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Prevalence of Physical Violence in Intimate Relationships, Part 1: Rates of Male and Female Victimization

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Physical violence in intimate relationships affects men, women, and families worldwide. Although the body of research examining the experiences of male victims of intimate partner violence (IPV) has grown, there have been few attempts to synthesize, compare, and contrast findings regarding the prevalence of male and female victimization. We examined research

ONLINE TABLES: Detailed summaries of the 249 studies reviewed in this article can be found in six tables available online at <http://www.springerpub.com/pa>. Click on the link to “The Partner Abuse State of Knowledge Project,” and go to Topic 1 in the online document.

published in the last 10 years to summarize the current state of knowledge regarding the prevalence of physical IPV victimization in heterosexual relationships. Our specific aims were to (a) describe the prevalence of physical IPV victimization in industrialized, English-speaking nations; and (b) explore study and sample characteristics that affect prevalence. Literature searches undertaken in three databases (PubMed, PsycINFO, and Web of Science) identified 750 articles published between 2000 and 2010. We included 249 articles that reported 543 rates of physical IPV victimization in our review: 158 articles reported 318 rates for women, 6 articles reported 8 rates for men, and 85 articles reported 217 rates for both men and women. Most studies were conducted in the United States ($k = 213$, 85.5%) and almost half ($k = 118$, 47.4%) measured IPV using a Conflict Tactics Scale-based approach. Unweighted, pooled prevalence estimates were calculated for female and male victimization overall and by sample type, country, measurement time frame, and measurement approach. Across studies, approximately 1 in 4 women (23.1%) and 1 in 5 men (19.3%) experienced physical violence in an intimate relationship, with an overall pooled prevalence estimate of 22.4%. Analyses revealed considerable variability in rates as a function of methodological issues, indicating the need for standardized measurement of IPV.

KEYWORDS: intimate partner violence; victimization; prevalence; physical assault; literature review

Physical violence in intimate relationships is a public health problem affecting hundreds of thousands of individuals and families worldwide (Centers for Disease Control and Prevention, 2012). The prevalence and impact of physical intimate partner violence (IPV) on female victims is well established. Data from the 2000 National Violence Against Women Survey (Tjaden & Thoennes, 2000), for example, indicated that women sustained physical injuries in 42% of IPV cases, received medical attention in 11% of cases, and were hospitalized in 9% of cases. In addition, 18% of women surveyed reported lost time from work or other economic hardship associated with victimization. Repeated physical assaults also can increase the risk for chronic diseases (e.g., chronic pain), neurological (e.g., fainting), cardiopulmonary (e.g., hypertension), and gastrointestinal symptoms (e.g., loss of appetite; Coker et al., 2002). Associations with adverse reproductive health outcomes such as spontaneous abortion, hemorrhage, poor fetal growth, and preterm labor and delivery also have been identified (Janssen et al., 2003). Importantly, these physical consequences can continue long after the abuse has ceased (Campbell, 2002). At its most severe, physical IPV can result in death (Campbell, Glass, Sharps, Laughton, & Bloom, 2007; Department of Justice, 2011).

The emotional impact of physical IPV on female victims is well documented as well. For example, a meta-analysis of 56 studies (Golding, 1999) found that the weighted mean prevalence of mental health problems among female victims of IPV was 48% in

studies of depression, 18% in studies of suicidality, 64% in studies of posttraumatic stress disorder, 19% in studies of alcohol abuse, and 9% in studies of drug abuse. Other research shows that female victims of IPV are more likely to meet diagnostic criteria for major psychiatric disorders, including depression and post-traumatic stress disorder compared to the general population (Coker et al., 2002; Kernic, Wolf, & Holt, 2000). IPV victimization also is a known significant risk factor for self-harming and suicidal behavior (Campbell, 2002). Moreover, psychological distress experienced as a result of physical IPV victimization can exacerbate physical health conditions (McNutt, Carlson, Persaud, & Postmus, 2002) and increase the likelihood of risk-taking behaviors, including substance misuse (Coker et al., 2002; Golding, 1999).

The economic impact of physical IPV victimization is substantial: costs to the U.S. health care system are estimated to increase by 1.4 to 4 times for victims compared to nonvictims (Arias & Corso, 2005; Bonomi, Anderson, Rivara, & Thompson, 2009; Coker, Reeder, Fadden, & Smith, 2004; Jones et al., 2006; Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004; Rivara et al., 2007). Other societal costs include those associated with victims' impaired occupational functioning (e.g., lost workdays, tardiness, decreased productivity, turnover, greater security costs, and medical expenses) and expenditures for social services, as well as criminal justice and legal services (Stanko, Crips, Hale, & Lucraft, 1998). Finally, economic costs at the individual level may include victims' difficulty maintaining employment (Lloyd, 1997).

Because physical IPV victimization is associated with such serious adverse outcomes, an understanding of prevalence will be critical to research and intervention. However, prevalence estimates range widely from study to study. For instance, reviewing 48 population-based studies, the World Health Organization (WHO; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002) found that 10%–69% of women reported lifetime experiences of IPV victimization. More recently, Alhabib, Nur, and Jones (2010) conducted a meta-analytic review of 134 empirical studies reporting prevalence of physical, sexual, and emotional IPV published between 1995 and 2006. Results showed that the lifetime prevalence of physical IPV victimization among adult women (ages 18–65 years) ranged between 20% and 60% for all included population types except for studies of college students (in which prevalence was slightly lower than 20%). The highest prevalence rates—between 30% and 60%—were found in studies conducted in psychiatric and obstetrics/gynecology clinics. Noteworthy, however, some of the eligibility criteria led to the exclusion of samples which may be of considerable interest to researchers and practitioners, such as women living with HIV, pregnant women, or refugee women. As evidenced by these two reviews, prevalence varies considerably as function of the nature of the population studied and may be attributable to differences in sociodemographic, clinical, and geographic characteristics.

Many other study characteristics can affect prevalence rates, such as the operational definition of IPV and the measurement approach (Nicholls & Dutton, 2001). For example, results of crime victimization surveys, which typically define IPV as a function of *officially* reported victimization experiences occurring in the *past year*, find much lower rates than studies that assess prevalence of IPV using behavior-based

measures. To demonstrate, findings of the National Crime Victimization Survey in the United States suggest that only about 5% of women have been physically assaulted or raped by an intimate partner (Rennison, 2003), a rate far below those found in the reviews discussed previously.

Although estimates of prevalence vary, there is now a wealth of evidence demonstrating the extent of the problem of physical IPV against women. Women's advocacy groups can be credited with bringing public attention to a problem once considered a private matter for families to resolve behind closed doors; however, the unintended consequence of the feminist movement is that the experiences of male victims of IPV largely have been ignored (Hamel & Nicholls, 2007; Straus, 2009). Women are disproportionately affected by serious IPV victimization; for instance, women are more likely than men to receive medical attention related to IPV victimization (Cowell & Burgess, 1996) and account for more than one third (70%) of the IPV-related deaths that occur each year (Department of Justice, 2011). However, men also experience IPV at significant rates. In the 2004 Canadian General Social Survey, for example, men and women reported almost identical rates of violent victimization perpetrated by a current or previous partner in the 5 years and 12 months preceding the survey (LaRoche, 2008). Importantly, there is an emerging body of research demonstrating that men do experience physical, emotional, and economic sequelae as a result of physical IPV victimization (e.g., [Coker et al., 2002](#); [LaRoche, 2008](#); [Reid et al., 2008](#)). Moreover, men are the victims of serious physical IPV, including homicide, although rates are much lower than among women (e.g., Department of Justice, 2011; Rennison, 2003). Despite increasing recognition that women *can* be violent and that men *can* be victims, there remain very few services for male victims (Dutton & Corvo, 2006; Hines & Douglas, 2011). This not only may reflect responsiveness to the increased frequency with which women experience severe IPV or are injured, but also may be attributable to the gender or patriarchal paradigm (see Dutton & Nicholls, 2005, and Hamel, 2007 for further discussion).

