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Definition: **Domestic Violence** from *The SAGE Glossary of the Social and Behavioral Sciences*

Physical, sexual, or emotional abuse of people in intimate relationships. The U.S. feminist movement of the 1970s brought attention to the nature and prevalence of domestic violence, and the term gained prominence. Domestic violence refers to violence, intimidation, and harm perpetrated by one person against another or others with whom the person is in a relationship. Typically, the term refers to incidents and patterns of terrorization in the home, within a family unit, and between those with personal connections. Domestic violence often involves a cycle of recurring acts that escalate so that the perpetrator cultivates and maintains power and control over the victim/s.



Image from: [Spousal abuse is pervasive in many societies and... in Encyclopedia of Murder and Violent Crime](#)

Summary Article: **Domestic Violence**

From *Encyclopedia of Gender and Society*

Domestic violence—also known as “interpersonal violence,” “battering” and “family violence”—is a widespread and serious public health problem, in the United States and internationally. The United Nations Development Fund for Women estimates that one in three women around the world will be beaten, coerced into sex, or otherwise abused in her own lifetime. This entry looks at definitions of domestic violence, historical perspectives, domestic violence statistics, causes of batter, effects of domestic violence, children of battered women, and response and prevention.

Definitions

The notion of a “battered woman” derives from the criminal violation known as “battery” or the willful or intentional touching of a person against that person’s will by another person, or by an object or substance put in motion by that other person. The notion of “battered women,” with its emphasis on physical violence, fails to entirely capture the various ways in which intimate partners of either gender can be manipulated and abused and as a consequence, the term has been largely replaced by *domestic violence* (DV), *intimate partner violence* (IPV), and the more generic *family violence*.

During the past 15 years, there has been a growing recognition that IPV is a highly prevalent public health problem with devastating effects on individuals, families, and communities. The term *family violence* has been used to describe acts of violence between family members, including adult and adolescent partners, between a parent and a child (including adult children), between caretakers or partners against elders, and between siblings. Although sometimes used interchangeably, the term *domestic violence* is generally seen as a subset of family violence between intimates so that the term *intimate partner violence* appears to be replacing *domestic violence* for the sake of definitional clarity.

The Family Violence Prevention Fund defines IPV as a pattern of assaultive and coercive behaviors that may include inflicted physical injury; psychological abuse; sexual assault; progressive social, physical, or financial isolation; stalking; deprivation; extreme jealousy and possessiveness; and intimidation and threats perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other. Threats may be directed at the partner, her or his friends, family members, pets, or property.

This term also includes children who are used by the perpetrator to intimidate and abuse the adult victim, as well as those who are forced by the perpetrator to participate in the abuse of an adult victim.

Legal definitions and remedies of IPV vary from state to state but generally refer specifically to threats or acts of physical or sexual violence including forced rape, stalking, harassment, certain types of psychological abuse, and other crimes where civil or criminal justice remedies apply. Violence between intimates is notoriously difficult to measure largely because it usually occurs in private, and victims are often reluctant to report incidents to anyone because of shame, guilt, or fear of reprisal.

Historical Perspectives

The battering of women is best understood within a sociopolitical context that explores the status of women's rights throughout time. Women in the United States did not acquire significant legal rights until the mid- to late-19th century and could not even vote until 1920. Before women achieved suffrage, married women were largely considered to be a form of marital property, and separated and divorced women were even more vulnerable to the whims of male authority figures. The battering of women, when publicly noticed, was largely attributed to the vagaries of unusually violent men or the pathology of the women involved.

Until the feminist movement of the 1960s and 1970s, DV was attributed to individual pathology, rather than as an extremely common and significantly destructive social problem. As a result of the women's liberation movement, battered women came to be understood as the most extreme victims of a universal and systematic oppression of women that extends far back into recorded history. In 1979, psychologist Lenore Walker interviewed 1,500 women who were victims of abuse perpetrated by their spouse and noticed that they all described a similar pattern that she called *battered woman syndrome*, in which the severity of the abuse escalates over time while both partners deny the severity of the abuse and are both convinced that each episode is a separate and isolated event. In such cases, as the abuse escalates, the husband stops apologizing for the behavior and becomes increasingly violent while his partner becomes increasingly depressed, fatalistic, self-blaming, helpless, and hopeless, developing a sense of personal entrapment and rejecting help from others. It became clear that the victim's preexisting personality was not a major factor in the development of battered woman syndrome and was not dissimilar to the adaptation that hostages make to their captors, also known as the Stockholm syndrome.

