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Men's violence against women and men are inter-related: Recommendations for simultaneous intervention

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ABSTRACT

Men are more likely than women to perpetrate nearly all types of interpersonal violence (e.g. intimate partner violence, murder, assault, rape). While public health programs target prevention efforts for each type of violence, there are rarely efforts that approach the prevention of violence holistically and attempt to tackle its common root causes. Drawing upon theories that explain the drivers of violence, we examine how gender norms, including norms and social constructions of masculinity, are at the root of most physical violence perpetration by men against women and against other men. We then argue that simply isolating each type of violence and constructing separate interventions for each type is inefficient and less effective. We call for recognition of the commonalities found across the drivers of different types of violence and make intervention recommendations with the goal of seeking more long-standing solutions to violence prevention.

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1. Introduction

In 2002, the World Health Organization published its first comprehensive global report focused on violence. The report helped solidify global recognition of violence as a major public health issue and highlighted that over one million individuals lose their lives each year due to violence (Krug et al., 2002). In the Forward to this landmark report, Nelson Mandela responded to the high global prevalence of violence by suggesting that "we must address the roots of violence" (p. 9). But, have the "roots of violence" – in particular those that operate across different types of interpersonal violence (e.g. intimate partner violence, youth violence) – been adequately identified and intervened upon? Are current interventions built around the common root causes identified in the literature? While much progress has been made over the past few decades in the area of violence prevention (WHO, 2010b), much work remains to be done.

In this paper, we focus on *interpersonal* violence (i.e. "the intentional use of physical force or power, threatened or actual, against another person" (Krug et al., 2002, p. 5)) and public health responses to this type of violence. We begin by reviewing the history and current state of interpersonal violence research and prevention. In doing so, we demonstrate that the process of establishing violence as a public health problem has resulted in segmentation into typologies of violence for both epidemiological research and prevention efforts. We then examine the empirical evidence which shows that men are more likely than women to be perpetrators of violence. Next, in order to understand the commonalities across types of violence, we synthesize theories of gender and masculinity and underscore how different types of violence are largely rooted in prevailing male gender norms. Finally, we argue that targeting interventions towards different types of violence is insufficient, and that an integrated approach could be more efficient and effective. Ultimately, we call for recognition of the interrelatedness of different types of violence by providing a fuller understanding of the root causes of violence. We then make intervention recommendations with the goal of seeking more long-standing solutions to violence prevention.

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1.1. The emergence of violence as a public health problem

In many parts of the world, morbidity and mortality from infectious disease began to recede in the early and mid-20th century and violence (including homicide and suicide) emerged as a leading cause of death (CDC, 2009; Dahlberg and Mercy, 2009; Peden et al., 2000). Further, due to a variety of factors (Blumstein and Wallman, 2006; Wilson and Petersilia, 2010), suicide and homicide rates rose steadily throughout the 70s and 80s, necessitating a response from governments and community organizations (CDC, 1994; Murray et al., 2013; UNODC, 2011). At the same time, the rise of the second wave feminist movement and the 'battered women's movement' were gaining momentum and raised awareness of the hidden problem of violence against women (Fox, 2002; Schechter, 1982). National governments began responding to this increasing violence. For example, in the 1979 report by the United States Surgeon General, violence was highlighted as a public health priority (U.S. Department of Health, 1979) and recommended that reducing mortality "lies less with improved medical care than with better Federal, State, and local actions to foster more careful behavior, and provide safer environments" (p. 9). Governmental and non-governmental institutions began considering how to best address violence, and prevention strategies soon became the responsibility of public health organizations and agencies. As Dahlberg and Mercy argued in their article on the history of violence and public health, the United States' Centers for Disease Control and Prevention – which established one of the world's first violence epidemiology departments in 1983 – launched epidemiological investigations that:

> "Contributed to the understanding of violence through the use of epidemiologic methods to characterize the problem and identify modifiable risk factors … Efforts were made to document each problem, understand the risk and protective factors associated with each type of violence, and begin building the evidence-base for prevention" (p. 169)(Dahlberg and Mercy, 2009).

