inte ett antingen eller." Läkartidningen 105(20): 1505-1506.

Janson, S. (2010). Barn som lever med våld i hemmet. Att fråga om våldsutsatthet som en del av anamnesen. G. Heimer and A. Berglund. Uppsala, NCK.

Johnson, J. L., J. L. Oliffe, M. T. Kelly, P. Galdas and J. S. Ogrodniczuk (2012). "Men's discourses of help-seeking in the context of depression." Sociology of Health & Illness 34(3): 345-361.

Johnson, M. P. (2006). "Conflict and control. Gender symmetry and asymmetry in domestic violence." Violence Against Women 12(11): 1003-1018.

Johnson, M. P. (2008). A typology of violence: intimate terrorism, violent resistance and situational couple violence. Boston, Northeastern University Press.

Juth, N. and C. Munthe (2012). Etiska aspekter på rutinfrågor om våldsutsatthet i hälso- och sjukvården samt socialtjänsten. Rapport beställd av Socialstyrelsen 2012. . Philosophica Communications, Web Series. Gothenburg, University of Gothenburg. Philosophy, Linguistics & Theory of Science.

Kapur, N. A. and D. M. Windish (2011). "Optimal methods to screen men and women for intimate partner violence: results from an internal medicine residency continuity clinic." Journal of Interpersonal Violence 26(12): 2335-2352.

Kay, M. and S. Jeffries (2010). "Homophobia, Heteronormativism and Hegemonic Masculinity: Male Same-Sex Intimate Violence from the Perspective of Brisbane Service Providers." Psychiatry Psychology and Law 17(3): 412-423.

Keeshin, B. R., P. F. Cronholm and J. R. Strawn (2012). "Physiologic changes associated with violence and abuse exposure: an examination of related medical conditions." Trauma Violence Abuse 13(1): 41-56.

Kimerling, R., J. Alvarez, J. Pavao, A. Kaminski and N. Baumrind (2007). "Epidemiology and consequences of women's revictimization." Womens Health Issues 17(2): 101-106.

Klevens, J. and L. E. Saltzman (2009). "The controversy on screening for intimate partner violence: a question of semantics?" J Womens Health (Larchmt) 18(2): 143-145.

Krug, E. G., L. L. Dahlberg, J. A. Mercy, A. B. Zwi and R. Lozano, Eds. (2002). World report on violence and health. Geneva, World Health Organization.

Langhinrichsen-Rohling, J. (2010). "Controversies Involving Gender and Intimate Partner Violence in the United States." Sex Roles 62(3-4): 179-193.

Lawoko, S., S. Sanz, L. Helstrom and M. Castren (2011). "Screening for Intimate Partner Violence against Women in Healthcare Sweden: Prevalence and Determinants." ISRN Nurs 2011: 510692.

Lehrner, A. and N. E. Allen (2014). "Construct Validity of the Conflict Tactics Scales: A Mixed-Method Investigation of Women's Intimate Partner Violence." Psychology of Violence 4(4): 477-490.

Leone, J. M., M. P. Johnson and C. L. Cohan (2007). "Victim help seeking: Differences between intimate terrorism and situational couple violence." Family Relations 56(5): 427-439.

Liang, B., L. Goodman, P. Tummala-Narra and S. Weintraub (2005). "A theoretical framework for understanding help-seeking processes among survivors of intimate partner violence." American Journal of Community Psychology 36(1-2): 71-84.

Liebschutz, J., T. Battaglia, E. Finley and T. Averbuch (2008). "Disclosing intimate partner violence to health care clinicians - what a difference the setting makes: a qualitative study." BMC Public Health 8: 229.

Linnarsson, J. R., E. Benzein, K. Arestedt and C. Erlingsson (2013). "Preparedness to care for victims of violence and their families in emergency departments." Emergency Medicine Journal 30(3): 198-201.

Lipman-Blumen, J. (1975). "Changing sex roles in american culture: future directions for research." Arch Sex Behav 4(4): 433-446.

Lloyd, D. A. and R. J. Turner (2003). "Cumulative adversity and posttraumatic stress disorder: evidence from a diverse community sample of young adults." Am J Orthopsychiatry 73(4): 381-391.

Lovestad, S. and G. Krantz (2012). "Men's and women's exposure and perpetration of partner violence: an epidemiological study from Sweden." BMC Public Health 12: 945.

Lykke, N. (2005). "Nya perspektiv på intersektionalitet. Problem och möjligheter." Kvinnovetenskaplig tidskrift(2-3).