The first responses to victims of battering originated as the grassroots efforts of women to help and support each other through the development of DV shelters and other services, including political and social advocacy. The criminal justice responses to battering, although far from perfect, have included model police protocols, significant changes in prosecution and legal defense, and judicial education. Efforts to train health care professionals, mental health care professionals, child care workers, child protective services, and other social services are still in their formative stages.

Domestic Violence: The Statistics

DV is the leading cause of injury to women. U.S. government surveys on violence against women show that at some point in their lifetimes, more than a quarter of women in the United States are physically assaulted, stalked, or undergo one or more attempted or actual rapes by a current or former spouse, cohabiting partner or date and one-third of all murdered women are killed by intimate partners. Around the world, studies have shown that 10 percent to 69 percent of women reported being physically assaulted by an intimate male partner at some point in their lives; intimate partners commit 40 percent

to 70 percent of homicides of women; and one in three women has been beaten, coerced into sex, or otherwise abused in her lifetime. Most often, the abuser is a family member.

The National Crime Victimization Survey (NCVS) gathers data about crimes using an ongoing, nationally representative sample of households in the United States. NCVS data include information about crime victims (age, gender, race, ethnicity, marital status, income, and educational level), criminal offenders (gender, race, approximate age, and victim-offender relationships), and the nature of the crime (for example, time and place of occurrence, use of weapons, and nature of injury). NCVS victimization data include incidents reported and not reported to police. The experiences and estimates of IPV reflect those of the individuals residing in households but do not capture the experiences of homeless individuals or those living in institutional settings such as shelters for homeless or battered persons. In 2005, 77,200 households and 134,000 individuals age 12 and older were interviewed. Between 1993 and 2005, response rates varied between 91 percent and 96 percent of eligible households and between 84 percent and 93 percent of eligible individuals. According to this survey, nonfatal IPV has declined since 1993. The rate of nonfatal IPV victimization for females was about 4 victimizations per 1,000 persons age 12 or older in 2005, down from about 10 in 1993. For females of most age categories, nonfatal IPV victimization declined over time.

Research has shown that victimized females are 2.5 times more costly to the health care system than are women who have never been the victims of abuse. Three-quarters of employed battered women were harassed at work, and DV is estimated to cost companies at least \$73 million a year in lost productivity.

Gender as a Factor

According to the National Coalition Against Domestic Violence, nonfatal IPV is most frequently committed by individuals of opposite genders. Females are more likely than are males to experience nonfatal IPV. Most victims of IPV are women. On average from 2001 to 2005, about 96 percent of females experiencing nonfatal IPV were victimized by a male, and about 3 percent reported that the offender was another female, whereas about 82 percent of males experiencing nonfatal IPV were victimized by a female and about 16 percent of males reported that the offender was another male. For homicides, intimate partners committed 30 percent of homicides of females, 5 percent of homicides of males. One of 14 men has been physically assaulted by a current or former spouse, cohabiting partner, boyfriend, girlfriend, or date at some time in their lives, and 86 percent of adult men who were physically assaulted were physically assaulted by a man and in only 56 percent of the times were these assaults by a stranger.

Sexual Orientation as a Factor

In a report describing incidents of DV against people of lesbian, gay, bisexual, and transgender (LGBT) experience that were reported during the year 2006 to community-based anti-violence organizations in 12 regions throughout the United States, approximately 50 percent of the lesbian population had experienced or will experience DV in their lifetimes. In one year, 44 percent of victims in LGBT DV cases identified as men and 36 percent identified as women, and 78 percent of lesbians report that they have either defended themselves or fought back against an abusive partner. Gay and bisexual men experience abuse in intimate partner relationships at a rate of 2 in 5, which is comparable to the amount of DV experienced by heterosexual women; 40 percent of gay and bisexual men will experience abuse at the hands of an intimate partner.

Age as a Factor

In general, males ages 12 to 15 and age 65 or older experienced the lowest rates of nonfatal IPV. Although in general, females ages 12 to 15 and age 50 or older were at the lowest risk of nonfatal IPV, battering may start when women are still quite young. Recent surveys show that 20 percent of teenagers and young women have already been exposed to some form of dating violence defined as controlling, abusive, and aggressive behavior in a romantic relationship. Females ages 20 to 24 were at the greatest risk of nonfatal IPV.

