Violence victimisation as a gender-specific process

PhD Thesis

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This Thesis is based on three publications

Paper 1

Physical violence, self rated health, and morbidity: is gender significant for victimisation? V Sundaram, K Helweg-Larsen, B Laursen and P Bjerregaard, J. Epidemiol. Community Health 2004;58;65-70

Paper 2

Is sexual victimisation gender-specific? The prevalence of forced sexual activity among men and women in Denmark, and self-reported well-being among survivors. Vanita Sundaram, Bjarne Laursen and Karin Helweg-Larsen. In Review.

Paper 3

Upholding the myth of masculinity: the gendered production of violence victims. Sundaram V & Jackson S. In Review.

Content

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”Because it is so pervasive, violence is often seen as an inevitable part of the human condition – a fact of life to respond to, rather than to prevent. Violence can be prevented.” (WHO World Report on Violence & Health 2002)

Preface

The present project is rooted in a wish to challenge the inevitability of violence as an aspect of the human (male) condition. Integral to this theoretical stance is naturally the notion that violence can be prevented. The project posits that violence must be analysed as a gendered phenomenon, whether its victims are male or female, in order for its inevitability to be challenged and for violence prevention to be effective. This requires us to analyse both the underlying reasons for, as well as the multitude of consequences of violence.

The project sought to build on the existing public health literature about health problems associated with violence for women, as well as to contest the relatively limited evidence on the health impact of violence for men.

Further, the project wished to ask why men are not positioned as victims, either in the research literature or in social and political discourse on violence. The narrow focus on men has victims has centered almost exclusively on male victims of sexual assault. The thesis thus wished to explore what implications the differential and gendered construction of victims might have for our understandings of gender, and how current conceptualisations of masculinity and femininity in turn maintain men's use of violence. Thus, the project did not wish to undermine the pervasiveness or impact of violence towards women; rather, it aimed to strengthen the critique of men's violence overall. It is hoped that the empirical findings and the theoretical analysis will contribute to knowledge that is necessary for long-term violence prevention.

Summary

Violence is recognized as a serious public health problem. Numerous studies have documented associations between physical and sexual violence and a number of short and long-term health problems – primarily among women. While it is well known that male violence towards other men is widespread, less knowledge exists on the health of male victims. Reliable data on the magnitude and causes of violence among men and women are needed to establish patterns of violence and gender differences herein. Additionally, evidence on the health status of male and female victims will contribute to our knowledge about gender-specific health problems associated with violence. This information may be used to develop meaningful and gender-specific prevention initiatives. Additionally, it is integral to violence prevention that the normalisation of physical violence among men be challenged. This requires an examination of the ways in which normative understandings of gender perpetuate the view that men's use of violence is inevitable and non-damaging to men and thus sustain men's violence overall. Male-on-male violence must thus be analysed as rooted in the very conceptions of gender that produce and perpetuate men's violence against women.

The overall aim of the present PhD study is to analyse violence victimisation as a gender-specific process, with particular reference to interpersonal violence. The project looks at victimisation in two ways:
1. An empirical analysis of gender differences in exposure to physical and sexualised violence and in health problems associated with violence
2. A theoretical analysis of victimhood as a discursively and subjectively constructed identification, which is shaped by binary and hierarchical gender categories that may perpetuate men's use of violence overall

The empirical analysis is based on data from two nationally representative health surveys conducted in Denmark in 2000 and 2002, respectively. The theoretical analysis draws on the present empirical findings and existing theory.

The thesis is based on the following three papers:

Paper I Physical violence, self-rated health and morbidity: is gender significant for victimisation?
In 2000, 4975 men and 5483 women aged between 16 and 67 years in Denmark answered questions on lifetime and last-year experiences of physical violence. The paper focused on physical victimisation within the past year. 6% of men reported at least one experience of physical violence compared with 4% of women. The prevalence of physical victimisation was highest among men aged 16-24 years and was signifi-

cantly higher than for women in all age groups. Women reporting violence victimisation were significantly more likely to rate their own health as poor and report a number of illness symptoms than female non-victims. This difference was not found among men. Victimisation was found to be gender-specific, in terms of exposure as well as the violence-health relation.

Paper II Is sexual victimisation gender-specific? The prevalence of forced sexual activity among men and women in Denmark, and self-reported well-being among survivors.
In 2000, 4857 men and 5296 women aged between 16 and 67 years in Denmark answered questions on lifetime and last-year experiences of sexual abuse and assault. The analysis focused on lifetime experiences among men and women aged between 16 and 39 years. Nearly 14% women and 2% of men in this sub-group reported at least one lifetime incidence of forced sexual activity. Sexual abuse was associated with poor health, illness behaviour and risk behaviour for both men and women. The pattern of association was comparable for men and women on a number of indicators.

Sexual victimisation was also analysed among a nationally representative sample of 14-16 year-olds. In 2002, 2910 boys and 2918 girls answered detailed questions about their sexual experiences before the age of 15. Close to 4% of girls and 1% of boys reported at least one sexually abusive experience. Associations between sexual victimisation and well-being were found for both genders and the pattern of association was almost identical for boys and girls. Sexual victimisation was thus found to be gender-specific in terms of exposure, but fewer differences were found in associations between abuse and health.

Paper III Upholding the myth of masculinity: the gendered production of victims
The paper explored how victimisation might be viewed as a constructed identification. It was argued that the binary and hierarchical construction of gender shapes our understanding of violence, and thus of victims. Further, it was argued that normative expectations of gender impact upon men and women's subjective experiences of victimisation, including one's self-perceived ability to resist and prevent being victimised. The analysis suggested that the gendered construction of victims actually upholds a view of men's violence towards other men as normal, and thus perpetuates men's violence overall.

Conclusion

Violence victimisation can be thought of as gender-specific, at the level of material experiences of violence, as well as the way in which violence victims are viewed and are discursively/ subjectively constituted.

Resumé

Vold udgør et alvorligt folkesundhedsproblem. Der er tidligere påvist sammenhænge mellem udsættelse for fysisk og seksuel vold og en række helbredsproblemer, primært blandt kvinder. Mænds vold mod andre mænd er udbredt, men der findes kun begrænset viden om helbredsstatus blandt mandlige ofre. Pålidelige data om voldens omfang, årsager og helbredsmæssige konsekvenser blandt mænd og kvinder er således nødvendige for at kunne belyse voldsmønstre samt for at kunne udvikle kønsspecifikke forebyggelsesinitiativer.

En holistisk tilgang til voldsforebyggelse må nødvendigvis udfordre den udbredte opfattelse af, at vold blandt mænd er et almindeligt fænomen. Dette indebærer, at sammenhænge mellem normative kønskonstruktioner og mænds brug af vold analyseres. Herunder, på hvilken måde kønskulturen styrker en forestilling om at vold blandt mænd er uundgåelig og er uden negative følger for ofrene. Mænds vold mod andre mænd skal således analyseres i sammenhæng med mænds vold mod kvinder, da de begge kan betragtes som værende forankret i rigide kønskonstruktioner.

Det overordnede formål med afhandlingen er at analysere den kønsspecifikke offergørelse, med særlig fokus på interpersonel vold. Projektet belyser offergørelse i to delelementer:

1. En empirisk analyse af kønsforskelle i udsættelse for fysisk og seksuel vold, og i helbredsproblemer blandt voldsofre
2. En teoretisk analyse af offergørelse som en socialt konstrueret identitet, der er forankret i kønskonstruktioner, som bidrager til, at mænds vold opretholdes

Den empiriske analyse baseres på to nationalt repræsentative undersøgelser gennemført i Danmark i henholdsvis 2000 og 2002. Den teoretiske analyse baseres på de anvendte data og foreliggende køns- og voldsteori.

Afhandlingen er baseret på følgende tre artikler:

Paper I Physical violence, self-rated health and morbidity: is gender significant for victimisation?
I 2000 besvarede 4975 mænd og 5483 kvinder mellem 16 og 67 år i Danmark spørgsmål om udsættelse for fysisk vold inden for det sidste år og nogensinde. Den første artikel tog udgang i data om voldsoplevelser inden for det sidste år. 6% af mænd rapporterede mindst én oplevelse af fysisk vold sammenlignet med 4% af kvinder. Forekomsten af fysisk vold var højest blandt mænd i aldersgruppen 16-24 år, og den var signifikant højere end blandt kvinder i samtlige aldersgrupper.

En signifikant større andel af kvindelige voldsofre vurderede deres eget helbred som dårligt og rapporterede en række sygelighedssymptomer sammenlignet med kvinder, der ikke havde været udsat for vold. Samme forskel fandtes ikke blandt mænd. Offergørelse var således kønsspecifik både med hensyn til udsættelse for vold, og sammenhænge mellem vold og dårligt helbred.

Paper II Is sexual victimisation gender-specific? The prevalence of forced sexual activity among men and women in Denmark, and self-reported well-being among survivors.
I 2000 besvarede 4857 mænd og 5296 kvinder mellem 16 og 67 år i Danmark spørgsmål om tvungen seksuel aktivitet oplevet inden for det sidste år og nogensinde. Analysen fokuserede på oplevelser nogensinde blandt mænd og kvinder i aldersgruppen 16-30 år. 14% af kvinder og 2% af mænd i denne delgruppe rapporterede mindst én oplevelse af tvungen seksuel aktivitet. Sammenhænge fandtes mellem ufrivillige seksuelle erfaringer, dårligt selvvurderet helbred, sygdomsadfærd og risikoadfærd blandt mænd og kvinder. Sammenhængene var sammenlignelige for mænd og kvinder på en række indikatorer.

Tvungen seksuel aktivitet blev også analyseret blandt et nationalt repræsentativt udsnit af 15-16-årige. I 2002 besvarede 2910 drenge og 2918 piger spørgsmål om deres seksuelle erfaringer før 15-års alderen. Tæt på 4% af piger og 1% af drenge rapporterede mindst ét seksuelt overgreb. Sammenhænge mellem overgreb og trivsel fandtes blandt begge køn og mønsteret var sammenligneligt for drenge og piger.

Offergørelse var kønsspecifik med hensyn til forekomsten af ufrivillige seksuelle erfaringer, men der var færre forskelle i sammenhænge mellem seksuelle overgreb og trivsel.

Paper III Upholding the myth of masculinity: the gendered production of victims
Den teoretiske analyse foreslog, at vores opfattelser af forskellige typer af vold – og således vores opfattelser af voldsofre - formes i forhold til binære og hierarkiske kønskonstruktioner. Endvidere kunne normative forventinger til mænd (maskulinitet) og kvinder (femininitet) tænkes, at have betydning for mænds og kvinders subjektive opfattelser af offergørelse, herunder deres egne evner til at undgå og forebygge vold mod dem selv.

Konklusion

Offergørelse kan siges at være et kønsspecifikt fænomen, både med hensyn til udsættelse for vold samt i forhold til den måde mænd og kvinder bliver konstrueret som, og opfatter sig selv som ofre for forskellige former for vold.

1. Introduction

The aim of the present project was to reconsider violence victimisation as a gender-specific process. The study was shaped by a dual understanding of victimisation: material experiences of violence victimisation and health outcomes among victims, and the discursive construction and naming of victims of violence. The study sought not only to shed light on gender differences in reported experiences of physical and sexual victimisation and associated health problems, but also to examine how the construction of victim status is shaped by understandings of gender and sexuality that frame different forms of violence as more or less acceptable. The latter may be thought to impact upon men and women's subjective experiences of victimisation.

Violence exists in a myriad of forms, including collective violence, self-directed violence and interpersonal violence. Indeed, violence researchers have argued that our understandings and constructions of violence are variable enough to warrant pluralizing the term – violences (Morgan 1987; Dobash & Dobash 1980). The present project focused on interpersonal violence, which itself is manifested in numerous forms. The thesis focused only on violence victimisation (rather than perpetration) and analysed physical and sexualised violence, while recognising the existence and impact of other forms of interpersonal violence. Reference to experiences of violence thus signifies victimisation; where perpetration of violence is addressed this will be made explicit. The use of the word 'violence' generally refers to men's physical and sexualised violence towards men and women. However, when the thesis addresses men's violence towards women (or men) specifically, this will be clearly distinguished.

There exists a vast body of literature on violence victimisation, including the health effects of different forms and patterns of violence for its victims. Owing to space constraints, the present thesis will provide a comparatively restricted overview of the literature on violence victimisation and health. However, the violence literature will be drawn in and expanded upon throughout the document.

In order to address the first definition of victimisation used, empirical data were analysed to describe gender differences in the prevalence of self-reported violence experiences and health outcomes among victims compared to non-victims. Physical and sexual victimisation were analysed separately in order to illuminate men and women's experiences of different types of violence and to describe health outcomes among victims for each type of violence.

The thesis comprised three papers, the first two of which described empirical findings. Paper 1

addressed the self-reported prevalence of physical victimisation among men and women and gender differences in associations between physical violence and health status. The analysis was based on secondary data collected in a nationally representative survey of a random sample of adults (16-67 years) in Denmark in 2000. Based on these data, it was found that physical victimisation was reported significantly more by young men than by women in all age groups. Violence was significantly associated with a number of health problems among women, but not among men.

In Paper 2, lifetime experiences of sexual victimisation were addressed. This paper sought to describe gender differences in the reported prevalence of sexual victimisation, as well as in health outcomes among male and female victims. The analysis was based on the same survey data as Paper 1, as well as data gathered in a nationally representative youth survey conducted among 15-16 year-olds in Denmark in 2002. The analysis showed that in the adult sample and the adolescent sample, women reported sexual victimisation experiences significantly more than men. Victims of both genders reported poor health outcomes and risk behaviours significantly more frequently than non-victims. Further, the pattern of association was comparable for men and women on a number of indicators.

The second definition of victimisation used in the present study was explored in a theoretical analysis of the gendered construction of violence victims. This analysis was described in Paper 3. It should be acknowledged that as with the empirical study, the theoretical analysis was located in a Western context and so understandings of violence, gender and sexuality were culturally, as well as temporally specific.