THE PRESENT REVIEW

The body of research examining the experiences of male victims has grown over the past 30 years; however, there have been few attempts to conduct systematic reviews of the literature. Such efforts are crucial to the development and implementation of effective interventions (Mears, 2003). In its most recent iteration, [Fiebert's \(2010\)](#) annotated bibliography summarizes the results of 271 scholarly investigations (211 empirical studies and 60 reviews), which reported rates of assaults by women against their male partners and spouses. A review of the article summaries suggests that women are frequently physically aggressive in their intimate relationships. Although this represents the most comprehensive summary of the research findings of which we are aware, the nature of the annotated bibliography prevents further synthesis or comparison of study results. The meta-analytic review conducted by [Archer \(2000\)](#) synthesized results of 82 studies, demonstrating comparable rates of IPV perpetration

by men and women. Findings of both the Fiebert and Archer reviews offer important insight into the prevalence of IPV perpetrated by men and women. However, they are limited by their focus on studies reporting rates of perpetration rather than victimization, a distinction which may be relevant to the interpretation of the results. Specifically, reported rates of assaults perpetrated by women against men may not necessarily represent the same rates of victimization experiences reported by men (Krahé, Bieneck, & Möller, 2004).

The present study builds on prior work by examining research published in the last 10 years, reporting rates of physical IPV victimization experiences of *both* men *and* women. Our goal was to synthesize the current state of knowledge regarding the prevalence of physical IPV victimization in heterosexual relationships. Our specific aims were to (a) describe the prevalence of physical IPV victimization among men and women in English-speaking nations, and (b) explore study and sample characteristics that may affect prevalence rates.

METHODS

Eligibility Criteria

In contrast with strict protocols which exclude studies that fail to meet a certain threshold of methodological rigor, we chose a comprehensive approach, more akin to a narrative review than a systematic review (Collins & Fraser, 2005). Such an approach is particularly useful for synthesizing findings of a body of literature that contains studies ranging widely in quality, as is the case for IPV. Studies were included in the current review if they met three broad inclusion criteria. First, they needed to present empirical data regarding the prevalence of physical IPV from the perspective of the victim (see Part 2 for perpetration rates; Desmarais, Reeves, Telford, & Fiebert, 2012). Second, the IPV must have occurred within the context of a heterosexual relationship. Third, articles were excluded if they reported the findings of studies in which participants were sampled from an identified population of IPV victims, such as women staying at a domestic violence shelter, because the prevalence of IPV victimization would be skewed.

Search Procedure

A systematic search of the published literature was carried out using PubMed (scholarly publications in the biomedical and life sciences), PsycINFO (scholarly publications in the psychological, social, behavioral, and health sciences), and the Social Sciences database of Web of Science. The following keywords and stems were used in separate and combined searches: date; dating; partner*; domestic; spous*; marital; wife; husband; intimate partner; batter*; violen*; abus*; aggress*. Findings were limited to peer-reviewed journal articles and studies sampling human subjects aged 13 years or older conducted in industrialized, English-speaking countries (including

Australia, Canada, New Zealand, South Africa, the United States, and the United Kingdom). Articles written in languages other than English were excluded. This led to an initial identification of more than 50,000 articles (including replicates) across databases and searches. We then selected articles published between January 2000 and December 2010, reducing the number of findings to 37,615.

Review Process

A preliminary screening of the titles and abstracts to assess whether the content was likely to meet our eligibility criteria reduced the number of articles to 6,203. Elimination of replicates and a second review of study abstracts led to retrieval of 750 articles for further analysis.

Data Synthesis

Full text was retrieved for these 750 articles and reviewed in detail for inclusion and data extraction. Final review narrowed the set of articles to 249. Data were extracted following a protocol developed and defined by the authors for the purpose of this review (available upon request). Information regarding measurement time frame (e.g., past year, lifetime) and instrument (e.g., Conflict Tactic Scale, CTS; Abuse Assessment Screen, AAS; WHO instrument) and sample details were extracted by research assistants and reviewed by four authors (SLD, KAR, TLN, & RPT). Results then were summarized by study and grouped according to sample type: population-based, community, university or college, middle or high school, clinical, and justice or legal samples.

Prevalence estimates were calculated including all relevant prevalence rates reported for mutually exclusive groups in each article; thus, each article may have contributed multiple rates. For instance, some articles reported unique prevalence rates as a function of participants' sociodemographic characteristics, such as race/ethnicity or socioeconomic status. Due to the high degree of variation in prevalence rates, we chose to calculate unweighted, pooled estimates to avoid confounding sample size with study quality; that is, values derived from larger samples do not necessarily represent a closer approximation of the true population prevalence rate compared to those derived from smaller samples ([Rosenthal & DiMatteo, 2001](#)). We report prevalence estimates for female and male victimization overall and by sample type, country, measurement time frame, and measurement approach to the extent possible.¹

RESULTS

In total, we identified 249 articles that reported 543 rates of physical IPV victimization. Prevalence of physical IPV was infrequently the primary study objective. Instead, most studies had other primary objectives, such as the identification of correlates or antecedents of abuse or the examination of intervention effectiveness, but

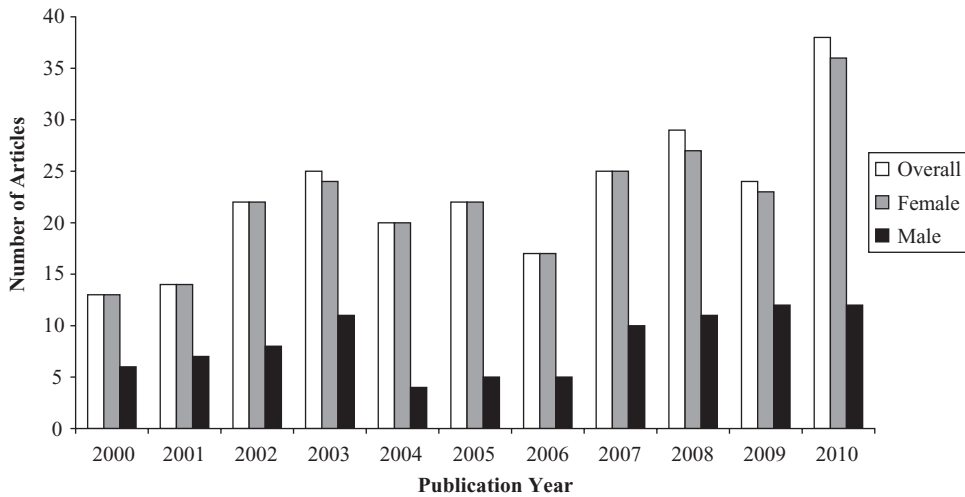


Figure 1. Number of articles reporting physical IPV victimization rates over time.

also reported the prevalence of physical IPV victimization in the sample. Many articles reported more than one prevalence rate: On average, each article included in our review reported 2.18 ($SD = 1.42$, range = 1–10) prevalence rates. Overall, 158 articles reported 318 rates for female victimization, 6 articles reported 8 rates for male victimization, and 85 articles reported 217 rates for both men and women. As may be seen in Figure 1, the number of articles reporting prevalence of IPV victimization appears to be increasing over the past 10 years.