Ethnicity as a Factor

Battering appears to occur within every culture, and every religious orientation and all races are equally vulnerable. Similar to other types of nonfatal violent victimization, nonfatal IPV is primarily intra-racial in nature. About 84 percent of white victims are victimized by white offenders and about 93 percent of black victims are victimized by black offenders. Between 1993 and 2005, rates of nonfatal IPV decreased for white females, white males, and black females. During the same period, intimate homicide rate fell for blacks in every relationship category, whereas the rate for whites remained unchanged for all categories. The average annual rate of nonfatal IPV from 2001 to 2005 was generally higher for American Indian and Alaskan Native females and similar for black females and white females. Between 1993 and 2005, the rate of nonfatal IPV victimizations declined for Hispanic females by two-thirds.

Pregnancy as a Factor

Twenty-three percent of pregnant women seeking prenatal care are battered. In a survey of pregnant low-income women, 65 percent of the women had experienced either verbal abuse or physical violence during their pregnancies.

Income as a Factor

From 2001 to 2005, females living in households with lower annual incomes experienced the highest average annual rates of nonfatal IPV. Females remained at greater risk than males within each income level.

Children's Exposure

On average between 2001 and 2005, children were residents of the households experiencing IPV in 38 percent of the incidents involving female victims and 21 percent of the incidents involving male victims.

Where and When

Males and females living in urban areas reported the highest levels of nonfatal IPV, and males and females residing in rural and suburban areas were equally likely to experience nonfatal IPV. Nonfatal IPV is more likely to occur between the hours of 6 p.m. and 6 a.m. Females and males experienced nonfatal IPV at similar times during the day and night. On average between 2001 and 2005, the majority of nonfatal IPV victimizations occurred at home; approximately two-thirds of females and males were victimized at home, and about 11 percent of female and 10 percent of male victims of nonfatal IPV were victimized at a friend's or neighbor's home.

Substance Use

On average between 2001 and 2005, victims reported the presence of any alcohol or drugs in about

42 percent of all nonfatal IPV, and victims reported that approximately 8 percent of all nonfatal IPV victimizations occurred when a perpetrator was under the influence of both alcohol and drugs. Female and male victims of nonfatal IPV were equally likely to report the presence of alcohol during their victimization. Female and male victims of nonfatal IPV both reported their attacker was under the influence of drugs in about 6 percent of all victimizations.

Weapons

On average between 2001 and 2005, for nonfatal IPV male victims were more likely than female victims were to face an offender armed with a weapon, but female victims were more likely than were male victims to face an offender armed with a firearm. About 6 percent of female and 10 percent of male victims faced an offender armed with a sharp weapon, such as a knife. The number of female and male IPV victims killed with guns has fallen. For females, the number of IPV victims killed by other weapons has remained stable.

Injuries

Thirty-two percent of all women who seek emergency room care for violence-related injuries were injured by an intimate partner. On average between 2001 and 2005, half of all females experiencing non-fatal IPV suffered an injury from their victimization; about 5 percent of female victims and 4 percent of male victims were seriously injured. Less than one-fifth of victims reporting an injury seek treatment following the injury. Females experiencing an injury are more likely than are their male counterparts to seek treatment at a hospital.

Reporting to Police

Between 1994 and 2005, reporting to police of nonfatal IPV increased for female victims. For 2001 to 2005, the percentage of nonfatal intimate partner victimizations reported to the police was higher for black females than for white females, higher for black females than for black males, and about the same for black and white males. Private or personal matter was the most frequent reason given for not reporting nonfatal IPV to police. On average between 2001 and 2005, almost 40 percent of male and 22 percent of female victims gave this reason. The reasons stated for not notifying police about the nonfatal IPV were fear of reprisal for 12 percent of female victims, to protect the offender for 14 percent of female and 16 percent of male victims, and because the police would not do anything for 8 percent of female victims.

Causes of Battering

As is the case for all complex social phenomena, there is no single cause of battering. The first—and perhaps the most important influence—is learning. The vast preponderance of violent acts in our culture are perpetrated by males and acted out against women, children, and other men. In about 95 percent of the cases of DV, the perpetrator is male, and even in situations where women are violent, the violence tends to be less damaging and far less lethal than when men are violent.

The dominant influence on male behavior is social expectation. Children learn the basics about how to relate to other people within the context of their own families. When they witness violence being used as a method for resolving problems, they learn violence as a fundamental intervention with other people. Boys are expected to both give and take physical violence as part of routine male conditioning. As adults, men are expected to control their violence; the amount of control that is expected has varied by time and historical period, but nonviolence has never been the social norm.