Paper 3 took root in the empirical findings, seeking to examine how the differential health outcomes of physical and sexualised violence among men and women, and within the category of men could be framed within a conceptualisation of victim status as constructed and as gendered. The paper proposed an argument for viewing the construction of victims as connected to variable understandings of violence as normalised and as legitimate. It was argued that these constructions of violence are in turn, shaped by normative understandings of the content of gender and sexuality. Also, it was argued that scripts of gender might be internalised by men and women and impact upon their subjective experiences of victimisation. The analysis suggested that the recognition of victimhood as constructed gives us the capacity to deconstruct and subvert the gendered and sexualised allocation of victim status, and in doing so, the potential to disrupt current constructions of violence and gender.

The three papers thus sought to fulfil the aim of the thesis to illuminate violence victimisation as a gender-specific process, by considering vic-

timisation as a material experience as well as a to contribute to existing knowledge about men and women's experiences of violence, including associated health problems. Further, the thesis aimed to apply a theory of gender and power to violence research by questioning the selective constructed identification. The project wished positioning of men and women as victims in relation to different types of violence and examining how this construction of victims may uphold current notions of gender, and thus, men's use of violence.

2. Background

2.1 Existing evidence

An increasing body of research documents that violence victimisation is not only associated with severe injury, but also with poor self-perceived health, short- and long-term illness, and psychological morbidity. The international literature on violence and health has focused primarily on women in an effort to increase awareness of violence against women as a pervasive phenomenon, which is neither contingent on culture nor on individual characteristics of the victim.

Physical violence

A glance at the literature thus reveals that physical violence against women has numerous physical and mental health effects, ranging from immediately visible lesions and severe physical injuries to long-term effects such as poor health status and poor quality of life, including loss of social networks and diminished ability to work (Campbell 2002; Watts & Zimmerman 2002; Jewkes 2000; Heise, Pitanguy & Germain 1994). Both the physical and the mental stress caused by violence can lead to long-term health problems, including chronic headache and back pain, fainting, seizures, cardiac symptoms and chest pain (Fisher & Regan 2006; Leserman, Li, Drossman et al. 1998; McCauley, Kern, Kolodner et al. 1995; Ratner 1993). Choking and severe blows to the head can also have critical neurological consequences (Campbell 2002). The negative physical and psychological effects of physical violence are also salient when violence is categorised as low-severity i.e. pushing and grabbing or threats, as compared with hitting, slapping or choking. Women with current violence of any severity are more likely to have a history of substance abuse, thereby putting them at an increased risk for physical and mental health problems (Lown & Vega 2001; Caetano, Cunradi, Clark et al. 2000; McCauley, Kern, Kolodner et al. 1998).

Sexualised violence

Similarly, sexualised violence has been associated with a multitude of emotional, behavioural and physical problems among women. Sexual victimisation in childhood and adolescence has thus been associated with psychological morbidity, binge drinking, suicide ideation, disordered eating and sexual risk behaviours (Briere & Elliot 2003; Ackard & Neumark-Stainzer 2000; Garnefski & Arends, 1998; Erickson & Rapkin, 1991; Schei 1990). Adult sexual abuse history has been linked to poor subjective health (Elliot, Mok & Briere 2004; Golding, Cooper & George, 1997), multiple sexually transmitted diseases and gynaecological symptoms (Ohene, Halcon, Ireland et al. 2005; Hilden, Schei, Swahnberg et al. 2004; Swahnberg 2003; Wijma, Schei, Swahnberg et al. 2003; Schei & Bakketeig 1989), panic and depression (Leserman 2005), alcohol disor-

ders (Ullman, Filipas, Townsend et al. 2005; Hughes, Johnson & Wilsnack 2001; Caetano et al. 2000), smoking (Hathaway, Mucci, Silverman et al. 2000) and increased hospital admissions and surgical procedures in adult life (Salmon & Calderbank, 1996).

The existing knowledge about health problems associated with physical and sexual victimisation among men is sparse. Relatively few studies have examined the impact of physical victimisation among men and have found that victimised men appear to be affected by violence, reporting shaking, shock, fear and disorientation (Maguire & Corbett 1987: 56; Shapland, Willmore & Duff 1985). Recent studies have reported that interpersonal violence and physical abuse among men are specifically associated with health problems (e.g. Watson & Parsons 2005) such as symptoms of depression and increased alcohol use (Holmes & Sammel 2005; MacDonald, Piquero, Valois et al. 2005; Porcerelli, Cogan, West et al. 2003; Chermack, Walton & Fuller 2001). The association between physical victimisation and health problems has been found to be constant, regardless of the victim-perpetrator relation. Studies of intimate partner violence and stalking among men have found that victims reported injury, depression, substance abuse and chronic mental illness (Coker, Davis, Arias et al. 2002; Davis, Coker & Sanderson 2002).

A comparatively greater number of studies have examined the impact of sexual victimisation on men. Research has reported that sexual abuse among men is associated with mental morbidity, including anxiety and affective disorders (Shack, Averill, Kopecky et al. 2004; King, Coxell & Mezey 2000), substance use and misuse (Johnson, Ross, Taylor et al. 2005; Ratner, Johnson, Shoveller et al. 2005) and sexually transmitted diseases (Ohene et al. 2005). The few studies that have compared health outcomes among male and female victims of childhood and adolescent sexual victimisation have found that patterns of association were gender-specific. Male victims have thus varyingly been found more likely than female victims to need psychiatric treatment and to display personality and affective disorders following sexual abuse (Spataro, Mullen, Burgess et al. 2004), to use drugs (Watts & Ellis 1993), to binge drink (King, Flisher, Noubary et al. 2004; Garnefski & Arends 1998) and to make attempts at suicide (Garnefski & Diekstra 1997).

There also exists a well-established tradition for violence research in Denmark and while the focus has been on describing the prevalence of violent victimisation among men and women based on crime/victim surveys (e.g. Bay 2005; Kyvsgaard 2000; Rigspolitichefen 1998; Balvig 1997; Balvig 1995; Balvig 1993; Christensen & Koch-Nielsen 1992; Balvig & Høigård 1988; Wolf 1974) or emergency department data (Helweg-Larsen & Kruse 2004; Helweg-Larsen, Sundaram, Raboni et al. 2002; Brink 1999; Brink, Villadsen, Davidsen et al. 1996; Charles, Schroder, Petersen et al. 1991; Jørgensen, Jørgensen, Jensen et al. 1981), some studies have examined associa-

tions between violence and health problems. These studies have been based on different data sources and have focused primarily on illuminating the consequences of intimate partner violence for women.

Studies using register-based patient data and emergency department data have thus shown that violence against women is primarily perpetrated by an intimate partner and that female victims are significantly more likely than non-victims to present with a range of health problems, including gynaecological symptoms, increased admission for surgical procedures, and injury (Helweg-Larsen & Kruse 2003; Helweg-Larsen & Sørensen 2000; Fabricius, Brink & Charles 1998; Breiting, Helweg-Larsen, Staugaard et al. 1989; Aalberg & Borup 1984). Recently, Denmark participated in the International Violence Against Women Survey. Interview data from the survey indicated that approximately 50% of women, who reported violence experiences, had been subjected to the abuse by an intimate partner (Balvig & Kyvsgaard 2006). However, no data on health risks associated with violence were available from the study. To the author's knowledge, no large-scale studies have previously examined the health status of physically or sexually victimised men in Denmark. Thus, the available knowledge on gender differences in experiences of violence and health problems associated with varying kinds of victimisation is limited.

A nationally representative health survey conducted in 2000 included questions on physical and sexualised violence, thus allowing for analyses of gender differences in health problems associated with violence to be conducted (Kjøller & Rasmussen 2000). In 2002, a youth survey was conducted to describe the well-being of young people in Denmark, with a particular focus on their experiences of sexual victimisation (Helweg-Larsen & Bøving Larsen 2002). The data allowed for analysis of gender differences in the reported prevalence of sexual victimisation, and of associations to a range of health indicators. The empirical analysis in the present thesis is based on data from these national surveys, which will be described in greater detail in Chapter 4.

3. Methodology

3.1 The public health approach

The public health approach to violence research has advocated documenting the health consequences of violence as a much-needed means of emphasising the highly gendered nature and impact of violence (WHO 2005, 1999; Krug, Dahlberg, Mercy et al. 2002; Watts & Zimmerman 2002). The onus has been on collecting large-scale, quantitative data with which patterns and trends in the prevalence and distribution of violence can be illuminated. The World Health Organisation has amongst others, stressed that reliable and comparative data on the magnitude and consequences of violence are necessary to moving away from a conceptualisation of violence as an individual problem and to identifying gender-specific patterns and forms of violence across different countries and cultures (Krantz 2002; European Women's Lobby 1999). Further, generalisable evidence is crucial to guiding policy on violence prevention, as well as to improving legislation, interventions and response mechanisms. For example, while the health care system is often the first point of contact with women who have experienced violence, relatively few doctors, nurses and other health personnel have the awareness and training to identify violence as an underlying cause of women's health problems. Existing scoping research has demonstrated the hurdles to engaging emergency department health care staff with the sensitive issue of violence (Helweg-Larsen, Sundaram, Raboni & Mulder 2002). Evidence on the pervasiveness of violence against women, as well the range of health problems seen among female violence victims are thus also necessary to raising awareness about the extent and nature of the problem among health care providers (WHO 2005: vii-viii). The implementation of large-scale studies on violence has thus been encouraged.

Historically however, the public health approach to violence has tended to be reactive and rather fragmented into specialised areas of interest and expertise (Krug et al. 2002). A holistic preventative approach that explores mechanisms underlying the specifically gendered use of violence, connections between different forms of violence and the reproduction of violence has often been overlooked in favour of a treatment-oriented perspective. Despite the emphasis on drawing attention to the gender-specificity of violence victimisation, the reactive focus has impeded efforts to reliably illuminate the differing magnitude and impact of violence for men and women and to design gender-specific prevention and intervention strategies.

The present thesis argues that while there is both a quantitative and qualitative distinction to be made between different types of violence, and

specifically the different forms of violence that men and women primarily experience (e.g. Stanko 2000, 1994; Dobash & Dobash 1992, 1980; Kelly 1992), it is necessary to recognise and address violence towards men, as well as women as a public health problem. The available knowledge indicates that violence victimisation is indeed gendered in its form and its impact, and that continued research must be conducted to document the consequences of men's violence towards women. However, the present project contends that a gender-aware public health analysis should aim to shed light also on the underlying reasons for, and the potential impact of men's violence towards other men. Further, the distinct lack of gender analysis in public health research thus far may have inadvertently created an acceptance of men's violence - towards men and women – as a fact of life to be responded to, rather than a specifically gendered behaviour that can be prevented. An analysis of male on male violence as gender-based may thus contribute to challenging the normalisation of men's violence overall and create a space in which violence between men can be seen also be seen as harmful. Public health initiatives to combat men's use of violence rely on this knowledge in order to be credible as preventative efforts, rather than merely reactive or responsive exercises.

3.2 Epistemology

It has been established that public health research on violence is undoubtedly necessary and valuable to increase awareness about violence as a globally pervasive phenomenon, as well as to shape evidence-based policy and prevention and treatment initiatives. However, the public health perspective on violence runs the risk of being 'gender-blind' in its emphasis on documenting the magnitude and consequences of violence. The focus on obtaining evidence has precluded an analysis of gender and power relations in the production of violence, as well as in our understandings of violence and thus, of victims. Further, a critical approach to the knowledge being produced about violence in public health research has not often been taken. The present project thus attempted to bridge public health methodology with an analysis of gender and power relations in order to contribute to a more comprehensive understanding of violence as a gender-specific phenomenon.

The project set out to illuminate violence as a gender-specific phenomenon through the use of large-scale survey data on violence and health. The thesis thus espoused the public health perspective that large-scale data on violence are necessary and relevant to exposing differences in the distribution, contexts, forms and consequences of violence that men and women experience. However, in seeking to shed light on the specifically gendered character of violence, it was acknowledged that taking an isolated or static methodological stance would be limit-

ing.The project could be located within a feminist analytical framework with regard to the aim of the research and the ontological position on gender and sexuality that informed both the interpretation of empirical data and the theoretical analysis.

It should be noted from the outset, that the present project was located in a Western cultural context, and aimed to produce (partial) knowledge about gender-specific violence victimisation which was premised on culturally, as well as temporally specific constructions and understandings of violence, gender and sexuality. Further, the experiences of violence upon which the empirical analysis was based were reported close to 5 years prior to the time of writing and the knowledge claims made about associations between violence and health do not necessarily represent a static reality.

The 'point' of feminist research

Debates have flourished as to what the aim of feminist research should be. There has been a concern with whether or not feminist research should take root in women's experiences of gendered social lives and should thus aim to bring 'women's' voices to the fore (Ramazanoglu & Holland 2002; Hekman 1997; Smith 1997). This interest was particularly relevant in light of research traditions which had silenced and excluded women's experiences and thus women's contributions to knowledge about a given aspect of reality (Stanley & Wise 1993). However, as several authors (e.g. Jackson 2005; Ramazanoglu & Holland 2002; Stanko 1994) have pointed out, women (and men) are separated by divisions across lines of class, age, ethnicity, disability and sexuality, to name an incomplete list. If gender is conceptualised as a socially constructed and maintained division between men and women, an essential 'female consciousness' cannot then be located within a female body (Harding 1987a; 1986). In differing situations, some women will share more commonalities with some men, than with other women and vice versa.

The present project maintained that by locating feminist research as exclusively concerned with women's experiences, the reality of gender in men's lives is ignored and thus, the aim of deconstructing and disrupting existing gender hierarchies may inadvertently be defeated. The thesis proposed that feminist research strive to include men and women as subjects and beneficiaries of the research, in order to actually 'mainstream' gender and identify it as a construction that impacts on both men and women's lives. The present project was thus concerned with uncovering the gendered realities of women's lives, as well as to make the gender of men explicit. This encompassed addressing the power that men gain relative to women from their location in the gender hierarchy, but it also entailed recognising the differences that exist between men and therefore oppress some men relative to other, more privileged men and women. The concern with identifying, deconstructing and challenging existing gender and

power relations thus located the present research project within a distinctly feminist analytical framework.