MacMillan, H. L., C. N. Wathen, E. Jamieson, M. Boyle, L. A. McNutt, A. Worster, B. Lent and M. Webb (2006). "Approaches to screening for intimate partner violence in health care settings: a randomized trial." JAMA 296(5): 530-536.

MacMillan, H. L., C. N. Wathen, E. Jamieson, M. H. Boyle, H. S. Shannon, M. Ford-Gilboe, A. Worster, B. Lent, J. H. Coben, J. C. Campbell and L. A. McNutt (2009). "Screening for intimate partner violence in health care settings: a randomized trial." JAMA : the journal of the American Medical Association 302(5): 493-501.

Margolin, G., K. A. Vickerman, P. H. Oliver and E. B. Gordis (2010). "Violence exposure in multiple interpersonal domains: cumulative and differential effects." J Adolesc Health 47(2): 198-205.

Mburia-Mwalili, A., K. Clements-Nolle, W. Lee, M. Shadley and Y. Wei (2010). "Intimate partner violence and depression in a population-based sample of women: can social support help?" J Interpers Violence 25(12): 2258-2278.

McCart, M. R., D. W. Smith and G. K. Sawyer (2010). "Help Seeking Among Victims of Crime: A Review of the Empirical Literature." Journal of Traumatic Stress 23(2): 198-206.

McCord-Duncan, E. C., M. Floyd, E. C. Kemp, B. Bailey and F. Lang (2006). "Detecting potential intimate partner violence: which approach do women want?" Fam Med 38(6): 416-422.

McDonald, S. D. and P. S. Calhoun (2010). "The diagnostic accuracy of the PTSD checklist: a critical review." Clin Psychol Rev 30(8): 976-987.

McFarlane, J., K. Soeken and W. Wiist (2000). "An evaluation of interventions to decrease intimate partner violence to pregnant women." Public Health Nurs 17(6): 443-451.

McFarlane, J. M., J. Y. Groff, J. A. O'Brien and K. Watson (2006). "Secondary prevention of intimate partner violence: a randomized controlled trial." Nurs Res 55(1): 52-61.

McHugh, M. C. (2005). "Understanding gender and intimate partner abuse." Sex Roles 52(11-12): 717-724.

McHugh, M. C., N. A. Livingston and A. Ford (2005). "A postmodern approach to women's use of violence: Developing multiple and complex conceptualizations." Psychology of Women Quarterly 29(3): 323-336.

McHugh, M. C., S. Rakowski and C. Swiderski (2013). "Men's Experience of Psychological Abuse: Conceptualization and Measurement Issues." Sex Roles 69(3-4): 168-181.

McKinney, C. M., R. Caetano, S. Ramisetty-Mikler and S. Nelson (2009). "Childhood family violence and perpetration and victimization of intimate partner violence: findings from a national population-based study of couples." Ann Epidemiol 19(1): 25-32.

Messman-Moore, T. L. and A. L. Brown (2004). "Child maltreatment and perceived family environment as risk factors for adult rape: is child sexual abuse the most salient experience?" Child Abuse Negl 28(10): 1019-1034.

Messman-Moore, T. L. and P. J. Long (2003). "The role of childhood sexual abuse sequelae in the sexual revictimization of women: an empirical review and theoretical reformulation." Clin Psychol Rev 23(4): 537-571.

Messman-Moore, T. L., P. J. Long and N. J. Siegfried (2000). "The revictimization of child sexual abuse survivors: an examination of the adjustment of college women with child sexual abuse, adult sexual assault, and adult physical abuse." Child Maltreat 5(1): 18-27.

Miller, K. E., M. Kulkarni and H. Kushner (2006). "Beyond trauma-focused psychiatric epidemiology: bridging research and practice with war-affected populations." Am J Orthopsychiatry 76(4): 409-422.

Montero, I., I. Ruiz-Perez, D. Martin-Baena, M. Talavera, V. Escriba-Aguir and C. Vives-Cases (2011). "Violence against women from different relationship contexts and health care utilization in Spain." Womens Health Issues 21(5): 400-406.

Muehlenhard, C. L. and L. A. Kimes (1999). "The social construction of violence: the case of sexual and domestic violence." Pers Soc Psychol Rev 3(3): 234-245.

Muelleman, R. L., P. A. Lenaghan and R. A. Pakieser (1998). "Nonbattering presentations to the ED of women in physically abusive relationships." Am J Emerg Med 16(2): 128-131.