Global recognition of violence as a public health problem grew as similar efforts were occurring in countries around the world. Importantly, this resulted in a resolution passed in 1996 by the World Health Assembly establishing violence as a public health priority and requesting that resources be dedicated to "characterize different types of violence, define their magnitude and assess the causes and the public health consequences" (WHO, 1996). Epidemiologists defined violence and categorized it into types such as homicide, suicide, intimate partner violence, child abuse, youth violence, etc. Eventually, researchers, community organizations, and policy-makers in a range of countries began to use these and related findings to inform the development of interventions to target violence (WHO, 2010b). The funding, research, and prevention lines began to be drawn systematically along typologies of interpersonal violence, an approach that continues to present day.

These divisions – though pragmatic and practical – have resulted in multiple fields of violence research that have different foci, stakeholders, and approaches. In research and practice, the fields of 'intimate partner violence' and 'sexual violence' are typically grouped together within one field. Most frequently, these studies and interventions are focused on men's *violence against women* (Abramsky et al., 2014; WHO, 2010a), despite the fact that men and boys are also victims of intimate partner violence and sexual violence (Douglas and Hines, 2011; Straus, 2004). This research – and the attendant prevention strategies – often note that gender inequalities between men and women are a root cause (Abramsky et al., 2014; Garcia-Moreno et al., 2005; Jewkes, 2002). 'Youth violence' – another major type of interpersonal violence –typically refers to violence between young people such as bullying, assaults, or homicides (Krug et al., 2002). The majority of victims and perpetrators of this type of violence are male (Krug et al., 2002; UNODC, 2011). It should be noted that, in contrast to the field of intimate partner violence, the field of youth violence rarely explicitly acknowledges that much of this type of violence is perpetrated by and against men (WHO, 2014). Instead, youth violence research and interventions often focus on interpersonal violence perpetrated by 'at risk' individuals in race and class marginalized communities or in neighborhoods that live at or below the poverty line (Dahlberg, 1998; Matjasko et al., 2012).

Indeed, different interventions are often pursued for preventing different types of violence. For example, a 2010 WHO report highlights that the evidence base for interventions used to prevent to intimate partner and sexual violence (e.g. programs addressing gender norms, microfinance programs) are distinct from those that are used to prevent youth violence (e.g. parent-child programs, social development programs) (WHO, 2010b). The few rigorous randomized trials that have been funded with a focus on gender equality and economic empowerment – such as the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) project (Pronyk et al., 2008) – measure their impact on intimate partner violence but do not measure impacts on other types of violence that might be occurring within the study population such as male-to-male peer violence. Similarly, interventions that are well-supported by evidence to prevent youth violence have not been evaluated for what relevance they might have for preventing intimate partner violence. For example, the WHO report shows that 'social development programmes' (those that teach children problem-solving, empathy, and conflict management) are the only type of intervention that is 'well supported by evidence' to prevent youth violence, but there is not yet any evidence base for the role these sorts of programs may play in reducing intimate partner violence (WHO, 2010b). While these divisions based on type of violence allow for targeted approaches, they simultaneously omit an examination of the risk factors and solutions that may exist across types of violence. Focusing on specific types of violence is important, but there may be a missed opportunity in violence prevention efforts to take lessons learned across the different areas of violence and work in synergistic ways to tackle what appears to be a key root cause of violence in most parts of the world. Below, we use epidemiological evidence and theoretical frameworks to argue that prevailing norms of masculinity undergird both intimate partner violence and youth violence (and possibly other types).

1.2. The epidemiology of violence perpetration and victimization

Men are overwhelmingly more likely than women to be both perpetrators and victims of interpersonal violence. In 2012, over half a million individuals worldwide died as a result of injuries from interpersonal violence (WHO, 2013b). Of these deaths, males were disproportionately impacted: 81% of interpersonal violence deaths were men (WHO, 2013b).

In addition to being more likely to die as a result of violence, men, as a group, perpetrate more physical violence than women and perpetrate more harmful types of physical violence than women. In 2012, there were approximately 437,000 intentional homicide deaths worldwide and 95% of persons convicted of homicide were males (UNODC, 2011). In a study of youth in 27 countries worldwide, males were both more likely than females to be in any fights and more likely to engage in 'frequent fighting' (12 or more times in a year) (Swahn et al., 2013). Additionally, sport – a central socializing institution for masculinity among young men throughout the world – has codified and rewarded violence

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