Producing 'feminist' knowledge

Ramazanoglu & Holland (2002) argue that feminist research may also be distinguished by the ways in which connections between ideas, experiences and reality are made. In identifying the process of knowledge production as a social one, feminist theorists have pointed to power relations inherent to this process. Contrastingly, what have conventionally been referred to as 'positivist' approaches to methodology have maintained that the reality of a given aspect of social life is directly accessible, given that the correct methods are used. The present thesis maintains that the public health approach to violence can be argued to encapsulate a variation on this ethos: that obtaining reliable and valid data is *the* prerequisite to accurately representing the reality about violence. Thus, by adhering to established rules for data generation and analysis, a direct link between data and reality can be made. It is undoubtedly true that some form of reality (and not necessarily a poor reflection) about the magnitude of violence and the health problems associated with violent experiences can be represented using the methods predominantly advocated by a public health approach. However, the role of the researcher in the interpretation of knowledge gathered is often 'unrecognised' in public health research reporting. Feminist theorists have noted the importance of reflexivity in research, of acknowledging one's own power as researcher in producing knowledge and representing this knowledge as a direct reflection of reality (Ramazanoglu & Holland 2002; Harding 1993). It is therefore argued here that the ontological assumptions that inform a researcher's interpretative framework are of vital importance to the reality that is represented through the data. Transparency in the research process is therefore of great import to being able to claim valid connections between data and reality.

Concepts of 'objectivity', 'neutrality' and 'validity' have been criticised in much feminist research, as they have traditionally been associated with claims to an uncontaminated truth, predominantly in natural science research. However, as Ramazanoglu & Holland (2002: 47) point out, if feminist researchers want to produce knowledge about gendered lives that they can somehow claim as 'truer' or 'better' versions of reality, they are confronted with the problem of finding general criteria for judging their knowledge as 'more valid' representations of reality. They suggest that feminist researchers can claim their knowledge to be 'valid' without masquerading it as a singular version of reality, by making explicit the criteria they use in producing and interpreting knowledge, including their limitations in linking data directly with reality. This stance then brings us back to concerns with "evidence, empirical adequacy and reasoned argument" (Ramazanoglu & Holland 2002: 135) and in the present case, no longer positions

feminist epistemology in seeming contradiction to a public health approach.

A concern of the present project beyond that of making the ontological position adopted explicit was to acknowledge the power relations inherent to representing the respondents' subjective reports of violence and health. As Ramazanoglu & Holland (2002) have pointed out, it is necessary to recognise the limitations of our languages, and the salience of our own gendered experiences and political beliefs in representing the experiences of the men and women we research. As will be discussed in following sections, the relative power of the researcher to represent a whole group of 'men' or 'women' or 'violence victims' as uniformly victimised (or non-victimised as the case might be) across a multitude of subjective as well as structural differences, between and within categories of analysis must be acknowledged. As the present empirical analysis was based on self-report data, the limitations of macro analysis were pertinent for discussion. This will be discussed further in Chapter 5. This power of interpretation and representation is precisely what necessitates the explication of a researcher's ontological motivations in judging whether the knowledge claim made is a 'better' version of reality.

3.3 Ontology

It is necessary to define the ontological position on gender and sexuality that informs the theoretical framework for this study, as well as the interpretation of empirical data. Firstly, it is relevant to clarify that the project is founded on an understanding of gender as a social construct, a conceptualisation of the 'normal' as normative, rather than natural (Jackson 2005: 02). Gender may be seen as the division between men and women, understood primarily in terms of a social hierarchy. Gender may also be signified by the content of its categories, hegemonically defined as masculinity or femininity. As Jackson (2005) notes, the division itself is fixed and institutionalised in a number of ways that are difficult to elude.

Sexuality on other hand, is often understood as a binary division between homosexual and heterosexual sexual preferences and desires, but can also be taken to encompass a wider range of sexual desires, practices and identities. Significant to the ontological framework of the present study, is the understanding that what is constituted as sexual and as 'erotic' is constructed and that sexuality is not necessarily fixed nor can it always be conceptualized of as binary. Men who identify as heterosexual and who sexually desire women, may thus also practice homosexual sex, have homosexual fantasies or find anal penetration arousing. Sexuality may thus be thought of as 'fluid' in a way that gender cannot be, leading some theorists to argue for a pluralisation of the term, to speak of sexualities (e.g. Jackson 2005). As Jackson points out, the pluralisation of the concept has previously been used to recognise and acknowledge the diversity of sexual identi-

ties and practices. However, the danger in conceptualising heterosexuality as just one of a number of sexualities (albeit a hegemonic one) may obscure its institutionalisation as a relation that orders not only sexual life, but also social and domestic divisions of labour, power and resources (Jackson 2005: 05).

The institutionalisation of heterosexuality renders its construction almost unrecognisable and imperceptible, despite it being maintained through everyday practices. Following Jackson (2005:07; 2000), the present study sees the institutionalisation of gender and (hetero) sexuality as constituted on a number of intersecting levels. Gender and sexuality are thus constituted and reproduced at the level of structure, for example through marriage and the law; through discursive constructions and representations of gender and sexuality; at the level of routine, whereby gender and sexuality are constituted and reconstituted through everyday social practices; and lastly gender and sexuality are constituted at the level of subjectivity, at which we construct ourselves as gendered and sexual beings through our own experiences (Skeggs 1997).

This conceptualisation of a compound construction of gender and sexuality is valuable in separating out the intertwining and often 'unrecognised' ways in which gender and sexuality are constructed and thus naturalised. Although it is not possible to separate out these levels of construction entirely, the present study considered it necessary to think about the multiple loci at which gender and sexuality are constituted specifically to illuminate how the constructed nature of these descriptors may be concealed, and also in order to draw attention to the sites at which gendered and sexual identities may be subjectively constituted and differentially experienced by men and women. The present thesis focused primarily on the discursive construction of gender and sexuality in relation to the legitimation of different forms of violence and 'victims', as well as how the permeation of gender scripts at the level of subjectivity may impinge upon men's and women's identities in relation to different types of violence.

The thesis acknowledges that while gender may be conceptualized as a binary and relatively 'fixed' division, it does not produce homogenous or static categories of 'man' and 'woman' or 'masculinity' and 'femininity'. As numerous theorists have emphasised, gender intersects with a multitude of social divisions that inform one's gendered experience, including the experience of power (or lack thereof) (Ramazanoglu & Holland 2002; Jackson 1996, 2005; Kimmel 1994). And naturally, individual men and women possess the agency to resist and subvert normative performances of gender (e.g. Butler 1990). As Delphy (1993 in Jackson 2005) has suggested then, gender as a concept may be characterised by its fixity as a social division and the simultaneous variability of its content. Thus, what is considered to be 'masculine' or feminine' may be contestable between individuals, across and

within cultures and over time, and in this sense, gender may be considered fluid and less easily definable.

Taking these caveats into consideration, the present project employed gender as a primary unit of analysis. It operated with a conceptualisation of gender that sees a hegemonic construction of 'man/masculinity' as defined in opposition to what is constituted as 'woman/femininity'. The work recognised that knowledge about gender can be produced and transformed at the level of people's subjective experiences, as well as through discourse and representation, thus highlighting the impossibility of producing one form of valid knowledge about gender (e.g. Ramazanoglu & Holland 2002). However, drawing on the ontological assumption that 'gender' and indeed heterosexual relations are cemented at the level of structure and institution, the project was motivated by a need to be able to produce knowledge about violence in relation to categories of gender, as more than constituted merely at transient levels of subjectivity and discourse. As Oakley (2000: 19) also notes, care must be taken not to obscure the 'classes' of men and women by adopting the postmodern position that there are only different social groups with distinct, but sometimes overlapping interests. A relativist position runs the risk of eclipsing the structural and social relations that create and maintain gendered power differences between and within the categories of 'men' and 'women. Since interpersonal violence is rooted in these gendered relations of power, it would be of limited gain to analyse violence only in relation to subjectively experienced gender identities, as we would be less able to make explicit the constructed nature of these relations, to quantify violence and to establish gender-specific patterns in its trajectory (ies). The present analysis thus differentiated between gender (and heterosexuality) as institution, practice and identity while acknowledging their interrelation (Jackson 2005).

3.4 Gender and power: (the recognition of) power difference and the power to 'know'

While a primary aim of the present project was to illuminate the gender-specific health risks associated with violence victimisation, it also sought to locate violence as a (global) social problem that reflects unequal gender and power relations (Johnsson-Latham 2006). The World Health Organisation has recently acknowledged that future public health research on violence should focus on uncovering the prevailing 'male' attitudes and beliefs that may contribute to (the perpetuation of) partner violence, in order for a comprehensive understanding of gender-based violence to be achieved (WHO 2005: 27). The present project maintained that not only is knowledge about men's attitudes to violence against women needed; men's violence towards men as well as women needs to be recognised as a gender-based phenomenon. As Kimmel (1994) has argued, we cannot analyze men's violence

towards women in isolation from men's violence towards other men, as both are mediated by, and constitutive of hegemonic notions of gender (masculinity). In order to improve our understanding of men's violence, not only does the significance of material violence victimisation for men need to be explored; gendered constructions of violence – and thus of victims - as more or less legitimate need to be re-examined. Further, the salience of gender scripts for men and women's identifications as violence victims in relation to different types of violence should be explored.

The absence of gender and power in Danish research

Despite an increasing focus on violence prevention in Denmark, gender analysis is invisible in the majority of Danish violence research. The recognition of gender as central to violence perpetration is reflected primarily in reiterations of men as the primary perpetrators of violence. The reasons for *why* it is overwhelmingly men who perpetrate violence are rarely addressed, as are the reasons underlying men's use of violence. The onus is overwhelmingly on documenting the magnitude of violence against women, victim support and increasingly, on implementing effective treatment for violent men. The limited notion that violence is mainly a reality to respond to is thus reiterated.

However, a recent Danish report on men's violence that focused on treatment options for violent men emphasised the need to incorporate gender and power analyses into Danish violence research (Reinicke 2005). The author pointed to the tendency to focus on social and gender-neutral factors when discussing the reasons and mechanisms underlying men's violence in a Danish context. Reinicke too underscored the need to analyse why it is primarily men who perpetrate violence whether it be against other men or against women, pointing out that there tends to be a 'systematic underplaying of the relationship between masculine culture and violence' as most people find it difficult to see well-informed and democratic men as violent (Reinicke 2005:05). An egalitarian and democratic society may be reluctant to see itself as producing and reproducing violent boys and men. Thus, as Reinicke (2005) observes, while the elimination of all forms of violence in Denmark is prioritised at a governmental level, the specific masculine culture that is responsible for producing the violence is neither recognised, nor addressed.

The present project suggests that the non-recognition of the link between masculinity and violence in research may reflect the frequent underplaying of gendered power differences in Danish social and political discourse. The discursive erasure of power differences between men and women has reduced the negotiation of gender equality to the level of the individual and her/his ability to choose equality and freedom, from violence, for example (Balkmar, Iovanni & Pringle 2005). Difference tends to be addressed primarily in terms of 'othering' in much Danish political and academic discourse. Thus, differ-

ence from hegemonic cultural norms may at best be acknowledged and at worst, made an example of as backward, undemocratic and oppressive. In this context, power differences between men and women are readily recognised, as the 'other' culture becomes emblematic of oppression, gender inequality and times long gone (from an enlightened society) in which women were the property of their fathers, brothers and then husbands. Violence then, tends to be addressed in terms of gender and power relations when the issue is violence among ethnic minority groups in Denmark or men's violence against women in Greenland (Balkmar et al. 2005) – the long-standing cultural 'other' of the Danish ethnic norm. By contrast, psychological explanatory frameworks are predominantly used in explaining violence against women by majority ethnic men (e.g. Madsen 2002). As Balkmar et al. suggest, the emphasis on gendered violence in ethnic minority groups may be seen as a means of diverting attention away from violence by majority ethnic men. This thesis contends that the exaggerated emphasis on cultural explanations for violence and 'recognised' unequal gender and power relations among ethnic minorities compared with the individualised, psychological framework for analysing men's violence amongst 'ethnic' Danes, could also represent an attempt to underplay the salience of patriarchal cultural and social norms in contemporary majority Danish society.

The 2002 Danish National Action Plan on Violence Against Women thus names physical violence as a means of 'conflict management' and emphasises that not all men use this strategy to deal with interpersonal disputes (Ligestillingsministeriet 2002: 05). Men's violence towards women is identified as a manifestation of fundamental gender inequality, however it is generally described in gender-neutral terms, such as 'domestic violence', 'violence in the family' and on occasion as 'domestic disturbances' (Ligestillingsministeriet 2002: 08). While the 2005 Action Plan does name men's violence, it does not address the link between men/masculinity and violence. The specifically gendered nature of violence is not mentioned and its pervasiveness may thus be overlooked. The focus of the Danish Action Plans (2002, 2005) is on obtaining reliable quantitative data on violence against women, securing support to victims and improving treatment for violent men. These are clearly commendable initiatives, but reflect a partial vision of violence and therefore of necessary measures for prevention.

The distinctly 'ungendered' stance of Danish policy and research on physical violence is reiterated in initiatives on sexualised violence and prostitution in Denmark. Rape and prostitution tend to be framed in psychological, health or social perspectives, rather than viewed as reflective of notions of gender, sexuality and the power differentials that characterise these. Recent legislative changes to increase penalties for rape locate sexual victimisation within a general spectrum of violent crimes, rather than within an explicit discussion of gendered power relations

or bodily integrity. Prostitution is essentially regarded as an individual choice to provide a 'service' of sorts, as is evident in the legitimation of sexual services offered specifically to disabled persons in order to "deal with their sexual needs and problems" (Balkmar et al. 2005: 06-07). The present analysis notes that this view does not question why disabled men's sexual needs should necessarily be more potent or urgent than those of disabled women, for whom no such service is available, sanctioned or even regarded as necessary. Heteronormative constructions of men's sexuality as inherently active and irrepressible in contrast to a passive 'feminine' sexuality are thus perpetuated in existing policy and interventions. The non-recognition of power difference is clear in Danish policy on prostitution. As Balkmar et al. (2005: 06) note, "[..] in Denmark, there is a tendency to view prostitution as an expression of *the freedom* to buy and sell services." (my italics).