Characteristics of articles included in the analyses are described in Table 1. There were 52 large population-based studies, 36 studies of small community samples, 26 studies of university or college student samples, 38 studies of middle or high school students, 3 studies of high school and university students, 80 studies of clinical samples, and 14 studies of justice or legal samples. Most articles (85.5%, $k = 213$) reported findings of studies conducted in the U.S. sample sizes ranged widely from $N = 42$ to $N = 134,955$, with a mean of 4,308.24 ($SD = 14,912.49$), median of 791, and mode of 120 participants per study. Studies varied in their operational definition and measurement of IPV, although a majority (47.4%, $k = 118$) of studies reported prevalence rates measured using items or scales drawn from the CTS family of instruments.

Overall Rates of Intimate Partner Violence Victimization

Across all studies included in this review, approximately one quarter of participants (22.4%) reported experiencing physical violence in a heterosexual intimate relationship. Physical IPV victimization was reported by approximately one third (33.6%) of participants in their lifetime and one fifth (19.2%) of participants in the year prior to

TABLE 1. Summary of Characteristics of Articles Included in Review

Characteristic	Number of Articles	Number of Rates Reported
Victims		
Women only	158	318
Men only	6	8
Women and Men	85	217
Sample type ^a		
Large population studies	52	123
Small community samples	36	67
University or college students ^b	26	60
Middle or high school students ^b	38	80
Clinical samples	80	171
Justice or legal samples	14	37
Measurement time frame		
Past year	108	228
Lifetime	85	144
Other	56	171
Measurement approach		
Conflict Tactics Scale	118	255
Abuse Assessment Screen	27	49
World Health Organization survey	5	17
Other	99	222
Country		
United States	213	448
Canada	10	28
United Kingdom	10	26
Australia	3	7
New Zealand	7	23
South Africa	5	9
Other	1	2
TOTAL	249	543

^aThree studies sampling high school and university students reporting five prevalence rates were not included in the summary statistics; however, study details are available online: <http://www.springerpub.com/pa>.

^bThese categories also included studies of same-age youth who were not necessarily identified through school.

TABLE 2. Pooled Prevalence Estimate (%) as a Function of Study Characteristics

Characteristic	Overall	Women	Men
Overall	22.4	23.1	19.2
Sample type			
Large population studies	16.7	17.6	14.6
Small community samples	24.3	24.4	22.1
University or college students ^b	27.1	27.2	26.7
Middle or high school students ^b	18.7	18.1	19.5
Clinical samples	23.9	24.5	16.6
Justice or legal samples	31.6	31.1	49.0 ^a
Measurement time frame			
Past year	19.2	18.8	19.8
Lifetime	33.6	35.8	21.7
Other	16.9	18.7	16.6
Measurement instrument			
Conflict Tactics Scale-based	25.9	26.1	24.8
Abuse Assessment Screen	20.2	20.6	2.0 ^a
World Health Organization survey	21.9	21.9	0.0
Other	18.4	20.5	14.4
Country			
United States	22.8	23.2	17.6
Canada	26.2	24.4	21.5
United Kingdom	22.9	18.2	25.1
Australia	18.1	18.1	18.1
New Zealand	36.3	23.7	37.9
South Africa	41.4	36.5	60.2
Other	3.3 ^a	3.3 ^a	0.0

^aIndicates only one study contributed to the prevalence estimate. ^bThese categories also included studies of same-age youth who were not necessarily identified through school.

the study. Table 2 presents pooled prevalence among women and men overall and as a function of study characteristics. We discuss these findings in more detail later.

Female Victimization. Pooled prevalence across the 243 articles reporting 427 rates of female physical IPV victimization was 23.1%. Prevalence ranged widely, from none of the women in the non-abortion group of Kazi, Reeves, and Creinin's (2008) study of victimization in the past two months to 99.0% of women reporting lifetime exposure in a study of sex differences in IPV among South Africans (Wong, Huang, DiGangi, Thompson, & Smith, 2008). When reported for the past year, prevalence rates ranged from 1.2% (Bair-Merritt, Holmes, Holmes, Feinstein,

& Feudtner, 2008) to 71.0% in Stampfel, Chapman, and Alvarez's (2010) sample drawn from the Chicago Women's Health Risk Study. Average pooled prevalence for past year's victimization was 18.8%. As would be expected, lifetime prevalence rates were higher, ranging from 3.5% in a sample of 1,072 female welfare recipients in Illinois (Staggs & Riger, 2005) to 99.0% in the Wong et al. South African sample, with an average of 35.8%. Several articles ($k = 24$) also reported rates of victimization in "current" relationships, although the measurement time frame often was not specified and appeared to vary substantially. For these articles, pooled prevalence was 12.5%, ranging from severe IPV victimization reported by 1.5% of Asian American women (Chang, Shen, & Takeuchi, 2009) to 57.0% of female low socioeconomic status high school students (Watson, Cascardi, Avery-Leaf, & O'Leary, 2001). A handful of articles ($k = 11$) reported rates of physical IPV victimization during pregnancy, ranging from 1.7% of mothers (Charles & Perreira, 2007) to 20.0% in an evaluation of an IPV screening tool for use in Child Advocacy Centers (Pulido & Gupta, 2002) for a pooled estimate of 10.2%.

In addition to examining prevalence by time frame, we also were interested in exploring differences by the country in which studies were conducted. Overall, pooled estimates were fairly comparable, although there was considerable variation in range. As noted earlier, most studies were conducted in the United States (see Table 1); for these studies, rates ranged from none (Kazi et al., 2008) to 89.7% (Engstrom, El-Bassel, Go, & Gilbert, 2008), with a mean of 23.2%. Pooled prevalence was similar in Canadian studies at 24.4% (low = 3.3%, Ahmad, Ali, & Stewart, 2005; high = 67.2%, Manseau, Fernet, Hébert, Collin-Vézina & Blais, 2007). The lowest pooled prevalence rates were 18.1% for the Australian studies (low = 11.3%, Brown, Cosgrave, Killackey, Purcell, Buckby, & Yung, 2009; high = 26.6%, Raj & Silverman, 2002) and 18.2% for studies conducted in the United Kingdom (low = 3.4%, Johnson, Haider, Ellis, Hay, & Lindow, 2003; high = 41.0%, Richardson, Coid, Petrukevitch, Chung, Moorey, & Feder, 2002). At 36.5%, the highest pooled estimate was found across studies conducted in South Africa (low = 9.5%, Jewkes, Levin, & Penn-Kekana, 2002; high = 99.0%, Wong et al., 2008). As will be discussed further, many differences reflect methodological issues that limit direct comparisons.