Munthe, C. and N. Juth (2014). Vi vill lägga dessa felaktigheter tillrätta. Dagens Medicin.

National Board of Health and Welfare (2014a). Att vilja se, vilja veta och att våga fråga. Vägledning för att öka förutsättningar att upptäcka våldsutsatthet. Stockholm, National Board of Health and Welfare [Socialstyrelsen].

National Board of Health and Welfare (2014b). Våld i Nära relationer, SOSFS 2014:4. Stockholm, National Board of Health and Welfare [Socialstyrelsen].

National Council for Crime Prevention (2014a). Brott i nära relationer. En nationell kartläggning, Brå Rapport 201:8. Stockholm, National Council for Crime Prevention [Brottsförebyggande rådet, Brå].

National Council for Crime Prevention (2014b). Nationella Trygghetsundersökningen 2013. Om utsatthet, otrygghet och förtroende, Rapport 2014:1. Stockholm, National Council for Crime Prevention [Brottsförebyggande rådet, Brå].

NCK (2014). Våld och hälsa. En befolkningsundersökning om kvinnors och mäns våldsutsatthet samt kopplingen till hälsa, NCK-rapport 2014:1. Uppsala, The National Centre for Knowledge on Men's Violence Against Women [Nationellt Centrum för Kvinnofrid, NCK].

Norman, R. E., M. Byambaa, R. De, A. Butchart, J. Scott and T. Vos (2012). "The long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis." PLoS Med 9(11): e1001349.

Nybergh, L. (2014). Exploring intimate partner violence among adult women and men in Sweden, http://hdl.handle.net/2077/35956. Doctoral thesis, Sahlgrenska Akademy, University of Gothenburg.

Nybergh, L., C. Taft, V. Enander and G. Krantz (2013a). "Self-reported exposure to intimate partner violence among women and men in Sweden: results from a population-based survey." BMC Public Health 13(1): 845.

Nybergh, L., C. Taft and G. Krantz (2012). "Psychometric properties of the WHO Violence Against Women instrument in a male population-based sample in Sweden." Bmj Open 2(6).

Nybergh, L., C. Taft and G. Krantz (2013b). "Psychometric properties of the WHO Violence Against Women instrument in a female population-based sample in Sweden: a cross-sectional survey." Bmj Open 3(5).

O'Brien, R., K. Hunt and G. Hart (2005). "'It's caveman stuff, but that is to a certain extent how guys still operate': men's accounts of masculinity and help seeking." Social Science and Medicine 61(3): 503-516.

O'Doherty, L. J., A. Taft, K. Hegarty, J. Ramsay, L. L. Davidson and G. Feder (2014). "Screening women for intimate partner violence in healthcare settings: abridged Cochrane systematic review and meta-analysis." Bmj-British Medical Journal 348.

Okasha, S. (2002). Philosophy of Science. A very short introduction. New York, Oxford University Press inc. .

Oliffe, J. L. and M. J. Phillips (2008). "Men, depression and masculinities: A review and recommendations." Journal of Mens Health 5(3): 194-202.

Parks, S. E., K. H. Kim, N. L. Day, M. A. Garza and C. A. Larkby (2011). "Lifetime self-reported victimization among low-income, urban women: the relationship between childhood maltreatment and adult violent victimization." J Interpers Violence 26(6): 1111-1128.

Pini, B. (2005). "Interviewing men - Gender and the collection and interpretation of qualitative data." Journal of Sociology 41(2): 201-216.

Plichta, S. B. (2004). "Intimate partner violence and physical health consequences. Policy and practice implications." J Interpers Violence 19(11): 1296-1323.

Polit, D. and C. Beck (2008). Nursing research. Generating and assessing evidence for nursing practice. Philadelphia, Lippincott Williams & Wilkins.

Porcerelli, J. H., R. Cogan, P. P. West, E. A. Rose, D. Lambrecht, K. E. Wilson, R. K. Severson and D. Karana (2003). "Violent victimization of women and men: physical and psychiatric symptoms." J Am Board Fam Pract 16(1): 32-39.

Postmus, J. L., M. Severson, M. Berry and J. A. Yoo (2009). "Women's experiences of violence and seeking help." Violence Against Women 15(7): 852-868.

Pratt-Eriksson, D., I. Bergbom and E. D. Lyckhage (2014). "Don't ask don't tell: Battered Women living in Sweden encounter with healthcare personnel and their experience of the care given." Int J Qual Stud Health Well-being 9: 23166.