Thus, the present project argues for the need to reintegrate an analysis of gender and power into research on violence in order to be able to situate men's violence as a culturally maintained phenomenon, whose endurance is (at least partially) contingent on our non-recognition of the salience of 'gender' in ordering social relations of power. A failure to make power difference explicit will only perpetuate partial analyses of physical and sexual violence as important issues of health, psychological, criminological and judicial concern.

Murdolo (1996: 69) has amongst others noted, that there is an important distinction to be made between acknowledging difference as benign diversity and recognizing difference as the potential for disruption (in Ramazanoglu & Holland 2002: 110). While a climate of 'individualism of independence' may tolerate the existence of social and cultural multiplicity, it does not advocate the disruption of the material bases of inequality. Further, the freedom to 'be different' is not equally available to all; paradoxically, it is highly contingent on being defined and perceived as 'belonging'. The freedom to be oneself may thus be curtailed if one is perceived as 'not belonging' (Balkmar et al. 2005; Ramazanoglu & Holland 2002). The present analysis thus reiterated the need to recognise power in shaping social relations and people's experiences of difference and sameness. Locating difference as a choice at the site of the individual ignores the location of that individual in a web of structural and social relations that are characterised by economic, ethnic, religious, gendered relations of power. In other words, claiming that everyone is equally positioned to make choices allows the privileged to ignore institutionalised power relationships. It allows for the erasure of power differences, so that while 'otherness' or subordination to the norm may be acknowledged as abstracted theory, 'otherness' as lived experience is silenced (Ramazanoglu & Holland 2002).

The power to 'know'

In seeking to make explicit and challenge existing gender and power relations through re-

search, it is imperative to recognise also the researcher's power to represent the researched, and thus her/his power in creating 'truths' about their lives. Researchers thus have considerable privilege in representing individuals or groups as 'different' or 'similar', powerful or powerless across any divisions. The present project analysed 'difference' in terms of gender. The recognition of power differences in gendered social relations (within and between gender categories) was viewed as essential to understanding the production of violence. However, as mentioned earlier, it must be acknowledged that by interpreting difference in terms of gender, this analysis might obscure more salient divisions between and among the men and women whose experiences are represented. Smith (1989) has pointed out that even if researchers identify politically and socially with the people whose lives they research, the former are still positioned as knowing actors and "have the power to distance the researched from their [actual] experience" (Smith 1989 in Ramazanoglu & Holland 2002: 107).

In the present project, a primary aim was to illuminate the reported prevalence of physical and sexual victimisation among men and women and to estimate the probability of poor health among victims. It must be acknowledged that the conclusions drawn on the basis of the data may be an erroneous interpretation of the lived and subjective realities of the respondents whose self-reported experiences are analysed. Here again, the significance of making known the theoretical and ontological assumptions that inform the interpretation of 'detached' data becomes apparent in the process of producing knowledge that can be claimed to 'make sense' in relation to a specified reality.

The present project also aimed to make explicit how constructions of gender (and sexuality) may be seen to shape our understandings of violence, of violence victims and of victims' subjective experiences of violence victimisation. In acknowledging the power of the researcher to produce knowledge about a given aspect a social life, it becomes necessary also to ask whether taking a feminist standpoint signifies access to better knowledge about gendered relations in the lives of the 'researched' than the latter have themselves. Is an empirical and theoretical interpretation of violence as potentially harmful to both men and women a serious misrepresentation of the experiences of the 'subjects'? If they do not experience their gendered lives as variably oppressive or necessarily problematic, then whose reality is being represented in the analysis? As Mohanty (1988) has shown, the process of 'othering' may not serve the best interests of those defined as 'subjugated'. The representation of 'third world women' in Western feminist texts produced a particular form of knowledge about their 'difference' from first world women, which further reinforced the latter's status as 'powerless'. It was by no means the intention of the present project to discursively reinforce the powerlessness of one group, despite the concern with acknowledging power difference in gender

relations. Rather, the project hoped to illuminate the constructed character of gender relations and thus the potential for disruption of these.

There may be no clear answers to the questions posed above and it is not helpful to succumb to a relativist "nothing is certain, and nothing can be known for sure" intellectual framework (Oakley 2000: 19). However, recognising and making explicit the power of the researcher to construct certain versions of reality and to represent other people's lives (people who may never read or use the outcome of the study) was considered to be an implicit part of research which aims to deconstruct and challenge existing gendered power relations.

3.5 Bridging public health analysis and feminist theory

The thesis aimed to integrate a public health approach to violence with an analysis of gendered power relations. The emphasis of the former on obtaining large-scale data and empiricist concerns with reliability and validity seemingly stands in contradiction to the concerns of the latter with reflexivity, transparency and bringing experiences to the fore. However, the present project argues that the potential for wedding a public health approach to violence with feminist methodology may lie in the emphasis of both paradigms on change or emancipatory action as a result or product of research. Both approaches stress the need or indeed, our obligation to challenge inequity, identified through the collection and interpretation of evidence or knowledge. It is argued that the main obstacle to bridging the two paradigms is thus not located in their contradictory aims, but rather, in the perceived irreconcilability of the approaches to knowledge production. It is proposed in the present thesis that if transparency in the research process is prioritised in making valid knowledge claims, then the quantitative-qualitative distinction is in some sense false. It can be assumed that at baseline, qualitative and quantitative researchers alike have an interest in securing quality of evidence and openness in the reasoning underlying connections made between evidence and reality. The methodology employed should accordingly be determined by the question(s) we strive to answer.

The public health approach to violence thus emphasises the need to obtain reliable and comparable evidence on violence, in order to increase global awareness of the pervasiveness of violence across cultures and at all levels of society. Public health evidence may be seen as vital to bringing about attitudinal changes, as well as contributing to a foundation on which policy and initiatives aimed at preventing violence may be based. Oakley (2000) has pointed out that establishing patterns of women's oppression requires quantification. Feminists have used survey research for exactly this purpose, to dispel common arguments that "the complaint of the particular woman was idiosyncratic" (Reinharz 1992: 79). Similarly, we need to be able to quantify and pattern violence against women and against men

in order to draw attention to its pervasiveness, its gender-specificity and to effectuate change – at the level of knowledge and the level of policy making. A growing body of research is thus beginning to acknowledge the importance of survey research in terms of formulating effective and meaningful initiatives and policy, which by their very nature are contingent on data which are generalizable (Reinharz 1992: 80).

The application of a feminist methodology in the present project intended to make explicit gender and power in structuring social relations, and thus to bring to the fore the gender relations underlying violence. The project was concerned with illuminating power relations between men and women, as well as between men, in order to emphasise also how men may be disadvantaged by current notions of gender and to challenge myths about the nature of violence and about the collective power of 'all' men. By naming gender as a constructed descriptor in men and women's lives, the project aimed to highlight the potential for subversion and change of current gender norms. Thus, in their mutual emphasis on disrupting the existing gender order, on producing evidence of gender-based oppression in order to negotiate change, the public health paradigm and feminist approach were considered to have overlapping aims.

Feminist researchers have often pigeonholed the use of traditional survey method as antithetical to the feminist project, which has striven to use "non-hierarchical, non-authoritarian and non-manipulative" research techniques by which to produce knowledge about women's lives (Reinharz 1983: 41 in Kelly, Regan & Burton 1992: 149). The present thesis has argued however, that the core of 'feminist' research methodology may be defined less by the research techniques employed and more by the purpose of the research and importantly, the way in which knowledge claims are made. Defining one's ontological position, acknowledging the limitations of methods employed in producing definitive knowledge about gendered social reality and recognising the power of the researcher to represent knowledge against the backdrop of her/his theoretical motivations and political beliefs are certainly not measures which are antithetical to a public health approach. A feminist standpoint may thus be brought to a range of methods if we distinguish between the research techniques used to ask questions and to collect and collate data, and the interpretation of data and the epistemology used (Kelly et al. 1992).

The present work argues that the distinction between traditionally defined quantitative methodology and qualitative research is characterised by the very power relations which uphold other hierarchical social divisions, such as gender. Feminist scholarship has significantly highlighted the way in which other binary forms of thinking and knowing (public/private, masculine/feminine, intellect/emotion and so on) paralleled the quantitative-qualitative distinction (Oakley 2000: 33). It is argued that in order to

challenge the categorisation of all feminist research as 'soft' and too specific to be counted as valid, generalizable knowledge, this constructed nature of this division must be exposed. It does not necessarily benefit feminist researchers to maintain this division and to be relentlessly sceptical towards any research stance that draws on quantitative methods. Further, as Kelly et al. (1992) point out, many of the charges levelled against quantitative methods, such as the attempted distancing of the researcher from the research process, the notion of objectivity being achieved and not deviating from the original research agenda to accommodate deviating/additional views from the researched, also informed the conduct of early research interviews (Kelly et al. 1992). Similarly, Oakley (2000) draws attention to the often blurry methodological distinction by noting that just as quantitative researchers can study experiences and feelings, and structured questionnaires can allow for respondents to give elaborate accounts of their experiences, so do qualitative researchers draw on 'evidence' and make numerical statements with which to elucidate and support themes in their research.

The present project looks to Spalter-Roth and Hartmann (1987), who argued the case for a 'dual vision', rather than ambivalence in relation to feminist survey research almost two decades ago. They argued that in order to produce research about women and for women that could be used in meaningful policy and political initiatives, feminist researchers would have to negotiate the seeming 'tension' between pursuing their agenda of viewing women's voices as representative of their reality and following a 'positivist' tradition of letting numbers represent the reality. They argued that "[...] we must [...] conduct policy research that meets the standards of [...] validity, reliability, objectivity and replicability. On the other hand, our work is influenced by the principles of feminist methodology and especially by its challenge to the rigid dichotomies between researcher and researched [...]" (Spalter-Roth & Hartmann 1987:01 in Reinharz 1992: 93-94).

In other words, the power relations which are an inevitable and significant aspect of the research process need to be made explicit. But the motivation for using quantitative research techniques does not in itself contradict a feminist epistemology; it does not require that power remains hidden. The present project thus considered the great potential for conducting 'better' emancipatory research by bridging the public health approach with a feminist methodology. In aiming to challenge the constructed division between men and women and the oppositional content of gender categories, it was also seen as relevant to challenge other hierarchical divisions characterised by the same power relations.

Ethical considerations in violence research

The public health literature on violence emphasises that the safety of respondents and the research team are paramount in undertaking any kind of violence research, and this applies particularly to female victims of intimate partner

violence. Considerations as to the mode of enquiry must therefore evaluate the potential danger that asking a woman about experiences of abuse may put her in. Additionally, studies should ideally build upon existing research experience to minimise the underreporting of violence and here also, the method and physical location of investigation may be of significance to the disclosure of experiences of violence. Moreover, the confidentiality of respondents' answers must be ensured, for the benefit of the respondents' safety as well as that of data quality.

No face-to face fieldwork was involved in collecting violence data in the present study. The data in the Danish National Health and Morbidity Survey were gathered using a self-administered questionnaire which was included as part of the general health survey, but which respondents were only asked to complete following the interview. The respondent could thus answer the questions on violence in a temporal and physical context of her/his own choosing. The selected participants had received a letter prior to the interview survey ensuring them that participation in the study was voluntary and that all answers given would be confidential, accessible only by selected researchers. The Danish Youth Survey was conducted using a multi-media computer-assisted self-interview. As will be detailed in Chapter 4, the tree structure of the questionnaire allowed students to skip over any themes or individual questions that they did not wish to answer. Further, the structure of the questionnaire ensured that students were asked questions about sexual victimisation that were relevant and specific to their experience(s). Students gave active and informed consent to participating in the study and were reassured that their answers would be anonymized.

The World Health Organisation recommends that violence studies incorporate post-research initiatives to address and reduce any potential distress caused to the respondents by the study and that fieldworkers/interviewers be adequately trained to refer respondents to local support services if requested. Also, violence questions should only be included in general surveys designed for other purposes if the outlined ethical and methodological requirements can be met (García-Moreno, Heise, Ellsberg & Watts 2001). Regrettably, no post-study initiati-ves were taken to follow-up on the well-being of adult respondents or to ensure that they would be referred to relevant support services if needed. To the authors' knowledge, no respondents contacted the National Institute of Public Health to report distress caused by participation in the study or the disclosure of violence victimisation. However, this is clearly a lesson to be borne in mind for future research initiatives of this character. The students participating in the Danish Youth Survey were given contact details of a psychologist whom they could contact if needed. Following the self-interview, a special class was held in which the purpose and implications of (participation in) the survey were reiterated. In this forum, the students were encouraged to discuss their

fears, doubts or other negative feelings associated with participation in the study.

Both studies included questions on physical and sexual victimisation as part of a more general survey. The response rates for the surveys were high both on the violence questions and the generic questions on well-being. Methodologically then, it was considered defensible to include questions on such sensitive topics in the respective studies. The studies were approved by the Danish Medico-Ethical Committee.

An integral ethical consideration of feminist methodology is transparency/reflexivity in the research process. In relation to researching violence and the experiences of violence victims, the accurate and equitable representation of the lives of 'the researched' must be a priority. While limitations of method, language and the researcher's own social values in interpreting the data gathered are inevitable, the recognition of the differential power of the researcher and the researched in producing knowledge about the latter's lives must be acknowledged. Additionally, it is argued that the using the most appropriate method to answer the research question at hand and with regard to the use of the research is an ethical issue. Using inappropriate methods that do not accurately capture the data needed may not only be harmful to research subjects, but may produce 'false' knowledge.