Male Victimization. We identified 91 articles that included 116 prevalence rates for men experiencing physical IPV perpetrated by a female partner. Prevalence varied dramatically, ranging from 0.6% in the 2005 wave of the Behavioral Risk Factor Surveillance System Survey conducted across 18 U.S. states, Puerto Rico, and the U.S. Virgin Islands (Breiding, Black, & Ryan, 2008) to 99.4% reported in a sample of South African men (Wong et al., 2008). Overall, pooled prevalence was slightly lower than observed for female victimization: 19.3%. Lifetime victimization was 21.7% averaged across studies, ranging from 3.4% (Carbone-Lopez, Kruttschnitt, & Macmillan, 2006) to 99.4% (Wong et al., 2008). Past year victimization was 19.8% across studies, with a low of 0.6% in the Breiding et al. study and 66.6% in a sample of men in New Zealand (Fergusson, Horwood, & Ridder, 2005).

In sum, the prevalence of physical IPV victimization ranged widely across studies overall and as a function of victim’s sex, with slightly higher rates observed for women compared to men. In the following sections, we explore rates of male and female victimization within each sample type. Figures 2 and 3 display prevalence estimates by measurement time frame and approach, respectively. Details of each study are available online (<http://www.springerpub.com/pa>).

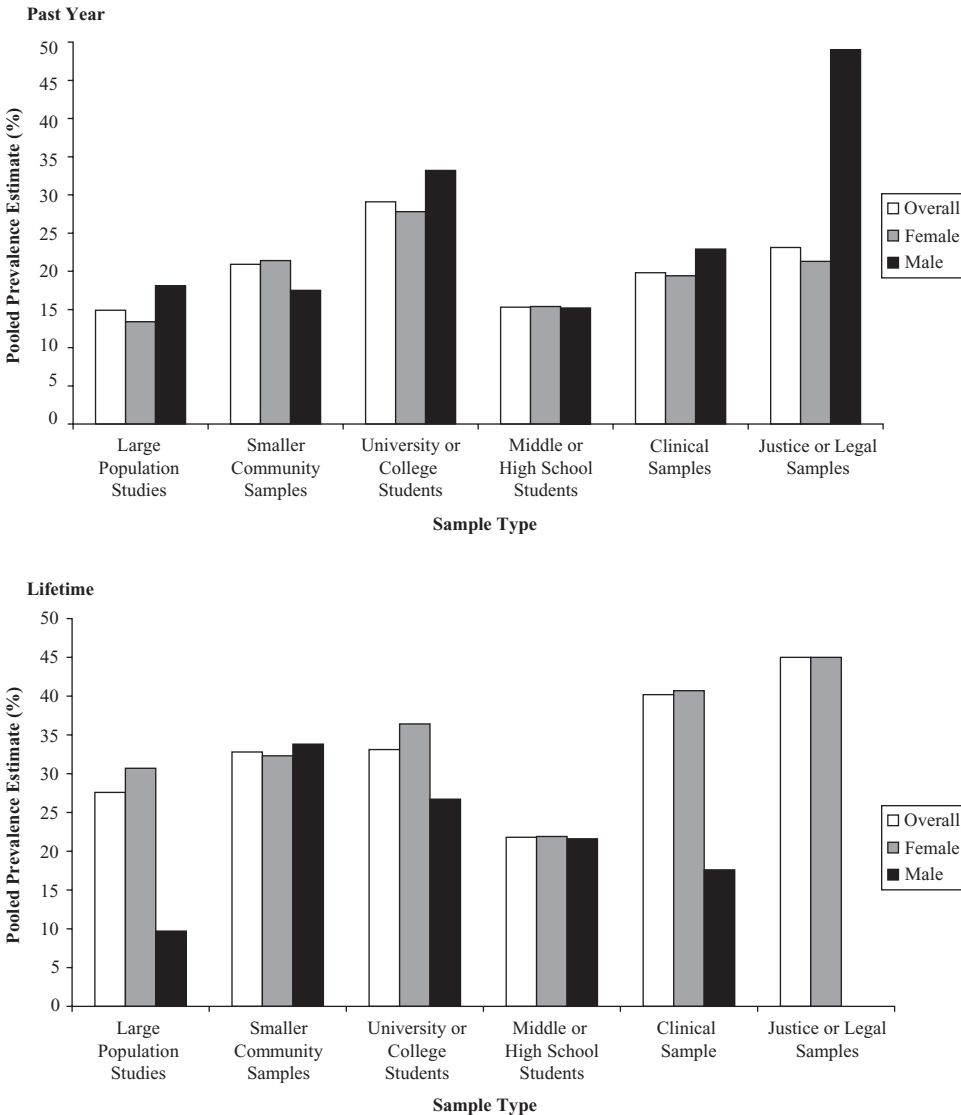


Figure 2. Prevalence of past year and lifetime physical IPV victimization.