Public Health Agency of Sweden. (2015, 2015-01-19). "Nationella folkhälsoenkäten. Sociala relationer. Se tabell Sociala relationer - tidsserier och regionala resultat 2014, http://www.folkhalsomyndigheten.se/amnesomraden/statistik-och-undersokningar/enkater-och-undersokningar/nationella-folkhalsoenkaten/sociala-relationer/." Retrieved 27th Jan, 2015.

Ramsay, J., Y. Carter, L. Davidson, D. Dunne, S. Eldridge, G. Feder, K. Hegarty, C. Rivas, A. Taft and A. Warburton (2009). "Advocacy interventions to reduce or eliminate violence and

promote the physical and psychosocial well-being of women who experience intimate partner abuse." Cochrane Database Syst Rev(3): CD005043.

Reid, R. J., A. E. Bonomi, F. P. Rivara, M. L. Anderson, P. A. Fishman, D. S. Carrell and R. S. Thompson (2008). "Intimate partner violence among men. prevalence, chronicity and health effects." Am J Prev Med 34(6): 478-485.

Renner, L. M. and S. D. Whitney (2012). "Risk factors for unidirectional and bidirectional intimate partner violence among young adults." Child Abuse Negl 36(1): 40-52.

Rich, C. L., C. A. Gidycz, J. B. Warkentin, C. Loh and P. Weiland (2005). "Child and adolescent abuse and subsequent victimization: a prospective study." Child Abuse Negl 29(12): 1373-1394.

Rodriguez, M. A., S. S. Quiroga and H. M. Bauer (1996). "Breaking the silence. Battered women's perspectives on medical care." Archives of family medicine 5(3): 153-158.

Romito, P. and M. Grassi (2007). "Does violence affect one gender more than the other? The mental health impact of violence among male and female university students." Social Science and Medicine 65(6): 1222-1234.

Romito, P., J. Molzan Turan and M. De Marchi (2005). "The impact of current and past interpersonal violence on women's mental health." Soc Sci Med 60: 1717-1727.

Rosenbaum, A., M. M. Rabenhorst, M. K. Reddy, M. T. Fleming and N. L. Howells (2006). "A comparison of methods for collecting self-report data on sensitive topics." Violence Vict 21(4): 461-471.

Rådestad, I., C. Rubertsson and I. Hildingsson (2008a). "Inte rimligt fråga alla gravida om partnervåld - andra metoder finns." Läkartidningen 105(20): 1506-1507.

Rådestad, I., C. Rubertsson and I. Hildingsson (2008b). "Screening inom mördrhälsovården för partnervåld. Nytta måste balanseras mot skada." Läkartidningen 105(11): 807-808.

Rådestad, I., C. Rubertsson and I. Hildingsson (2008c). "Screening måste grundas vetenskapligt." Läkartidningen 105(20): 1507.

Sabina, C., C. A. Cuevas and J. L. Schally (2012). "Help-seeking in a national sample of victimized Latino women: the influence of victimization types." J Interpers Violence 27(1): 40-61.

Samelius, L., B. Wijma, G. Wingren and K. Wijma (2007). "Somatization in abused women." J Womens Health (Larchmt) 16(6): 909-918.

Samelius, L., B. Wijma, G. Wingren and K. Wijma (2010). "Lifetime history of abuse, suffering and psychological health." Nord J Psychiatry 64(4): 227-232.

Scarpa, A., S. C. Haden and J. Hurley (2006). "Community violence victimization and symptoms of posttraumatic stress disorder: the moderating effects of coping and social support." J Interpers Violence 21(4): 446-469.

Schreiber, V., A. Maercker and B. Renneberg (2010). "Social influences on mental health help-seeking after interpersonal traumatization: a qualitative analysis." BMC Public Health 10: 634.

Schreiber, V., B. Renneberg and A. Maercker (2009). "Seeking psychosocial care after interpersonal violence: an integrative model." Violence and Victims 24(3): 322-336.

Schumm, J. A., M. Briggs-Phillips and S. E. Hobfoll (2006). "Cumulative interpersonal traumas and social support as risk and resiliency factors in predicting PTSD and depression among inner-city women." J Trauma Stress 19(6): 825-836.

Scott-Storey, K. (2011). "Cumulative abuse: do things add up? An evaluation of the conceptualization, operationalization, and methodological approaches in the study of the phenomenon of cumulative abuse." Trauma Violence Abuse 12(3): 135-150.