The present study had to negotiate the tension between acknowledging limitations in accurately representing the individual experiences of violence victims in the present study and attempting to obtain large-scale data with which to produce some generalizable knowledge about violence and health. The very nature of social research implies that no homogenous answer will be given to a single question and people's understandings and experiences of violence may differ greatly. Nonetheless, in order to be able to use the evidence gathered towards improving current policy and prevention strategies, some macro-level assumptions had to be made. It is acknowledged in the present study that every individual's violent experience will not be accurately reflected in the conclusions presented; however, the primary findings were supported by a vast body of existing evidence. Placing demands on the outcome of our research, making explicit who might benefit or be disadvantaged by the outcome of the research, interrogating the process and techniques by which we come to 'know' thus constitute an important aspect of ethical (violence) research (Tuana 1996).

4. Material and method

4.1 Empirical analysis

The empirical component of the present project aimed to describe the prevalence of physical and sexualised violence reported by men and women in Denmark, and to analyse gender differences in health outcomes and indicators of risk behaviour among victims. The analyses were based on data derived from two nationally representative surveys conducted between 2000 and 2002 in Denmark. These surveys and the operational definitions of physical and sexualised violence are described in the following section.

The Danish National Health and Morbidity Survey (2000)

The National Institute of Public Health has conducted nationally representative health interview surveys amongst the adult population (16 years and above) in Denmark with regular intervals since 1987. The main objective of the health surveys are to describe the incidence and distribution of health and morbidity in the adult population and factors that are of significance to health status, including health behaviour, life style, health risks at home and at work, use of health care services and external health resources (Kjøller & Rasmussen 2000). The core elements of the health survey are described in Figure 1.

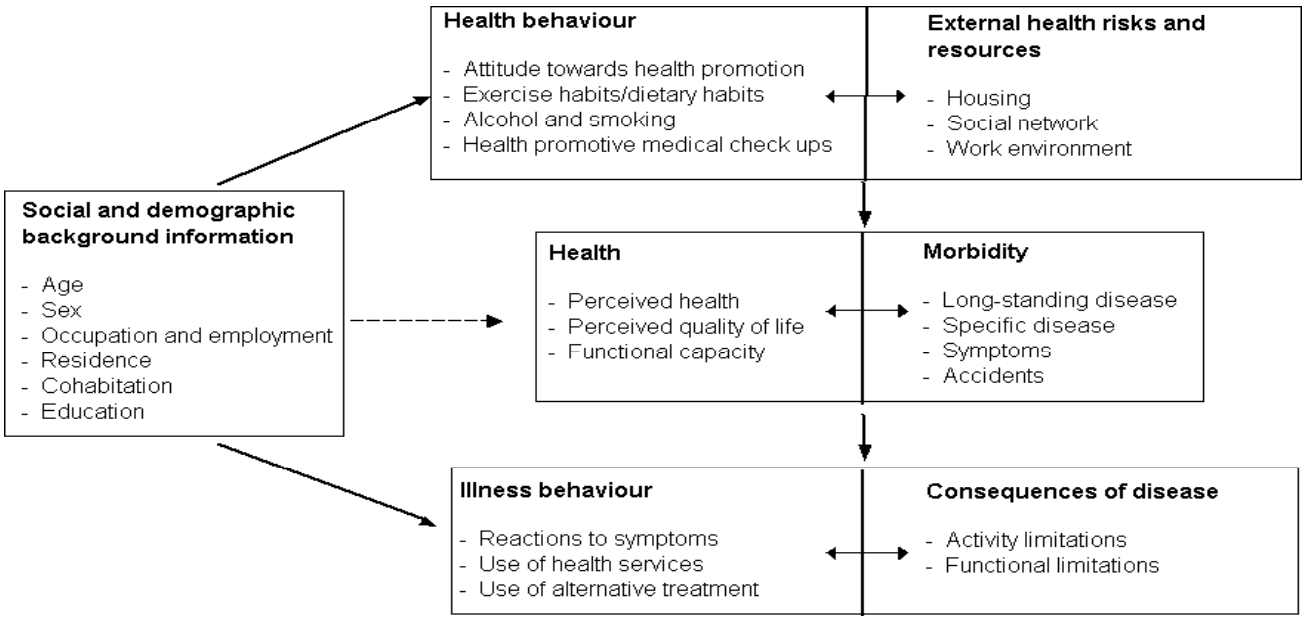

Figure 1

The health survey used here was conducted in 2000 and comprised three sub-samples, a national sample, a follow-up and a supplementary county sample. The survey data were collected in three rounds by systematic random sampling during the course of the year, in order to reduce seasonal-variation bias in reporting of health and illness. The total sample was representative of the Danish adult population. Prior to data collection, all selected persons received a letter explaining the purpose of the survey and ensuring them that participation in the interview was voluntary and confidential.

The health survey consisted of a face-to-face interview and a self-administered questionnaire. The face-to-face interviews were conducted by trained interviewers in the respondents' homes. The self-administered questionnaire was given to the respondent following the interview. Questions on experiences of physical and sexualised violence were included in the questionnaire, which covered a range of topics, not limited exclusively to sensitive issues. The questions on violence and sexual assault were however couched by questions on more sensitive topics, such as quality of sexual life and suicidal behaviour. The questionnaire was to be completed at the respondent's discretion and returned by post in a provided addressed and stamped envelope.

The questions on violence were included in the follow-up and supplementary county samples of the survey. This representative sample consisted of 16,648 adult Danish citizens. A total of 12,333 persons (74%) were personally interviewed about their health status and of these 12,084 (5853 men and 6231 women) agreed to receive a self-administered questionnaire. The questionnaire was completed and returned by a total of 10,458 interview persons, corresponding to 63% of the original sample.

The inclusion of questions on violence in a self-administered questionnaire meant that the response rate – and representativity – of the general health survey was not affected. Additionally, among respondents who had originally received the questionnaire, a relatively high response rate (87%) was achieved on the violence questions, 85% amongst men (N= 4975) and 88% amongst women (N= 5483). A similarly high response rate was obtained on the sexual assault measure, 84% in total (N= 10,153), corresponding to 83% of men (N= 4857) and 85% of women (N= 5296). The response rate was high and relatively consistent across all age groups, but was slightly lower for the oldest groups of respondents (60 years +).

Measures

The World Health Organisation has pointed out that one of the main challenges facing international research on violence against women is the development of clear definitions of different types of violence that accurately capture women's experiences as well as allow for comparisons across different cultural settings (WHO 2005). The questions on physical violence applied in the present project were developed as part of a European initiative to include standard-

ised questions on physical and sexualised violence in regular health interview surveys in different European Member States, so as to obtain comparable, large-scale data on violence (Helweg-Larsen, Sundaram, Piispa et al. 2002). The project was conducted in Denmark and Finland and it was found that it was practically feasible and methodologically defensible to incorporate questions on such a sensitive topic into a general health survey.

The questions on physical violence were developed based on the widely acknowledged and applied Conflict Tactics Scale (CTS), which was developed by Straus (1990) and is the one of the most frequently used quantitative techniques to obtain estimates of the magnitude of physical violence towards women. The original CTS consists of nineteen measures of three major 'conflict tactics' – reasoning, verbal aggression and physical violence. These items are ranked on a continuum of severity, with the last eight items describing acts of physical violence (Straus 1990; DeKeseredy & Schwartz 1998). The present study used questions based on five forms of physical violence included in the CTS.

Lifetime and past-year experiences of physical violence were measured by different forms of physical violence, ranging from slaps and pushing to strangulation and the use of weapons (Appendix 1). The questions had previously been tested in the Canadian Violence Against Women survey (1993), as well as in several Nordic large-scale surveys on violence towards women, namely in Iceland (1997) and Finland (1998). A separate question assessed the victim's relationship to the perpetrator (Appendix 1).

In the present survey, sexual victimisation was measured using a relatively broad and one-dimensional measure (Appendix 2). The question asked about coerced or attempted coerced sexual activity experienced as a child (below the age of 13), as an adolescent (between the ages of 13 and 17) and as an adult (above 18 years). A further question about coercive sexual experiences within the past year (only as an adult) was included in the self-administered questionnaire. A separate question assessed the victim's relationship to the perpetrator (Appendix 2).

The Danish Youth Survey (2002)

The National Institute of Public Health conducted a youth survey amongst 15-16 year-olds in a nationally representative segment of 9th grade (Year 10) classes in Denmark in 2002. The main objective of the survey was to illuminate the well-being of adolescents in Denmark, with a particular focus on early and abusive sexual experiences. The survey described a range of social and health-related factors of significance for young people's well-being, including school performance, family relations, friendships, self-rated health status, illness, risk behaviours and sexual experiences before and after the age of 15 (the age of sexual consent in Denmark).

The survey was conducted by means of a multi-media computer-assisted self-interview (M-

CASI). The questions were presented in text form on the computer screen and were accompanied by a voiceover in a set of headphones connected to each individual computer. The questions on sexual experiences were included in the main M-CASI, however each student had the option of skipping any question or theme he/she did not wish to answer. Further, the students were only introduced to individually relevant questions as the branching structure of the questionnaire allowed a tailoring of questions to each individual's particular sexual experience (Helweg-Larsen & Bøving-Larsen 2002; 2005).

The original random sample comprised a nationally representative cross-section of 324 schools. Of these, 183 schools (56%) comprising 7241 students aged 15-16 years agreed to participate in the survey. Non-participating schools predominantly indicated lack of time as the reason. A total of 6185 (85%) students (3142 boys and 3043 girls) were present at school on the day of the study and participated in the M-CASI. The questions on sexual experiences were answered by 5828 (94%) of students, corresponding to 2910 boys and 2918 girls (Helweg-Larsen & Bøving Larsen 2002).

Measures

Sexual experiences were measured by fifteen different forms of sexual activity - ranging from non-physical actions to completed intercourse (Appendix 3). The Danish Penal Code criminalizes sexual activity with a child below the age of fifteen, regardless of consent. Additionally, sexual activity between a young person aged between 15 and 18 years and a guardian/caregiver, coach, teacher or family member is criminalized. Respondents were asked about their own perception of the experience(s), specifically whether they experienced it as abusive. In the present study, it was considered important to accurately represent those experiences that the respondent him/herself considered abusive, rather than to classify all criminalised relationships as necessarily abusive. Sexual abuse was thus defined only as those experiences that were perceived as clearly abusive by the adolescent, regardless of the legal status of the relationship. Separate questions on the ages of victim and perpetrator and the victim's relationship to the perpetrator were included in the survey (Appendix 3).

4.2 Method

Variables

Data from the Danish National Health and Morbidity Survey were used in order to assess gender differences in the prevalence of physical victimisation and associations between exposure to physical violence and poor health outcomes.

Exposure to physical violence

In order to compare victims and controls, violence victimisation was measured by a positive answer to at least one form of violence and to having experienced the violence within the past 12 months. The measures of violence were di-

chotomised to a single categorical variable to indicate yes or no to victimisation.

Health

Variables describing the health status of victims compared with controls were selected a priori from the health survey. Health status was covered by a question on self-perceived current state of health. This variable was dichotomised to indicate good (excellent/good) versus poor (fair/poor/very poor). Recent symptoms of physical and psychological morbidity were described by questions on anxiety (anxiety/nervousness/uneasiness/restlessness), depression (depression/melancholy/unhappyness), stomach ache and headache. Recent illness was then defined by a positive answer to an indicator, as well as to having been 'very bothered' by the symptom.

Confounding variables

A semi-partial correlation analysis was conducted to control for the independent effects of socio-economic status and age on health outcomes. Socio-economic status was described using employment status which was covered by 13 categories, including students and retirees. The results were age-adjusted using the largest age group (25-44 year olds) as the reference group.

Data from the Danish Health and Morbidity Survey and from the Danish Youth Survey were used in order to assess gender differences in prevalence of sexual victimisation and associations between exposure to sexualised violence and indicators of well-being.

Exposure to sexualised violence

In order to compare adult victims with adult controls, sexual victimisation was defined by a positive answer to at least one form of abuse: in childhood, adolescence or adulthood. The three forms of sexual abuse were dichotomised to indicate 'yes' or 'no' to sexual victimisation.

In order to compare adolescent victims with adolescent controls, sexual assault was defined by a positive answer to one of the fifteen abuse items, as well as to the question about the experience being perceived as abusive. Although fifteen measures of sexual abuse were included in the original survey, the present study included only the last thirteen questions all of which involved an action, rather than incitement to a sexual act.

Well-being

Using the Danish national health survey data, health was described by the same questions as outlined above, as well as further questions on stress and vitality. The stress variable was dichotomised to indicate often stressed (often) versus not often stressed (occasionally/rarely/don't know). Vitality was described by a question on feeling well enough to accomplish the tasks you want to. This variable was dichotomised to indicate often or always feeling well enough (most of the time) versus rarely feeling well enough (occasionally/rarely).

Illness behaviour was covered by binary measures on use of sleeping medication and/or tranquilisers within the past 14 days, contact to general practitioner and to psychologist within the past 3 months and annual sick leave (where 16 days or more a year was classified as high sick leave).

Risk behaviour was assessed by binary variables on physical victimisation within the past year, suicide ideation within the past year, lifetime suicide attempts, exceeding the recommended limit for alcohol consumption within the past week (14 units or more for women and 21 units or more for men) and smoking. A question on movement in deserted urban areas (often/occasionally/rarely/never avoid deserted areas due to fear) was also included.

Using the Danish Youth Survey, well-being was covered by a number of variables selected using a priori reasoning. Health status was covered by a question on self-rated health. The variable was dichotomised to indicate good (excellent/good) versus poor (fair/poor/very poor). Symptoms of physical and psychological morbidity were described by questions on depression (depression/melancholy/loss of interest/sleeping problems), illness within the past 14 days and vitality. Vitality was assessed by a question on the extent to which the respondent felt everything was overwhelming. The variable was dichotomised to indicate yes (yes/maybe) and no.