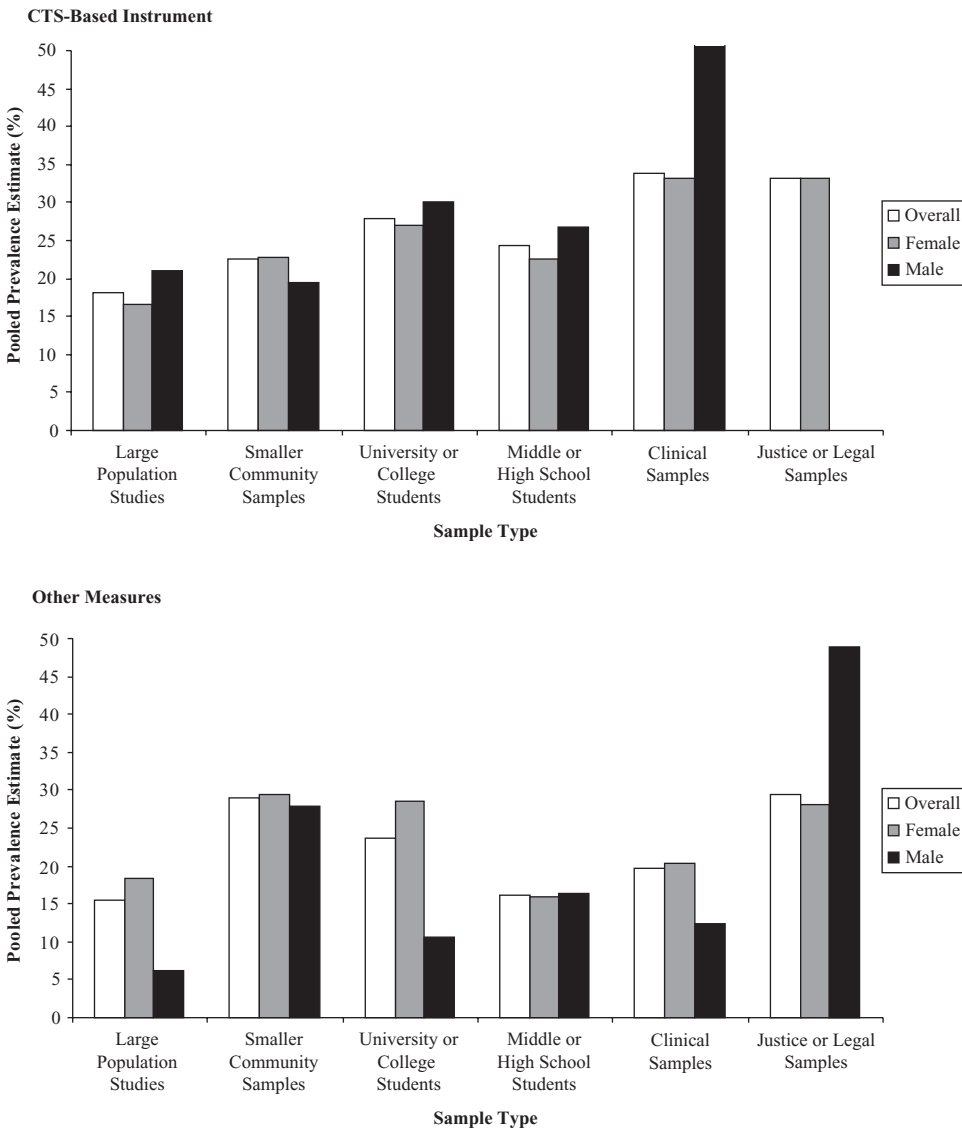


Figure 3. Prevalence of physical IPV victimization by measurement approach.

Large Population Studies

Articles included in this category drew data from studies of representative samples that typically exceeded $N = 1,000$ in size.

Female Victimization. We identified 51 large population studies reporting 88 rates of female physical IPV victimization. At 17.6%, pooled prevalence was slightly lower than the overall rate for female victimization, ranging from 1.2% of women in Bair-Merritt

et al.'s (2008) study to 67.3% of women who reported a history of child abuse and witnessing IPV as a child in Cannon, Bonomi, Anderson, Rivara, and Thompson's (2010) study. In these large population studies, past year prevalence ranged from 1.2% (Bair-Merritt et al., 2008) to 66.2% in Christchurch, New Zealand birth cohort (Fergusson et al., 2005). The average past year prevalence rate was 13.4%. Pooled prevalence for lifetime victimization was 30.7%, ranging from 8.4% reported in two studies (Fanslow, Robinson, Crengle, & Perese, 2010; Jun, Rich-Edwards, Boynton-Jarrett, & Wright, 2008) to 67.3% reported by Cannon et al. Rates in current relationships were identified in three studies, demonstrating the lowest pooled prevalence at 9.0% and a restricted range (low = 1.5%, Chang et al., 2009; high = 15.2%, Afifi et al., 2009).

We further explored prevalence of female physical IPV victimization in large population studies by country. In general, the lowest rates were found in North American samples: pooled prevalence was 15.3% for large population studies conducted in the United States (low = 1.2%, Bair-Merritt et al., 2008; high = 67.3%, Cannon et al., 2010) and 12.0% for studies conducted in Canada (low = 3.3%, Ahmad et al., 2005; high = 52.0%, Beydoun, Al-Sahab, Beydoun, & Tamim, 2010). Rates in the two large Australian studies were similar. One study of South Australian adults sampled using a telephone monitoring system (Grande, Hickling, Taylor, & Woollacott, 2003) reported a rate of 14.2%, and the Australian sample of an international study of dating violence (Chan, Straus, Brownridge, Tiwari, & Leung, 2008) reported a rate of 20.2%, for an average of 17.2%. Rates reported in U.K. studies ranged from 13.0% in a British study of partner aggression and alcohol (Graham, Plant, & Plant, 2004) to 35.5% in the British sample in the international study of dating violence cited earlier, for an average of 24.3%. Studies conducted in New Zealand had a similar pooled prevalence rate at 23.7%, ranging from 2.9% among ever-partnered women of Asian descent reporting past year prevalence (Fanslow et al., 2010) to 66.2% in the Christchurch birth cohort (Fergusson et al., 2005). Pooling across large population studies conducted in South Africa revealed a prevalence estimate similar to those seen for other countries: 24.0%. Rates in these studies ranged from 9.5% in Jewkes et al.'s (2002) sample drawn from urban and rural areas of three provinces in South Africa to 35.2% in Chan et al.'s South African sample.

Of note, almost half of the prevalence rates ($n = 39$, 44.3%) reported in large population studies were derived from CTS-based measures. A substantial minority ($n = 15$, 17.0%) were drawn from the WHO survey. Four studies used the AAS and the remainder used some other approach. Use of the WHO survey was associated with the highest pooled estimate (22.0%; range = 2.9%–53.5%), followed by the use of the CTS (16.7%, range = 1.5%–66.2%). Pooled prevalence was lowest in studies that used the AAS (9.6%, range = 7.8%–11.4%).

Male Victimization. We identified 24 large population studies reporting 35 rates of male physical IPV victimization. Compared to studies of female victimization in this category, pooled prevalence for male victimization was slightly lower at 14.6% (see Table 2). Rates ranged from 0.6% in Breiding, Zimbroski, and Black's (2009)

study of rural areas in the United States to 66.6% in the [Fergusson et al.'s \(2005\)](#) Christchurch birth cohort. Across those studies reporting past year prevalence, the average rate was 18.1% (low = 0.6%, [Breiding et al., 2009](#); high = 66.6%, [Fergusson et al., 2005](#)). Pooled prevalence for lifetime victimization was lower, 9.7% and ranged from 3.4% in the National Violence Against Women Survey ([Carbone-Lopez et al., 2006](#)) to 20.1% in a large sample of Christian couples from 49 churches across the United States ([Drumm, Popescu, & Riggs, 2009](#)).

As for female victimization, we explored prevalence of male physical IPV victimization in large population studies by country. Again, the lowest rates were found in North American samples. In Canada, the average rate across four studies was 11.0%. The prevalence estimate for studies conducted in the United States was 11.1%. A handful of large population studies were conducted in other countries and evidenced higher rates compared to Canadian and American samples. Two Australian studies were included in our review, with pooled prevalence of 19.4%. Rates reported in these, both measuring IPV victimization with respect to respondents' most recent partners, varied considerably from 7.1% ([Chan et al., 2008](#)) to 31.7% ([Grande et al., 2003](#)). Two studies also were conducted in the United Kingdom, with a pooled prevalence of 25.1%. One study reported a rate of 18% for the past 2 years ([Graham et al., 2004](#)) and the other, a rate of 32.1% in the past year ([Chan et al., 2008](#)). Two studies were conducted in New Zealand, with prevalence estimate of 46.8%. Victimization in the past year was reported by about one quarter (27%; [Chan et al., 2008](#)) to more than one third (66.6%; [Fergusson et al., 2005](#)). Finally, one study of South African men ([Gass, Stein, Williams, & Seedat, 2010](#)) reported a rate 20.9% in their most recent relationship.

Community Samples

This category included a wide range of samples, such as those drawn from rural and urban populations, military samples, or specific ethnic/racial groups. The defining feature of studies included in this category was that they were conducted in community settings but were not necessarily representative of the characteristics of the larger population.