Skeggs, B. (1997). Formation of Class & Gender. Becoming respectable. London, Sage Pbulications Ltd.

Smith, P. H., J. A. Earp and R. DeVellis (1995). "Measuring battering: development of the Women's Experience with Battering (WEB) Scale." Womens Health 1(4): 273-288.

Smith, P. H., J. B. Smith and J. A. L. Earp (1999). "Beyond the measurement trap - A reconstructed conceptualization and measurement of woman battering." Psychology of Women Quarterly 23(1): 177-193.

Smith, P. H., G. E. Thornton, R. Devellis, J. Earp and A. L. Coker (2002). "A population-based study of the prevalence and distinctiveness of battering, physical assault, and sexual assault in intimate relationships." Violence Against Women 8(10): 1208-1232.

Spangaro, J., A. B. Zwi and R. Poulos (2009). "The elusive search for definitive evidence on routine screening for intimate partner violence." Trauma Violence Abuse 10(1): 55-68.

Stanko, E. A. (2006). "Theorizing about violence: observations from the Economic and Social Research Council's Violence Research Program." Violence Against Women 12(6): 543-555.

Stark, E. (2006). "Commentary on Johnson's "conflict and control: gender symmetry and asymmetry in domestic violence"." Violence Against Women 12(11): 1019-1025; discussion 1003-1018.

Statistics Sweden. (2014, May 23rd 2014). "ULF/SILC Utsatt för hot eller våld 2012-2013." Retrieved Jan 27th, 2015, from http://www.scb.se/sv_/Hitta-statistik/Statistik-efter-amne/Levnadsforhallanden/Levnadsforhallanden/Undersokningarna-av-levnadsforhallanden-ULFSILC/12202/12209/ULFSILC-2010-/Trygghet-och-sakerhet/362627/.

Stenson, K., M. Öberg, Å. Witkowski and G. Heimer (2008). "Oansvarigt att inte fråga." Läkartidningen 105(20): 1507.

Stenson, K., M. Öberg, Å. Witkowski, G. Heimer, U. Högberg and K. Edin (2008). "Hur frågar vi för att identifiera utsatta kvinnor." Läkartidningen 105(22): 1694.

Stevens, N. R., J. Gerhart, R. E. Goldsmith, N. M. Heath, S. A. Chesney and S. E. Hobfoll (2013). "Emotion regulation difficulties, low social support, and interpersonal violence mediate the link between childhood abuse and posttraumatic stress symptoms." Behavior therapy 44(1): 152-161.

Straus, M. A. (2012). "Blaming the messenger for the bad news about partner violence by women: the methodological, theoretical, and value basis of the purported invalidity of the conflict tactics scales." Behav Sci Law 30(5): 538-556.

Straus, M. A., S. L. Hamby, S. Boney - MacCoy and D. B. Sugarman (1996). "The revised conflict tactics scales (CTS2). Developement and preliminary psychometric data." J fam issues 17(3): 283-316.

Swahnberg, K. (2011). "NorVold Abuse Questionnaire for men (m-NorAQ): validation of new measures of emotional, physical, and sexual abuse and abuse in health care in male patients." Gender Medicine 8(2): 69-79.

Swahnberg, K., J. Davidsson-Simmons, J. Hearn and B. Wijma (2012). "Men's experiences of emotional, physical, and sexual abuse and abuse in health care: A cross-sectional study of a Swedish random male population sample." Scand J Public Health 40(2): 191-202.

Swahnberg, K., J. Hearn and B. Wijma (2009). "Prevalence of perceived experiences of emotional, physical, sexual, and health care abuse in a Swedish male patient sample." Violence Vict 24(2): 265-279.

Swahnberg, K. and B. Wijma (2003). "The NorVold Abuse Questionnaire (NorAQ): Validation of new measures of emotional, physical, and sexual abuse, and abuse in the health care system among women." The European Journal of Public Health 13(4): 361-366.

Swahnberg, K., B. Wijma, B. Schei, M. Hilden, K. Irminger and G. B. Wingren (2004). "Are sociodemographic and regional and sample factors associated with prevalence of abuse?" Acta Obstet Gynecol Scand 83(3): 276-288.

Taft, A., L. O'Doherty, K. Hegarty, J. Ramsay, L. Davidson and G. Feder (2013). "Screening women for intimate partner violence in healthcare settings." The Cochrane database of systematic reviews 4: CD007007.