Risk behaviour was estimated by binary variables on physical victimisation during the past year, daily consumption of wine/beer/liquor and smoking.

Analysis

Physical violence

Male and female violence victims were compared with male and female counterparts who had answered no to experiencing violence. Logistic regression analysis was conducted to predict the probability of negative health outcomes among male and female violence victims compared with non-victims. Odds ratios were calculated to estimate associations between violence victimisation and indicators of physical and psychological morbidity. A 5% level of statistical significance was used.

Sexualised violence

In order to compare sexually victimised men and women with non-victimised counterparts in the adult sample, male and female control groups were created by selecting 2 non-abused persons for each case, matched for age and socio-economic group. Prevalence estimates of health outcomes among victims and non-victims and 95% confidence intervals were calculated. The significance of difference in health status between victims of abuse and non-victims was tested using Pearson's chi-square test and Fisher's exact test when numbers were small ($N \leq 5$).

In the adolescent sample, students reporting at least one incidence of sexual abuse were compared with non-abused counterparts, using gender as a matching criterion. Prevalence estimates of health outcomes among victims and non-victims and 95% confidence intervals were calculated. Pearson's chi-square test and Fisher's exact test (when numbers were small) were used to test the significance of the associations between violence and health in two-dimensional contingency tables.

4.3 Theoretical framework

The theoretical component of the present project aimed to explore how and why constructions of victimhood come to be gendered. Specifically why men, despite experiencing significantly more physical violence than women are less likely to be constructed (and view themselves) as 'victims'. Conversely, why men are unquestioningly constructed as 'victims' of sexual assault, while women's legitimacy as victims of sexualised violence is often under scrutiny. The analysis took root in the empirical data in the present study, as well as drawing on existing theory. The theoretical study sought to consider the link between constructions of gender and violence and the 'recognition' or naming of victims. The analysis aimed to broaden the existing focus on violence towards women to conceptualise men's use of violence as a specifically gendered phenomenon, whether its victims are men or women. It was argued that the gendered construction of victims in fact serves to uphold the existing hegemonic and binary understandings and expectations of gender, in which men's violence is rooted.

The theoretical component of the project was considered necessary precisely because empirical evidence on gender-specific violence victimisation tends to be analysed solely in terms of the way in which violence towards women is gender-based. While some public health evidence does exist on physical and sexual victimisation of men, this is rarely analysed in terms of the way in which gender relations shape the lives of men, specifically how gender operates in men's experiences of violence. The present theoretical analysis thus proposed a model in which the differential violent victimisation of men and women as evidenced by public health research could be analysed in terms of power relations between as well as within gender categories, aiming also to make explicit the gender of men.

The gender of 'men'

Ramazanoglu & Holland (2002: 148) point out that feminist researchers have had to manage the personal and political discomfort of producing knowledge of how women exercise power, how women collude in perpetuating hegemonic masculinity, how some women benefit from the subordination of other women, and increasingly, how men may also be disadvantaged by existing gender relations.

It is argued in this thesis that violence prevention cannot be inclusive or effective without an examination of why it is men who are the primary perpetrators of violence, and how the normalisation of men's violence is bound up with current, prevailing constructions of masculinity. As the reality of men's violence holds true across cultural, religious, class and age boundaries, it appears evident that it should not go unquestioned. However, it should be emphasised that the present analysis addressed a temporally specific, Western conceptualisation of masculinity in relation to violence. Masculinity was not seen as existing in isolation from the hierarchy of gender, but the analysis focused particularly on the content of masculinity in some places, because this construction was viewed as producing and sustaining the very hierarchy. In other words, femininity as a weak and subordinated gender identity can only have meaning in relation to an oppositionally constructed masculine gender category. Further, the link between gender and violence is mediated through constructions of masculinity.

(Pro-)Feminist researchers (e.g. Brod 1990) have noted that there is a danger of re-marginalising women in the renewed focus on men and masculinities. However, a way of avoiding this re-exclusion is by consistently positioning men and masculinities as constructed identities that constitute power relations with women and femininities, as well as other men and masculinities (Hearn & Collinson 1994: 98). The present project notes that the almost exclusive association of gender with women in critical research and policy thus far, has reinforced the normative status of men and masculinity and maintained a conceptualisation of women as deviant, as 'other' to the male norm. Thus, the naming of men and masculinities not only enables us to challenge, disrupt and reject current constructions of gender but also opens for an analysis of men and women as equally gendered. The present analysis sought to illuminate how current notions of gender underlie the construction of violence victims, and may contribute to legitimising and thus perpetuating men's use of violence towards other men (and women). In this way, the project aimed to strengthen the critique of men's violence overall.

In discussing the link between 'masculinity' and violence, the conceptualisation of masculinity used in the present project has to be clarified. As has been pointed out by several authors, the concepts of men and masculinity are not fixed (Connell 1995; Hearn & Collinson 1994; Kimmel 1994). Indeed, it has been argued that constructions of masculinity are sufficiently variable to warrant pluralizing the term to masculinities (Morgan 1987: 180). As Kimmel (1994) observes, masculinity is neither static nor timeless and men and masculinities have different meanings and power within different discourses and in relation to one another. Thus, material and discursive conceptualisations and enactments of masculinities form social divisions within, as well as between societies and cultures.

It is important to note however, that unities may also be formed by men practicing various types of masculinity, and that these reflect and reinforce other social divisions (Hearn & Collinson 1994: 105). As Kimmel (1994) has argued, being a man in Western culture is defined "in opposition to a set of 'others'…and above all, women." (Kimmel 1994: 120). Thus, while some men and masculinities may be subordinated in relation to and by other men and masculinities, it should be acknowledged that some form of collective power may be practiced and enjoyed in relation to less powerful social groups, namely 'women'.[1] The present work considered it relevant to analyse gender at the level of macro analysis while acknowledging its malleable content, in order to be able to illuminate the interweaving levels at which heteronormative gender relations are institutionalised. This is not equivalent to suggesting that a universalizable form of or knowledge about masculinity exists, for as Hearn & Collinson note, the diversities between men render the possibility of a unified masculinity unlikely (Hearn & Collinson 1994: 107). But as suggested by Kimmel (1994: 120), the notion that manhood or masculinities are socially constructed, diverse and historically shifting "should not be understood as a loss… [rather, it gives us] agency, the capacity to act."

Taking into account the variable and diverse constructions of 'men' and 'masculinities', the project drew on Hearn's conceptualisation of men as existing in relation to particular social relations of production and reproduction which produce material inequalities, and masculinities as constituted at the level of discourse and ideology, often in terms of production and reproduction, to link the two constructions (Hearn 1987 in Hearn & Collinson 1994: 107). Further, the present analysis saw masculinity (ies) as being produced and reproduced at the level of interaction, routine practices and subjective experiences. The conceptualisation of a 'hegemonic' masculinity (Connell 1987) might then offer potential for analysing masculinity as a composite, yet hierarchical construction. However, this concept has been criticised for muddying the potential for deconstructing and theorising the ways in which relations of power and oppression are negotiated between men (e.g. Newburn & Stanko 1994). The present analysis maintains that the concept of a hegemonic masculinity may be particularly useful precisely for illuminating the multiplicity of masculinities and thus the potential for subverting 'gender'. The notion of a hegemonic masculinity is viewed as reflecting culturally hegemonic expectations of what it means to 'be a man'. Men who 'do' hegemonic masculinity are thus practicing dominant ideologies and discourses of masculinity. By making the construction explicit, we are able to conceptualise hegemonic masculinity as a reflection of hegemonic discourse rather than as the hegemonic, or dominant way of practising masculin-

[1] Here, I refer to 'women' to signify a constructed 'class' of heterogeneous people, who share communalitites and are simultaneously separated by great differences within and between local, regional and global contexts.

ity. This deconstruction paves the way for exploring how men may reject the ideology of hegemonic masculinity and practice alternative, 'subordinate' masculinities. As Jefferson (1994: 12) has also argued, the notion of a hegemonic masculinity captures both the notion of multiple masculinities and their hierarchical ordering in relation to each other, as well as in relation to women.

By the same token, Jefferson (1994) points out that accounts of masculinity, which exclusively emphasise the visible social and sexual power of hegemonic masculinity tend to overlook the insecurity and self-doubt that men may experience in relation to masculinities. In fact, it may be this very insecurity rather than their experience of being 'masculine' that can be linked to their use of violence towards women and towards other men. As Kimmel (1994: 127) argues, masculinity is "born in the renunciation of the feminine, not in the direct affirmation of the masculine, which leaves masculine gender identity tenuous and fragile."

It should be restated that the discursive and symbolic power of 'men' and of 'masculinity' may be much greater than the power individual men experience in their specific social and cultural locations. This may be a particularly relevant point in relation to deconstructing men's experiences of violence and in exploring the potential to situate men as powerless in the script of physical violence. The discursive and ideological construction of masculinity may render it less acceptable for men to view themselves as/be viewed as victims, yet the power of this construction may not actually offer protection to men. The experienced powerlessness of some men may thus be obscured by the inflated power created by the hierarchy of gender, specifically of masculinity.

Masculinity and violence

An increasing body of literature on men and violence has examined the link between masculinity and violence perpetration (e.g. Stoudt 2006; Pappas, McKenry & Catlett 2004; Totten 2003). Violence has been argued to reinforce and reproduce masculinity, through material perpetration of violence, as well as through representations of violence e.g. men's talk about their violences (Hearn 1998). Historically, the links between 'masculinity' and 'violence' have come close to being naturalised, although what links them are in fact constructions of masculinity, dominant assumptions about what men 'are', and by implication, what women are. One way in which violence may be legitimated or go 'unrecognised' is through a process of normalisation, which may be so effective that the violence 'disappears' (Morgan 1987: 180-183). Popular images of violence thus rest upon unquestioned (normalised) understandings and constructions of gender and of masculinity in particular (Stanko 2002: 33), that perpetuate a myth of the inevitability of men's violence and conversely, the abnormality or pathology of violence by women.

The unproblematized link between masculinity and violence is still reflected in the limited critical work on the relation between masculinities and (violent) crime (Stanko 2002; Newburn & Stanko 1994; Stanko 1994). Stanko (1994) notes that violence has traditionally been framed in criminological discourse and theories, although paradoxically, these have done little to acknowledge the role of the law or the state in sanctioning and perpetuating various forms of violence. Rather, the criminological tradition tends to focus on the documentation and prevention of individually located acts of violence committed by individual actors (Stanko 1994: 33). As the present thesis argues, this serves to conceal the patterning of violence and its base in specific structural/social relations, rather than in individual pathology or as merely an aspect of marginalised or delinquent subcultures. By ignoring the pattern of violence, the specific gendered power relations which produce and maintain violence can be disregarded.

Accordingly, while a vast body of feminist research has shown that many women live in constant fear of potential assault by men as an 'ordinary' part of their daily lives (e.g. Kelly 1987; Stanko 1985; 1990), men's fear of violent crime has not ordinarily been addressed through appropriate measures, despite their consistent position as the primary perpetrators and victims of serious interpersonal violence (Hough & Mayhew 1983, 1985; Mayhew, Dowds & Elliot 1989 in Stanko 1994: 35). This reinforces the construction of violence as a relatively unproblematic aspect of men's lives and strengthens the normalisation of the relation between men/masculinities and violence. Overlooking or trivialising men's potential fear of, and harm from violence fortifies a monolithic, hegemonic construction of masculine men as strong, fearless and in control – and in turn, perpetuates men's violence.

As Stanko amongst others points out, the type of violence predominantly reported in crime statistics and police figures represents 'public' or 'street' violence. It is therefore relatively unsurprising that men feature quite prominently compared to women, as women's differing experiences of violence are not easily captured by these data sources. However, it is very probable that men do experience more public violence than women and their 'position' in crime figures should not be dismissed completely. It should be reasserted that a renewed focus on men's experiences of violence is not intended to overrule or undermine women's physical and sexual victimisation by men. Rather, the thesis contends that a continued uncritical approach to analysing the evidence of men's victimisation of other men serves only to fortify the gender constructions in which men's violence (towards men and women) are rooted.

It must be also be restated that gender cannot be constituted as the unitary key to explaining violence (Connell 2005). Firstly, masculinities can of course not be viewed as monolithically encompassing or engendering violent tendencies. Fur-

ther, the enactment of masculinities in doing interpersonal violence cannot be directly compared with the masculinities deployed in conflict situations or in military institutions (Connell 2005: 258). The present thesis does focus only on interpersonal violence; even so, other social divisions and contexts which may influence subjective practices of masculinity cannot be addressed within the scope of this project. It is therefore reiterated that the present analysis proposes only one way of partially understanding the link between gender, violence and victimisation.

The normalisation of physical violence as an aspect of male/masculine relations has been outlined. However, despite the complicity of men at all levels of violence, not all forms of violence are equally legitimated. The present analysis suggested that the legitimation of some forms of violence is contingent upon their framing as a male and thus, 'ungendered' phenomenon. When male violence is framed in relation to an 'other' to the white, heterosexual male norm, the violence is recognised – it is named as such. Male-on-male violence is recognised only in relation to specific forms of abuse, where the violence is not identified as gendered, but in relation to its departure from the norm, for example racist violence, homophobic violence, child abuse and so on. The fact that this is primarily *male* violence is hardly mentioned. Thus, the institutionalisation of a hierarchical gender division and of heterosexual relations as the norm is emphasised, as is the naturalisation of the link between men/masculinity and violence.

The recognition of violence need have little to do with different forms of violence being perceived as 'understandable' however (Morgan 1987). The present analysis contended that the construction of violences as more or less understandable is bound up with prevailing understandings of gender and sexuality. Thus, whether violence is constructed as explicable or not has as much to do with hegemonic constructions of masculinity (whether men can control their violent 'impulses', whether men are 'naturally' more aggressive/sexually driven) as it has to do with constructions of appropriate femininity (whether the victim was 'provocative', whether she was sexually assertive, whether she was drunk and so on). So while violence against women is largely 'recognised' as violence by both men and women, this does not signify a uniform condemnation of violence against women by all men or all women. In some contexts, different types of violence can be 'explained' by gendered characteristics of the victim or the perpetrator, and are thus constructed as understandable to some extent.