Female Victimization. In this category, we identified 36 studies reporting 55 rates of female physical IPV victimization. Pooled prevalence was slightly higher than that found for the large population studies at 24.4% (low = 1.5%, [Bracken, Messing, Campbell, La Flair, & Kub, 2010](#); high = 99.0%, [Wong et al., 2008](#)). This higher rate of victimization may be attributable to the inclusion of studies that targeted high risk groups, such as [Bassuk, Dawson, and Huntington's \(2006\)](#) sample of women on welfare or [Salomon, Bassuk, and Huntington's \(2002\)](#) sample of homeless women. Studies included in this category frequently relied on CTS-based measures (75.0%, $k = 27$). Pooled prevalence for past year victimization was higher than found in the large population studies at 21.4%, ranging from 1.5% ([Bracken et al., 2010](#)) to 71.0% ([Stampfel et al., 2010](#)). At 32.3%, the lifetime prevalence estimate was similar to

that found for large population studies, although the range was wider (low = 4.9%, Sormanti, Wu, & El-Bassel, 2004; high = 99.0%, Wong et al., 2008). Rates for current relationships were reported in only one study (Hicks, 2006).

Only three studies included in this category were conducted outside of the United States (Robertson & Murachver, 2007; Schei, Guthrie, Dennerstein, & Alford, 2006; Wong et al., 2008); thus, pooled prevalence was not calculated as a function of country. When pooled across studies of community samples, rates of female IPV victimization were almost identical for those that used CTS-based measures (22.7%; low = 2.0%, Hicks, 2006; high = 66.1%, Bassuk et al., 2006) and the AAS (22.8%; low = 10.5%, high = 29.5%, Campbell et al., 2003), although the latter was used infrequently ($k = 4$). Studies that employed other measurement approaches yielded higher rates: pooled estimate = 31.4%.

Male Victimization. We identified 13 articles reporting 16 rates of male physical IPV victimization in community samples. Analyses revealed an average prevalence of 22.1%, with a range from 2.3% in a study of workplace violence at a municipal government in the Midwest (Swanberg & Macke, 2006) to 99.4% among a sample of South African men (Wong et al., 2008). Past year prevalence across studies was 17.5%, from a low of 2.3% as mentioned earlier to 48.8% in a sample of gamblers (Korman et al., 2008). Lifetime prevalence ranged from 8.6% in a study examining the cost of employee IPV to the workplace (Swanberg & Macke, 2006) to 99.4% (see preceding discussion), for a pooled prevalence of 35.8%.

Further investigation revealed some interesting findings as a function of sample characteristics. For example, a subset of two studies focused on the experiences of Asian American, Chinese American, and Filipino American men. Across these studies, the average prevalence was 12.9% (Leung & Cheung, 2008; Shibusawa & Yick, 2007). This rate is much lower than the prevalence of 35.0% found in a study of male Mexican Americans (Sugihara & Warner, 2002). There were seven studies that sampled couples, including gamblers, military couples, couples living in rural areas, and government or office employees. Across these studies, the average prevalence rate was 16.4%, ranging from 2.3% for past year victimization (which we could not disaggregate from experiences of emotional abuse) (Swanberg & Macke, 2006) to 48.8% (Korman et al., 2008).

University or College Samples

Studies included in this category typically sampled undergraduate students ranging in age from 18 to 24 years, although some included older students or students completing graduate degrees. For the most part, these studies used convenience sampling strategies.

Female Victimization. We included 25 articles reporting 43 rates of physical IPV victimization among female university or college students. Across studies, the prevalence estimate was higher than seen in the previous two sample categories at 27.2%

(see Table 2). These rates ranged from 3.2% of university students in the United States and Canada who reported victimization in the past 6 months (Saewyc et al., 2009) to 77.8% in a study of lifetime IPV victimization among women at the University of North Carolina at Greensboro (Smith, White, & Holland, 2003).

As in previous sections, we were interested in comparing past year rates with lifetime prevalence rates, when possible (see Figure 2). Half of the studies included in this category ($k = 13$) measured past year victimization. Across these studies, pooled prevalence was similar to the estimate for female university college students (27.8%) and ranged widely (low = 5.5%, Orcutt, Garcia, & Pickett, 2005; high = 65.0%, Amar, 2007). Fewer studies ($k = 7$) examined lifetime prevalence. When reported, the lifetime rates of physical IPV among university and college students were similar to those reported in large population and community samples (see Table 2): pooled prevalence estimate = 36.4%, ranging from 15.0% in a sample of undergraduates in an introductory psychology course (Simonelli, Mullis, Elliot, & Pierce, 2002) to 77.8% in the University of North Carolina Greensboro sample (Smith et al., 2003). Only one study examined current victimization and reported a rate of 34.3% among undergraduates aged 18–20 years (Bookwala, 2002). All but one study were conducted in North America and similar pooled estimates were found in Canadian (25.5%) and American (27.9%) samples. Most of the reported data were derived from CTS-based measures and yielded lower estimates compared to two studies using the AAS (Amar, 2007; Amar & Gennaro, 2005): pooled prevalence = 26.9% versus 56.5%.

Male Victimization. We identified 15 studies of university and college samples reporting 17 rates of male physical IPV victimization. Pooled prevalence of IPV victimization rates were almost identical to those reported previously for female students. Across studies, results revealed that more than a quarter (26.4%) of male college or university students have experienced physical IPV, on average. Despite a very broad conceptualization of physical IPV, the lowest rate, 2.8%, was reported in a study of students from a community college, a large Ivy League university, and a midsized Catholic university regarding victimization experiences during college (Forke, Myers, Catallozzi, & Schwarz, 2008). The highest rate, 59.8%, was found in a sample of introductory psychology students reporting lifetime victimization (Cercone, Beach, & Arias, 2005).

On average, past year victimization was reported by 33.2% of university and college males, with rates ranging from 21.6% (Taft, Schumm, Orazem, Meis, & Pinto, 2010) to 44.0% (Próspero & Fawson, 2010). Lifetime prevalence was reported in four studies, with a pooled prevalence estimate of 26.7% (low = 8.5%, Forke et al., 2008; high = 59.8%, Bookwala, 2002). All studies were conducted in the United States and only two used measures other than the CTS.

Middle or High School Samples

This category of studies sampled middle or high school students or youth who were in this age range but were not necessarily identified through their school (e.g., homeless

youth participating in a larger study; Slesnick, Erdem, Collins, Patton, & Buettner, 2010). Although there may exist important differences between “intimate” relationships of middle and high school-aged youth, studies often presented rates in aggregate and few studies uniquely reported rates for middle school students.

Female Victimization. Pooled prevalence across the 36 studies reporting 47 female physical IPV victimization rates was 18.1%, an estimate considerably lower than seen among women in university and college or community samples but quite similar to that found in large population studies (see Table 2). Prevalence ranged from 3.3% among participants in the 2001 Youth Risk Behavior Surveillance regarding past year physical IPV victimization (Hanson, 2010) to 57.0% among low socioeconomic status high school students (Watson et al., 2001). Across the studies reporting past year prevalence, the pooled estimate was 15.4%, ranging from 6.6% of girls in a nationally representative sample (Hanson, 2010) to 56.4% among African American or Hispanic teenage girls (Teitelman, Ratcliffe, Morales-Aleman, & Sullivan, 2008). Lifetime prevalence rates ranged from 9.0% in Ackard and Neumark-Sztainer’s (2002) sample of girls in the 9th and 12th grade to 36.4% in Slesnick et al.’s sample of homeless youth. Interestingly, these rates are quite similar to those found for other age groups (see Table 2). All but one study were conducted in North America: two were conducted in Canada and the others were conducted in the United States. In contrast with other sample types, CTS-based measures were used to derive only about one third (31.9%) of the prevalence rates. Use of the CTS was associated with higher estimates, on average (22.6% vs. 16.0%).