Taylor, C. A., N. W. Boris, S. S. Heller, G. A. Clum, J. C. Rice and C. H. Zeanah (2008). "Cumulative experiences of violence among high-risk urban youth." J Interpers Violence 23(11): 1618-1635.

Tjaden, P. and N. Thoennes (2000a). Full report on the prevalence, incidence and consequences of violence against women. Washington DC, U.S. Department of Justice.

Tjaden, P. and N. Thoennes (2000b). "Prevalence and consequences of male-to-female and female-to-male intimate partner violence as measured by the National Violence Against Women Survey." Violence Against Women 6(2): 142-161.

Tubman, J. G., M. J. Montgomery, A. G. Gil and E. F. Wagner (2004). "Abuse experiences in a community sample of young adults: relations with psychiatric disorders, sexual risk behaviors, and sexually transmitted diseases." Am J Community Psychol 34(1-2): 147-162.

Turner, H. A., D. Finkelhor and R. Ormrod (2006). "The effect of lifetime victimization on the mental health of children and adolescents." Soc Sci Med 62(1): 13-27.

Turner, H. A., D. Finkelhor and R. Ormrod (2010). "Poly-victimization in a national sample of children and youth." Am J Prev Med 38(3): 323-330.

Ullman, S. E. (2007). "Mental health services seeking in sexual assault victims." Women & Therapy 30(1-2): 61-84.

West, C. and D. H. Zimmerman (1987). "Doing Gender." Gender & Society 1(2): 125-151.

Whitfield, C. L., R. Anda, S. R. Dube and V. Felitti (2003). "Violent childhood experiences and the risk of intimate partner violence in adults." Journal of Interpersonal Violence 18(2): 166-185.

WHO (2013). "Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines."

Widom, C. S., S. J. Czaja and M. A. Dutton (2008). "Childhood victimization and lifetime revictimization." Child Abuse Negl 32(8): 785-796.

Wijma, B., B. Schei, K. Swahnberg, M. Hilden, K. Offerdal, U. Pikarinen, K. Sidenius, T. Steingrimsdottir, H. Stoum and E. Halmesmaki (2003). "Emotional, physical, and sexual abuse in patients visiting gynaecology clinics: a Nordic cross-sectional study." Lancet 361(9375): 2107-2113.

Wijma, K., L. Samelius, G. Wingren and B. Wijma (2007). "The association between ill-health and abuse: a cross-sectional population based study." Scand J Psychol 48(6): 567-575.

Wilkins, N., B. Tsao, H. Marci, R. Davis and J. Klevens (2014). Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence. Atlanta, GA, National Center for Injury Prevention and Control, Centers for Dieseas Control and Prevention, Oakland, CA, USA, Prevention Institute.

Winstok, Z. (2013). "From a Static to a Dynamic Approach to the Study of Partner Violence." Sex Roles 69(3-4): 193-204.

Vogel, D. L., S. R. Heimerdinger-Edwards, J. H. Hammer and A. Hubbard (2011). ""Boys don't cry": examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes for men from diverse backgrounds." Journal of Counseling Psychology 58(3): 368-382.

Woodin, E. M., A. Sotskova and K. D. O'Leary (2013). "Intimate Partner Violence Assessment in an Historical Context: Divergent Approaches and Opportunities for Progress." Sex Roles 69(3-4): 120-130.

Wuest, J., M. Merritt-Gray, M. Ford-Gilboe, B. Lent, C. Varcoe and J. C. Campbell (2008). "Chronic pain in women survivors of intimate partner violence." J Pain 9(11): 1049-1057.

Wylie, A., E. Potter and W. K. Bauschspies (2010). Feminist Perspectives on Science. Stanford Ecnyclopedia of Philosophy. E. N. Zalta. Stanford, CA, USA., The Metaphysics Research Lab, Center for the study of Language and Information, Stanford University.

Zbikowski, A. (2014). Counteracting Abuse in Health Care from a Staff Perspective. Ethical Aspects and Practical Implications, http://urn.kb.se/resolve?urn=urn:nbn:se:liu:diva-79334. Doctoral Thesis, Linköping University.

Zigmond, A. S. and R. P. Snaith (1983). "The hospital anxiety and depression scale." Acta Psychiatr Scand 67(6): 361-370.

Papers

The articles associated with this thesis have been removed for copyright reasons. For more details about these see:
http://urn.kb.se/resolve?urn=urn:nbn:se:liu:diva-114605