In this way then, the hierarchy of gender may be viewed as shaping constructions of violence and thus of victims of violence. Further, the normative content of gender categories and the gendered constructions of violence may be internalised by individual men and women to impact upon their subjective identities as victims or

non-victims in relation to different types of violence. In considering how current understandings of violence reflect thinking about gender, and masculinities in particular, it is important that more attention be paid to the ways in which violence is experienced by men in order to destabilize prevailing gender myths. This need to problematize men's violence towards each other is summarised well by Stanko who notes that this should be done with the purpose of deconstructing men's (discursively inflated and constructed) power, which is "killing men more than it is killing women" (Stanko 1994: 45).

The (gendered) construction of victims

The question of how violence is socially defined, the contexts in which violence is legitimated or punished, have implications for how violence is experienced by the victim, as well as for the 'recognition' of the victim. The analysis and naming of forms of violence which have previously gone unrecognised not only broadens our understanding of violence, and what may be rationalised as acceptable and unacceptable behaviour (Richardson & May 1996); it may also shape and alter our recognition of victims. Drawing on Richardson & May's (1996) conceptualisation of 'deserving' and 'less deserving' victims and on Simon & Gagnon's (1986) notion of sexual scripts, the present analysis argues that constructions of gender and sexuality shape our understandings of violence and thus of violence victims, and further, that scripts of gender impact upon men's and women's subjective experiences of victimhood in relation to different types of violence. The theoretical analysis thus sees victimisation as constituted at the intersecting levels of discourse/representation and subjectivity.

Richardson & May (1996) frame interpretations of violence and notions of deserving and less deserving victims in terms of a gendered and sexualised access to space, where the public sphere is associated with rationality, production and masculinity and the private sphere is contrastingly associated with nurture, reproduction and femininity (Walby 1990). They use the example of homophobic violence to suggest that the sexual status of the victim may mediate socially constructed meanings of violence to constitute the violence as deserved and the victim as less deserving of their status (Richardson & May 1996: 309, 316).

The present analysis argues that gendered constructions of violence as recognised, understandable/explicable or illegitimate variably shape understandings of victims as more or less deserving of their victim status. So, physical violence between men is legitimated and normalised and may not be seen as productive of victims. It is argued that discursive representations of male-on-male violence position men as consenting equals in the script, thus obscuring power relations between men and the potential for subjectively experienced victimisation. The interrelation between perpetration and victimisation in many scenarios of physical violence between men often renders it difficult to identify a

'victim' in its classic sense of relative powerlessness and defencelessness vis a vis an attacker.

However, while the myth of 'masculinity' may dominate the story of men's physical violence towards each other, some men do experience assault and violence without an 'equal' part in the exchange. Men who are assaulted walking home from a night out, mugged, and men who experience random, 'non-consensual' victimization in other, similar scenarios cannot be said to be participating as equally motivated or positioned social actors in a mutually-agreed upon violence script. The victims may suffer extensive injuries and be affected emotionally and psychologically by the assault. However, these men do not often come to be discursively produced as, perceived as or treated as victims, nor is it – at a societal level - encouraged for them to perceive themselves as such. It is argued here that hegemonic constructions of masculinity as a dominant, resistant and powerful gender identity and the normalisation of the link between this construction and violence render the naming of male victims less accessible. The non-recognition of male victims at the level of discourse and representation may be internalised by men themselves, rendering it illegitimate to perceive oneself as a victim.

Sexual victimisation is however not normalised when perpetrated against either men or women. Male sexual assault is constituted as undeniably victimising. The sexual victimisation of men disrupts not only norms for gender but also for sexuality – and is thus discursively distinguished as inexplicable, as productive of victims who are clearly deserving of their status as such. Employing Simon & Gagnon's (1986) theorisation of sexual scripts, the subversion of cultural norms for acceptable masculine (hetero) sexual behaviour could be seen to impinge upon the male victim's sense of 'manhood' at the intrapsychic or subjective level at which socially shared scripts are internalised. At the level of subjective experience, the male victim of sexual assault may subsequently constitute himself as 'less of a man'.

Women, on the other hand, may variably be constructed as deserving and less deserving of their victim status, depending on the context of the violence directed towards them, as well as the victim's perceived transgression of culturally scripted gender and sexual norms. 'Others' may thus be more likely than white heterosexual men to be made culpable in their experience of violence, for being in the 'wrong' place at the 'wrong' time, thus courting (understandable) violence. At the level of structure and institution, women's legitimacy as victims, particularly in relation to sexual victimisation, is under constant scrutiny. Even in comparatively extreme scenarios such as gang rape, the female victim's non-culpability in the abuse may be doubted. The actions, language and even thoughts of the woman may be dissected to ensure that she was not contravening salient scripts for appropriate female/feminine behaviour. When a victim is seen as partially or wholly culpable in her own victimisation, the perpetrator of the violence may

conversely be constructed as a 'victim' of circumstance or of a misunderstanding brought about by a transgression of norms by the victims. Similarly, when a woman's own behaviour is not specifically called into question, she may be made responsible for the thoughts or behaviour of her attacker.

Paradoxically however, at the level of discourse/representation women are inevitably constituted as victims in relation to potential and powerful attacker(s). The script of sexual violence tends to position women as 'sitting ducks', vulnerable and practically defenceless in the face of assault. The content of appropriate 'femininity' reinforces the representation of women as powerless, innocent; 'natural victims', as it were. Women are unevenly warned to be cautious, to be wary of their surroundings and are kept in a state of fear in relation to a potential assault. Discursive constructions of sexuality may be seen to structure physical action and responses, as well as words and thoughts in the woman's feelings of powerlessness and helplessness in relation to a potential attacker, as well as the would-be rapist's feelings of power (potency) vis a vis his victim (e.g. Scully 1990). This discursive disempowerment is here argued to potentially have a material impact on women's recognition of self-perceived ability for resistance and subversion of the script. The representational script of female victimisation is thus viewed as being internalised and reinforced at the level of subjectivity.

The present analysis sees the construction of victims in terms of a cyclical connection between gender, violence and victimisation. Constructions of appropriate masculinity and femininity render violence among men 'normalised', whereas the reverse is true for women. Thus, certain forms of violence are legitimated to a greater extent than others, and are as such not recognised as violence. In turn, unrecognised violence may be seen as not producing 'violence victims'. On the other hand, some forms of violence may be recognised but may be construed as more or less understandable as a function of salient norms for appropriate gendered and sexual behaviour. Thus, victims who are perceived as transgressing norms for acceptable femininity (and masculinity) may be represented as deserving of the violence perpetrated against them and thus, less deserving of identification as a non-culpable victim. It is maintained that the gendered naming of victims perpetuates oppositional and hierarchical categories of gender and sex, which in turn reinforce (differential perceptions of) violence.

As it has been argued here, the hegemonic connotations of victim status may not capture the violent experiences of men, as well as standing in seeming contradiction to dominant constructions of masculinity. Newburn & Stanko (1994) also argue that the dominant construction of victims as relatively powerless groups of people, who are helpless, vulnerable and in need of advice to avoid future victimisation have failed to accommodate the relation between victims and

perpetrators and the complexities that may characterise such relationships. As they point out, the static dichotomy between 'victim' and 'perpetrator' may be difficult to maintain, particularly in the lives of young men. It may not always be the least powerful, or even less powerful members of society who are victimised. In conceptualising victimisation, power relations in individual interactions need to be considered, including between members of socially and structurally privileged groups (Newburn & Stanko 1994). The present project maintains that hegemonic gender discourse has ignored the power differences between men in conceptualising violence and this has been an effective way of upholding the myth of a uniformly powerful masculinity. Simultaneously, this monolithic than perpetuate the false division between oppressors and the oppressed, the present project wished to draw attention to the potential for seeing how men and women may occupy both spaces interchangeably and how a denial of an analysis of men as 'underdogs' (Newburn & Stanko 1994: 158) might contribute to upholding binary constructions of gender, which may in fact obscure the reality of experiences of power and powerlessness in men and women's lives. Construction of masculinity has positioned women as vulnerable and defenceless in relation to violence. The construction of victims as always weak, unsuspecting or defenceless (Fattah 1992 in Newburn & Stanko 1994) neither helps us to view men as potential victims or to recognise the victimisation of women, without viewing them as eternally damaged.

The present analysis did not merely seek to name the construction of binary, seemingly oppositional and mutually exclusive 'victim' and 'perpetrator' categories, much less to perpetuate them, but rather to uncover the process by which the binary categories are reproduced (Ruggiero 1992 in Newburn & Stanko 1994) and how they may reflect our thinking about gender. Rather versely, how a contradictory construction of women as perpetual victims serves to uphold not only constructions of femininity, but to reinforce the discursive and symbolic power of 'masculinity' and 'men'. As Newburn & Stanko (1994: 159) note, it becomes necessary to acknowledge that men not only victimise women, but that they also victimise each other, and to explore what impact such victimisation may have upon those men who experience it.

5. Results

The objective of this thesis was to illuminate gender-specific violence victimisation in two ways. Firstly, through an empirical analysis of material victimisation and health outcomes reported by male and female violence victims. Secondly, by considering victimhood as a mutable and constructed identification that is shaped by hegemonic notions of gender and sexuality, which in turn uphold variable understandings of violence (and thus, of victims).

5.1 Empirical findings

Overall, the empirical analysis found that there were significant gender differences in exposure to physical and sexualised violence and that there were gender-specific patterns in associations between violence and health outcomes amongst victims of violence. Physical and sexual victimisation were relatively prevalent among women and were both associated with poor health outcomes. The reported prevalence of sexual victimisation was much less prevalent than physical victimisation among men; however, sexual assault was associated with poor health while physical violence clearly was not.

Physical violence (Paper 1)

Gender differences were found in the reported prevalence of physical violence during a 12-month period. Significantly more men than women reported experiencing one or more forms of physical abuse at least once in the 12-month period preceding the interview. Thus, 6% of men aged between 16 and 67 years reported victimisation compared with 4% of women in the corresponding age bracket. The gender difference was significant only among young men aged 16-24 years and this group reported a significantly higher prevalence of violence than women in all age groups.

Women who had experienced physical victimisation within the past year were significantly more likely to report poor health and recent illness than women who were classified as non-victims. The association between physical violence and health was significant on the majority of indicators after data had been adjusted for age and socio-economic status. For women, violence significantly predicted poor self-rated health (OR=2.20, 95% CI 1.41-2.89), psychological morbidity, including depression (OR=2.36, 95% CI 1.55-3.60) and symptoms of physical morbidity, such as stomach ache (OR=1.58, 95% CI 1.01-2.47). A corresponding difference was not found amongst men; violence predicted only a single indicator of poor health, stomach ache (OR=1.73, 95% CI 1.03-2.89).

Sexualised violence (Paper 2)

Significant gender differences in lifetime experiences of sexual abuse were found among the adult (16-39 years) sample and the adolescent

(15-16 years) sample. Significantly more women than men reported at least one experience of sexual victimisation in both samples. In the adult sub-sample, 14% of women reported sexual victimisation compared with 2% of men (6% of all women and 1% of all men who answered questions on sexual victimisation), while 4% of adolescent girls reported at least one sexually abusive experience compared with 1% of boys.

Poor health outcomes and risk behaviours were reported by sexual abuse victims of both genders. Male and female victims of sexual abuse were significantly more likely to report poor health and engaging in risk behaviours than their non-victimised counterparts. Among adult women, associations were found between sexual victimisation and psychological and physical symptoms such as vitality ($p<0.001$), stress ($p<0.001$), anxiety ($p<0.001$) and stomach ache ($p<0.05$). Among adult men, sexual victimisation was found to be associated with stomach ache ($p<0.01$) and high annual sick leave ($p<0.05$). The pattern of association was comparable for men and women on a number of indicators of risk behaviours. Male and female victims of sexual abuse were significantly more likely than non-victims to report having suicidal thoughts and having attempted suicide within the past year, as well having exceeded the recommended limit for alcohol consumption at least once within the past week.

Among adolescents, boys and girls who had been sexually victimised were significantly more likely to report morbidity symptoms and risk behaviours than non-victimised counterparts. Among girls, sexual victimisation was associated with poor self-rated health ($p<0.001$), psychological morbidity such as depression and sleeping problems ($p<0.001$). Victimised boys were significantly likely to report psychological morbidity than controls ($p<0.001$). Among adolescents, associations between sexual victimisation and experienced violence and daily drinking were found for both genders. Smoking was only associated with victimisation for girls ($p<0.001$).

5.2 Interpreting the evidence

The empirical findings indicated that gender differences in material victimisation did exist, and that health problems associated with physical and sexual victimisation were not only gender-specific, but also specific to the type of violence experienced. While physical violence was confirmed to be associated with a number of illness symptoms for women, it was not found to be linked with poor health among men. Feminist research has done much to show that the types of violence women experience differ greatly in character, context, relational dynamic and patterning from those of men, and that the impact of violence against women, which is often repetitive and escalating can be long-lasting, even after the abuse has ended (Dobash & Dobash 1992; Edwards 1987; Hanmer & Maynard 1987). While information about the context of physical violence was limited in the present study, the available data indicated that men primarily re-

ported physical victimisation by strangers, while women reported victimisation by former or current intimate partners. The evidence appeared to confirm the pattern that men predominantly experience 'public' violence while women's victimisation experiences are located within the context of an intimate relationship. However, the power relations that characterise men's experiences of violence could not simply be conceptualised as equal because this type of violence typically involves members of the relatively powerful 'class' of men. As has been argued in the present thesis, fluid categories of gender position men in hierarchical relations to each other, as well as to women. Also, it should be emphasised that no information about the gender of the perpetrator was available in the present survey data. Theoretical conceptualisations based on the literature drawn on in the thesis support the notion that the majority of violence towards men and women was perpetrated by men; however, this cannot be determined with certainty.