In the large Adverse Childhood Experiences (ACEs) study, the greater the likelihood that children were exposed to IPV, the greater the likelihood that they were also physically, sexually, or emotionally abused. Among women, the ACEs study found a strong graded relationship between the number of adverse experiences they had survived as children and the risk of becoming a battering victim. Similarly, among men, the study found a strong graded relationship between the number of these types of experiences as children and the risk of subsequently becoming a batterer.

It has been repeatedly substantiated that children who are exposed to violence are far more likely to become violent themselves. Exposure to violence in childhood is a serious risk factor for adolescent and adult violent and criminal behavior. Over many studies, the most consistent risk factor for men becoming abusive to their own female partners is growing up in a home where their mother was beaten by their father.

Although substance abuse does not cause DV, it can play a role in exacerbating battering incidents. Reportedly, one-fourth to one-half of men who commit acts of DV also have substance abuse problems. Women who abuse alcohol or drugs are more likely to be victims of battering, and victims of DV are more likely to receive prescriptions for and become dependent on tranquilizers, sedatives, stimulants, and painkillers and are more likely to abuse alcohol.

Poverty, homelessness, and racism are all stressors that in and of themselves do not cause violence but alone and in combination, they put enormous stress on families. Families that are stressed, isolated, and socially unsupported are more likely to be violent. Many women and children are made homeless as a result of DV when they flee the perpetrator. The system of DV shelters and services was initially created largely by and for white, middle-class women. As a result, the issue of systematic oppression based not just on gender but also on race and class has not necessarily informed services for battered women. Women from lower socioeconomic classes have far fewer opportunities to leave abusive partners because they have less available resources to support themselves and their children.

Effects of Domestic Violence

There are immediate, short-term, and long-term effects of being battered, and many studies connect a wide variety of physical, psychological, social, and existential problems with DV. Typically, a woman who is battered lives with constant terror and anxiety with fears of imminent doom. To others, she may appear passive and lacking in energy, seemingly helpless to take charge of her own life. She may suffer from chronic depression, exhibit suicidal behavior, and develop overt post-traumatic stress disorder. She may turn to the use of drugs and alcohol to afford herself some relief, thus compounding existing problems. She is likely to feel hopeless and powerless to make any significant changes, fearing that anything she does will lead to something worse. She may be unable to relax and have difficulty sleeping. Her sleep may be interrupted by violent nightmares.

The manner in which a battered woman will be individually affected by battering will be determined by a number of interactive factors, including her previous exposure to violence as a child and adolescent; genetic, constitutional, and psychobiological factors; the presence of coexisting physical, psychological, or social problems; the presence of substance abuse; her belief systems as well as the belief system(s) of her family, ethnic group, religious affiliation; and the supports that exist within the community.

The Children of Battered Women

Children exposed to DV show many different responses that negatively affect their physical and

mental health, their social adjustment, and their school performance. For children, the more severe the violence, the more severe their problems are likely to be. Childhood exposure to violence also has serious consequences for adult physical health as well as mental health and social adjustment. When compared with people who had safe and secure childhoods, people who had experienced four or more categories of childhood adversity—including witnessing DV—had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempts; 2- to 4-fold increases in smoking, poor self-rated health, sexual promiscuity, and sexually transmitted disease; and 1.4-to 1.6-fold increases in physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The seven categories of adverse childhood experiences were strongly interrelated, and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life.

Response and Prevention

A problem cannot be solved until it is properly recognized. During the last 30 years, public awareness of battering as a significant social problem has radically increased. Nonetheless, a great deal of work is yet to be done in educating health care and mental health care providers, social service workers, educators, criminal justice officials, and the general public about the reality of DV, including the costs to society of failing to adequately address the problem. Adequate responses require that the community provide sufficient legal, health, mental health, and other community resources to protect victims and ensure that they receive the services that lead to healing and recovery. This includes sufficient resources to treat the physical, emotional, and social consequences of battering in the victim, the child witnesses, and the perpetrators. To efficiently deliver these resources, research is needed to discover those interventions that are the most effective. Ultimately, although individual suffering must be addressed, the solution to the problem of battering resides in cultural transformation so that intimate violence and all forms of interpersonal violence are no longer considered acceptable.

See also

Access to Justice; Mentors in Violence Prevention Model; Rape; Sexual Harassment; Sexual Slavery; Torture

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