Male Victimization. This was the category for which we identified the most articles addressing male physical IPV victimization; specifically, 28 articles reported 33 rates. Pooled prevalence was 19.5%. Rates ranged from 3.3% in a study measuring violence victimization from more than a year ago (physical or sexual) self-reported by male middle and high school adolescents in Minnesota (Ackard, Eisenberg, & Neumark-Sztainer, 2007) to 53.7% of male sixth grade students reporting physical aggression by “someone [they had] dated, gone out with, or gone study with” in the past 3 months (Simon, Miller, Gorman-Smith, Orpinas, & Sullivan, 2009). Across the articles reporting lifetime prevalence, the average prevalence rate was 22.6%. Range for lifetime physical IPV victimization was between 3.8% (Ackard, Neumark-Sztainer, & Hannon, 2003) and 41.0% (Sears & Byers, 2010). The average past year prevalence rate was 15.2% (low = 5.3%, Coker, McKeown, Sanderson, Davis, Valois, & Huebner, 2000; high = 43.0%, Holt & Espelage, 2005).

Clinical Samples

Studies included in this category recruited participants from any type of clinical setting, such as emergency rooms, primary care settings, maternity wards, inpatient treatment centers, and outpatient treatment clinics, among others.

Female Victimization. This was the most common category for studies of female physical IPV victimization: 78 studies reporting 159 prevalence rates. Approximately one quarter of women in these studies reported victimization (pooled prevalence = 24.5%), ranging from none of the women in the non-abortion group of Kazi et al.'s (2008) study of victimization in the past 2 months to most women (89.7%) included in Engstrom et al.'s (2008) sample of women enrolled at a methadone treatment clinic. Pooled prevalence for past year victimization was 19.4%, ranging from 2.2% of older women attending a health maintenance clinic in Washington state (Bonomi et al., 2007) to 62.5% of women recruited after completing detox at a substance abuse treatment facility (Call & Nelson, 2007). Lifetime rates were high: The prevalence estimate was 40.7%, ranging from 5.1% of women screened in a family medicine residency clinic (Wenzel, Monson, & Johnson, 2004) to 89.7% in the Engstrom et al.'s study mentioned earlier. A handful of studies also reported prevalence in current relationships, with an average rate of 8.4% (low = 2.9%, Wenzel et al., 2004; high = 26.4%, Testa, Livingston, & Leonard, 2004). Ten studies examining prevalence of physical IPV during pregnancy were included in this category.

Roughly 9 out of 10 prevalence rates were drawn from studies conducted in the United States; the others were drawn from studies conducted in the United Kingdom. Rates were higher across the American compared to British samples: pooled prevalence = 25.2% versus 17.7%, respectively. CTS-based measures and the AAS were most commonly used, representing almost one third (31.4%) and one quarter (23.9%) of the rates, respectively. Two rates came from the WHO survey (Sethi, Watts, Zwi, Watson, & McCarthy, 2004) while the rest were measured using "other" approaches. Use of the CTS yielded the highest rates (pooled prevalence = 33.2%). Estimates for studies using the AAS (pooled prevalence = 20.0%), the WHO instrument (pooled prevalence = 20.5%), and other approaches (pooled prevalence = 20.7%) were comparable.

Male Victimization. Eight articles reported 21 rates of physical IPV victimization among men in clinical samples. Although we may have anticipated higher rates of victimization in clinical samples, across studies, the average prevalence rate of 16.6% was lower than previously reported for other sample types. Rates ranged from 1.6% for male clients at a nonprofit health care center (Reid et al., 2008) to 65.1% of men seeking substance abuse treatment at a Veterans Affairs Medical Center (Chermack, Walton, Fuller, & Blow, 2001), both with respect to the past year. Pooled prevalence for past year prevalence was 22.9%. The lifetime rate of physical IPV victimization was reported in one study, at a rate of 17.6% (Reid et al., 2008).

Examination of the findings with respect to specific types of clinical samples revealed some interesting differences. For example, in a study of risky sexual behavior and HIV, Bogart et al. (2005) found that 24.2% reported IPV victimization (physical or sexual) in the past 6 months. As another example, Charles and Perreira (2007) found that 8.2% of men were physically victimized by their partner while she was pregnant.

Justice or Legal Samples

Studies included in this category sampled participants from justice or legal settings but excluded studies in which participants were sampled from an identified sample of IPV victims, such as women and men seeking restraining orders against an abusive partner, to prevent conflation of prevalence rates (i.e., prevalence in such samples would necessarily be very high).

Female Victimization. Fourteen articles reporting 36 rates of female physical IPV victimization were identified for inclusion in this category. Across these studies, pooled prevalence was higher than in other categories at 31.1% (see Table 2) and ranged between 3.5% (Staggs & Riger, 2005) and 87.5% (Yoshihama, Hammock, & Horrocks, 2006). Past year prevalence rates were similar to those seen in other categories, with an average of 21.3% (low = 5.0%, Pulido & Gupta, 2002; high = 63.0%, Wekerle et al., 2009). As found in clinical samples, lifetime prevalence among women in justice or legal samples was high: pooled prevalence was 45.0%, ranging from 3.5% to 87.5% as cited earlier. One study reported the prevalence of 17.0% in current relationships (Magen, Conroy, & Del Tufo, 2000) and another reported prevalence of 20.0% during pregnancy (Pulido & Gupta, 2002). All studies were conducted in North America. Just over half of the studies (57.1%, $k = 8$) used the CTS, with a pooled prevalence of 33.1% (low = 7.6%, Renner, 2009; high = 67.2%, Manseau et al., 2007). Use of other instruments yielded slightly lower rates: pooled prevalence = 28.2% (low = 3.5%, Staggs & Riger, 2005; high = 87.5%, Yoshihama et al., 2006).

Male Victimization. We identified only one study of male physical IPV victimization that met our inclusion criteria for this category. Wekerle et al. (2009) surveyed a random sample of youth from a large urban child protective service caseload and found that almost half of the males who reported dating (44%–49%) had been the victim of physical IPV (actual or threatened) in the past 12 months.

DISCUSSION

We conducted a review of 249 studies published in the last 10 years to summarize the current state of knowledge regarding the prevalence of physical IPV victimization in heterosexual relationships. In doing so, we sought to estimate prevalence across studies and to explore study and sample characteristics that affect reported rates of physical IPV victimization. To our knowledge, this is the most comprehensive review of this subject to date.

The main results of this review demonstrate that physical IPV victimization is prominent among men and women in heterosexual relationships. Across studies, approximately one in four women (23.1%) and one in five men (19.3%) experienced physical violence in an intimate relationship, with an overall prevalence estimate of 22.4%. However, for both men and women, prevalence rates ranged widely. Physical IPV victimization was reported by approximately one third (33.6%) of participants

in their lifetime and one fifth (19.2%) of participants in the year prior to the study. Inconsistent with prior research and reviews (e.g., [Alhabib et al., 2010](#)), clinical samples yielded rates similar to the overall estimate. The highest rates were found in samples of university or college students and justice or legal samples. Studies that defined and measured physical IPV victimization as a function of behaviors demonstrated higher rates overall, particularly among men. As discussed at length elsewhere, this finding suggests that many victims (especially men) do not identify their experiences as 'violence' or 'abuse' or see themselves as victims of IPV (cf., Hines & Malley-Morrison, 2001; Straus, 1999).

Whether victimization rates were higher for women or men fluctuated as a function of sample type, measurement time frame, and study location. For example, in large population studies, studies of community samples, university or college samples, and clinical samples, pooled prevalence was higher among women than men; but across studies of middle or high school students and justice or legal samples, pooled prevalence was higher among men than women (although only one study examined male victimization in a justice or legal sample). Lifetime rates generally were higher among women than men, whereas past year prevalence was slightly higher among men than women. We also found differences by country. In studies conducted in the United States and Canada, pooled prevalence was higher among women than men. In studies conducted in the United Kingdom, New Zealand, and South Africa, pooled prevalence rates were higher among men than women. In studies conducted in Australia, pooled prevalence rates were identical. Beyond the scope of the present review, these differences may reflect differences in societal stance on IPV or gender roles more broadly (Krahé et al., 2004).

Taken together, results presented here add to a growing body of literature documenting symmetry in rates of IPV among men and women ([Straus, 2010](#)). That said, it is well established that women are more frequently injured and, often, more severely injured at the hands of intimate partners. It is also true, however, that men represent approximately 25% of IPV-related homicide cases (Rennison, 2003) and 30% of IPV-related deaths (Department of Justice, 2011). Rates of injury and severity of victimization were not the focus of the current review, but are important topics to be addressed in future research synthesis efforts. Additionally, our search strategy identified almost three times as many studies reporting prevalence of physical IPV victimization among women than men, the significance of which is twofold. First, this finding emphasizes the empirical gap regarding our knowledge of male IPV victimization experiences, despite some increases in the number of topical studies published in recent years. Second, although rates for men and women were comparable, the relatively smaller evidence base upon which prevalence estimates were calculated for men compared to women reduces the reliability of those findings. Nonetheless, the high rates of violence experienced by women *and* men suggest a need for victimization prevention strategies targeted at both sexes.

Our findings regarding the prevalence of physical IPV victimization among student samples merit further discussion. Overall rates of physical IPV victimization

among middle or high school students (or other similar age youth) were comparable to rates found in other samples, and overall rates among university and college students were second only to those seen in justice or legal samples. One interpretation of these results is that the prevalence of physical IPV victimization is increasing; that is, adolescents and young adults are experiencing higher rates of victimization and that future research will demonstrate associated increases in other sample categories. Alternatively, these results may reflect what has been shown in other research: while the prevalence of violence and aggression during adolescence may be high, these behaviors typically abate over time as part of normative development (Loeber & Hay, 1997). Additionally, operationalizing IPV is difficult in any population but may be particularly challenging among adolescents. For adults, the term IPV typically applies to violence between married, cohabitating, or dating partners. For adolescents who infrequently are married or cohabitating with a partner, IPV may be applied to violence that occurs in the context of a “date” for a single event (cf., Hickman, Jaycox, & Aronoff, 2004). Finally, it also is possible that the high rates found among student samples reflect increased rates of disclosure rather than higher rates of victimization. In other words, adolescents and young adults simply may be more comfortable answering surveys and reporting victimization experiences than are older research participants.

Our findings should be understood in the context of some limitations. First, we used an inclusive selection strategy and did not conduct a systematic assessment of study quality. Second, because of the range in study quality, we chose to present descriptive but not inferential statistics. Third, although we found some differences in prevalence as a function of study location, we did not measure characteristics of the countries that may have accounted for the differences; for instance, the meaning of victimization may vary across cultures (Krauss, 2006), even within a country. Fourth, we did not include variables that may clarify the context within which the victimization occurred. Thus, we are unable to speak to whether rates reflect victimization occurring as a result of unilateral or reciprocal abuse, for example (but see Langhinrichsen-Rohling, Misra, Selwyn, & Rohling, 2012). Fifth, we examined rates of victimization, but not rates of injury, and were unable to systematically code severity of victimization reported across studies. Our findings do not address whether there are differences or similarities in the rates of injury or severity of victimization experiences among men and women. Finally, although we coded the instruments used to measure victimization, we did not assess the mode of administration (e.g., face-to-face interview, self-administered survey, telephone interview). Previous research indicates considerable variation in rates as a function of this variable (Alhabib et al., 2010). For these reasons, findings of the present review are not intended to inform guideline recommendations (National Institute for Health and Clinical Excellence, 2009, January) but rather as intended to characterize the current state of knowledge, as well as highlight the methodological differences and limitations of the extant literature.

Despite these limitations, the present study represents the most comprehensive summary of the prevalence of physical IPV victimization among heterosexual men

and women in English-speaking, industrialized nations available to date. We found considerable variability in rates, although rates for men and women were more often similar than different. Instead of victim sex, the many methodological differences in the 249 studies included in our review may be the most important sources of variability affecting estimates of prevalence. Unfortunately, these methodological differences reduce the meaningfulness of comparisons across, and even sometimes within studies. Although many studies relied on standardized assessment instruments, such as the CTS, AAS, or WHO survey, a considerable proportion (16.9%) used other approaches, including invalidated tools developed for the purpose of the study or a single yes/no item. Additionally, researchers differed in whether sexual violence was included in their definition of physical IPV victimization and if so, whether rates of sexual violence could be disaggregated from the total rate. This sometimes was problematic even within studies, with rates of physical IPV victimization reported for men but combined rates of sexual and physical IPV victimization reported for women. Finally, many studies reported lifetime and past year prevalence rates, whereas others combined rates of current or past year victimization, or used different time frames altogether (e.g., past 2 months, past 6 months). These results indicate that continued efforts need to be directed at standardizing the measurement of IPV so that data can be compared across studies, sample types, and countries (cf., Krug et al., 2002; Saltzman, 2004). The WHO multi-country study and the international study of dating violence conducted by Straus and colleagues represent important attempts to collect internationally comparable data through the use of standardized methods; however, there remains considerable debate in the field regarding which instruments should be used to measure IPV prevalence and how (Dutton & Nicholls, 2005; Hamby, 2009; Langhinrichsen-Rohling, 2010).

All told, our findings highlight that IPV continues to be a reality for individuals and families worldwide, despite local, national, and international prevention efforts. Although rates varied across individual studies, our analyses suggest that approximately one quarter of individuals—men and women—in heterosexual relationships are physically assaulted by their partner. Yet, fewer services are available for male victims (Hines & Douglas, 2011) and prior research suggests reduced responsiveness to male compared to female victims (Hines, Brown, & Dunning, 2007; Lipsky, Caetano, & Roy-Burne, 2011; Muller, Desmarais, & Hamel, 2009). This comprehensive review of the current state of the field demonstrates the diversity of victims who experience physical IPV and documents the need for gender inclusive intervention strategies (Hamel & Nicholls, 2007).

NOTE

1. Due to variation in research designs as well as inconsistent reporting of methodological details across studies, we were not able to systematically compare findings as a function of country, measurement time frame, and measurement approach for all sample types.

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