Physical and sexual victimisation were both associated with indicators of poor health among women. These findings thus support existing evidence that interpersonal violence, and specifically men's violence, towards women is linked to a number of psychological and somatic morbidity symptoms, as well as risk behaviours among victims. However, while physical victimisation was also found to be prevalent among men, overall, violence did not predict poor health among male victims. It has been argued in the present thesis that constructions of violence shaped by gender and sexuality legitimate some forms of violence, thus rendering them and thus their victims 'unrecognised'. It is suggested that men's physical victimisation is legitimated by normative constructions of gender that naturalise the link between masculinity and physical violence. Thus, men are not recognised as victims when they experience this form of violence. While acknowledging that individual men may indeed be traumatised by violence at the level of subjectivity, it could be argued that the salience of institutionalised gender and sexual norms (and thus gendered constructions of violence) preclude men's conceptualisation of themselves as violence victims. Thus, victimised men may make sense of their experiences in terms of 'crime' or 'fighting' rather than in terms of an assault on their bodily integrity. It is suggested that this may be one way of viewing the lack of association between victimisation and poor health among men. Alternatively, health may not be an outlet easily available to men through which to express potential trauma or distress.

A number of studies have analysed gender differences (and similarities) in reporting of morbidity and perception of health in the general population. It has frequently been observed that while women in industrialised societies tend to live longer than men, they are 'sicker' than men, as reflected in higher reported rates of morbidity, disability and health care use (e.g. Macintyre, Ford & Hunt 1999). Explanations for gender differences in self-reported health and morbidity encompass biological differences, gender-

specific risks acquired through social roles and behaviours, differential access to health care, gender differences in self-assessed personal health resources and gender bias in the diagnosis and treatment of disease (Kruse & Helweg-Larsen 2004; Malterud, Hollnagel & Witt 2001; Macintyre et al. 1999; Verbrugge 1985).

However, gender differences in self-reporting of morbidity symptoms have also been shown to differ according to the gender of the interviewer. A Danish study conducted already in 1950 thus showed that men reported fewer morbidity symptoms to a male interviewer than to a female one (Verbrugge 1982; Lindhardt 1960), although this finding might be generation-specific.[2] While earlier research has suggested that women are more likely to report less serious and primarily psychological symptoms due to gender differences in the perception and evaluation of symptoms (Hibbard & Pope 1986), there is little direct evidence to support the hypothesis (Macintyre et al. 1999). As Oakley (2000) points out, it is not clear from the debate about women's greater tendency to suffer from psychological 'morbidity', whether women really are ill more often than men, whether women are gender socialised into seeking help more readily than men, whether women are sick because of their social roles – "does women's work make women sick?" or whether physical illnesses are misclassified as psychological symptoms when they are manifested in women (Oakley 2000: 300).
Data from the Danish National Health and Morbidity Survey (2000) confirmed a gendered pattern of self-reported morbidity in response to a checklist of specific symptoms. Women were more likely than men to report one or more of the symptoms described in a list, ranging from muscular/joint pain to anxiety and depressive symptoms. However, there was no consistent pattern of gender difference in response to a question on chronic illness or condition (Kruse & Helweg-Larsen 2004). Thus, no evidence-based consensus has been reached on gender differences in reporting of illness in the general population, although women are generally perceived as being more ready to rate their health as poor and to report morbidity. Among non-victims in the present study, women did tend to report illness symptoms more frequently than male counterparts in matching age groups. However, no analyses were carried out to determine the statistical significance of the difference.

The empirical findings on sexual victimisation in the present study did not wholly support the hypothesis that women tend to somatize their distress to a greater extent than men. Sexual victimisation was reported significantly more by women than by men, but it was associated with some indicators of poor health among both genders. Among adults and adolescents, both male and female victims reported indicators of illness. There were more and comparable associations on indicators of risk behaviour for men and

[2] The Danish Health and Morbidity Survey (2000) did not match interviewers to respondents for gender or age.

women in both samples. However, it must be acknowledged that the number of male cases in both samples was very small. While there was a clear difference in the frequency of reported morbidity between male victims and controls in both samples, the statistical significance attached to these differences must be interpreted with a degree of caution. This limitation will be discussed further in the following section.

It could be argued that the comparable association between abuse and well-being for men and women may be explained by greater similarities in the context of sexualised violence compared to that of physical violence. Due to the relatively small size of data, it was not possible to appropriately analyse whether the perpetrator relation influenced associations between victimisation and health. Nonetheless, the data indicated that the perpetrator of sexual assault was a person known to the victim in the vast majority of cases amongst women, and also in a large proportion of cases amongst men. However, stranger assaults also accounted for a large number of victimisation experiences amongst men (and the majority among adolescent boys). Thus, similarities in the relational context of abuse could not be easily used as a sole explanatory factor for the comparable associations between abuse and health for men and women.

Situating the empirical findings in the theoretical framework, it could be argued that sexual victimisation represents a non-legitimated form of violence among men (and women).

Hegemonic constructions of masculinity constitute male sexual assault as unquestionably victimising. In a heteronormative culture 'masculinity' may be located in opposition to homosexuality. The sexual victimisation of men may thus be seen as a specific devaluation of manhood, through the discursive, symbolic and embodied positioning of the victim as a 'woman' by another man. Further, if hegemonic constructions of 'masculinity' are seen as contingent on physical capability to protect one's bodily integrity (using violence is necessary), then male sexual assault may be seen as robbing a man of his physical and symbolic power as a man. In a culture shaped by binary constructions of gender, this failure to perform 'masculinity' discursively positions him as a woman.

Naturally, not all men will condone violence or use violence, but it could be argued that maintaining a façade of strength is integral to many men's subjective experiences of masculinity. Newburn & Stanko (1994) note however, that an understanding of male sexual assault as destroying male victims' prior sense of 'invulnerability' may be a misconception, which perpetuates an ideology of masculinity as unequivocally powerful, controlling and dominant, leading us in turn to view men as though they were invulnerable (Newburn & Stanko 1994: 162). They prefer to state that sexual victimisation may increase men's sense of vulnerability, rather than shatter their sense of invulnerability. The thesis accepts this consideration, speaking of the capacity for endurance as a mask rather than as an innate

quality of 'men'. As proposed earlier, the violences of men may indeed be viewed as stemming from their insecurities about 'doing' masculinity, rather than their empowering experiences of 'being' masculine.

The exception to the 'non-culpable' male victim of sexual assault is the homosexual victim, who may be subjected to sexual victimisation as a form of punishment for his 'deviance' from sexual (and thus gender) norms. In accordance with binary gender constructions, the gay men may be discursively positioned as a woman in light of his 'failure' to distinguish himself entirely from 'the feminine'. His status as a legitimate victim of sexual assault may thus come to be questioned under the same norms as that of a woman. In prioritising gender over sexuality in shaping their interrelation (Jackson 2005), the present analysis views gay men as constituted as 'men' prior to their signification as 'gay'. In this way, it may be possible to understand how gay men experience sexual victimisation as an assault on their gender (their sense of masculinity) as well as an assault on their sexual/bodily integrity.

The finding that sexual abuse is associated with indicators of poor well-being among men while physical abuse is not, may seem unsurprising or even banal in keeping with prevailing understandings of physical violence as an ordinary aspect of men's lives and the conversely gendered construction of sexualised violence as indisputably victimising for men. Unquestioned however, this interpretation serves to reinforce notions that men's physical violence towards each other is not harmful. This implicit tolerance of men's violence towards each other renders it difficult to advocate and advance non-violence towards women, as a tenuous distinction between different forms of violence must be made. The distinction may dually reinforce notions of violence as inherent and unpreventable in men, as well as of women as more vulnerable and in need of protection than men.

As Newburn & Stanko (1994) point out, accepting that men may also be violently victimised does not erase the fact of their privileged position in relation to women or the fact that women are victimised in different and very serious ways. Rather, it opens up the possibility of disrupting static and essentialist gender categories which monolithically position women as victims and men as oppressors, doing neither 'class' any favours in doing so (Newburn & Stanko 1994: 165). Indeed, as has been argued here, positioning femininity in static opposition to masculinity may not only undermine women's capacity for self-determination, it may actually increase their physical and psychological vulnerability to physical and sexual victimisation by men.

5.3 Caveats

The present project has proposed an argument for the gendered construction of victimhood founded on an empirical analysis, which indicated that violence victimisation was gender-

specific in terms of prevalence of violence and health outcomes among violence victims, as well as in associations between health and different forms of violence. It has to be acknowledged however, that there are limitations to constructing generalizable links between gender, violence and victimisation that represent the reality for 'all' men and 'all' women. Victim status defined as antithetical to hegemonic masculinity - weak, powerless or vulnerable - may be a relative concept that is variable depending on the context of the violence and the relative status of the perpetrator in relation to the victim. It should be noted that naturally, there are multiple ways in which men and women live and experience gendered social lives and just as there may be relatively powerful men, there may also be weak men. Some women may experience more social power than some men, across divisions of ethnicity, age, disability, class and so on. Additionally, the risk of 'false classification' of victims was inherent to this study, as the time frame used for measuring victimisation only covered 12 months. Men and women who had experienced violence prior to this cut-off point were classified as non-victims, although it is unknown whether they had experienced severe victimisation and indeed, continued health problems as a consequence. Therefore, the knowledge produced about the violence-health association can only be seen as partial.

Further, there are several limitations to drawing conclusions about gender-specific sexual victimisation based on the data available in the present study. The number of male respondents reporting sexual assault was comparatively small. Underreporting may be a considerable factor in the low reported prevalence of sexual assault by males. As Adler (2000: 138) has argued, "Where the victim [of sexual assault] is male, any claim that he consented projects onto him a homosexual identity. Where the victim is homosexual, this can lead to considerable feelings of guilt, which tend to act as a deterrent to reporting. Where the victim is heterosexual, the very fear of being thought a homosexual may well stop him from reporting." Further research clearly should be done to illuminate factors related to disclosure of non-consensual sexual experiences among men and women.

While associations were established between sexual victimisation and well-being for men, it must be noted that due to the small number of victims, even a slight variation in the subject group or the control group could be manifested in a considerable effect on the association. Further, confidence intervals for the prevalence of reported illness among male victims and controls were very wide, indicating less security in concluding that the true population means had been found. True differences between control and victim means might therefore exist where significant associations between sexual assault and well-being had not been found (Type II error). Additionally, a relatively large number of outcome variables were included in the study on sexual victimisation. It could conversely be argued that due to the problem of mass signifi-

cance, the associations found between sexual victimisation and well-being were spurious or so-called false positives. However, 50% or more of the indicators included were significantly associated with sexual assault among adults and adolescents of both genders, thus indicating a pattern of association rather than a spurious finding. It should be acknowledged that these findings should be considered rather exploratory in nature as a consequence of the limitations attached to the data.

As stated earlier in this thesis, it should be recognised that there are also limitations to representing accurately the experiences of the researched – particularly on the basis of large-scale data. The present project considered the need to use research methodology appropriate to the intentioned outcome of the research; in light of the motivation for using public health methodology to illuminate material violence victimisation in the present study, claims to the generalizability of the knowledge produced thus have to be confronted. The present evidence does not represent ethnic differences in violent experiences among women or among men. This may be significant in light of recent research reports that ethnic minority women are overrepresented in some violence statistics, yet they represent a small percentage of the sample used here (e.g. LOKK 2004). Differential experiences of violence across divisions of class, sexuality or disability to name a few could not be illuminated either. Additionally, it cannot be claimed with any certainty that the evidence on violence victimisation is generalizable to different populations, as the findings on sexual victimisation in particular were based on a relatively small, and presumably selective sample.

The analysis did then run the risk of obscuring divisions within the groups of men and women that may differentiate their experiences of violence. It could not be assumed that all violence experiences reported by women were of a similar character, likewise for men, or that extraneous factors (other than those controlled for) did not influence the health status of victims. However, the data obtained on physical violence were robust and could be used to illustrate the relative prevalence of violence in Danish society (although we assume some degree of underreporting). Further, gender-specific patterns of violence victimisation were found and despite its limitations, the new knowledge could be used to increase awareness and promote further research initiatives to uncover the themes the present study could not address, at least in a national (local) context.

The thesis has emphasised the need for transparency in making connections between evidence and reality as a criteria for making strong claims to knowledge. Therefore, some limitations to the knowledge obtained about violence must be mentioned. The present project asked questions about different forms of violence that were originally derived from the Conflict Tactics Scale (CTS). The motivation was to include questions on tangible and more recognisable forms of vio-

lence rather than to use overarching concepts such as 'rape' or 'domestic violence'. The CTS has however, been the subject of much criticism in feminist and violence research. The fundamental objection to the scale is its ideological base in the notion that violence is used as a means of conflict management in heterosexual intimate relationships (DeKeseredy & Schwartz 1998). The CTS has also been criticised for ranking acts of violence in a "hierarchy of abuse based on seriousness" (Kelly 1987 in DeKeseredy & Schwartz 1998: 03), as victims often describe emotional abuse as more detrimental than physical abuse (Chang 1996) and a one-dimensional question on violence cannot determine the severity of e.g. a slap. A complete picture of the nature and impact of violence cannot therefore be claimed.

The five forms of violence used in the present study were not explicitly ranked according to severity. However, it should be acknowledged that some forms of violence, such as biting, burns or physical restraint might not have been reported as they were not specifically included as examples of violence. However, respondents were given the opportunity to specify any other types of violence experienced in a supplementary open-ended question. These free-text questions were not included in the present analysis due to inconsistencies in reporting and a general scarcity of data.

Significantly, the questions on physical violence did not ask about the frequency or timing of violence experiences and therefore could not illuminate repeat victimisation or escalating patterns of violence. Neither could it be established how much time had elapsed between the experience of victimisation and the interview. Incidents of physical violence were recorded as though they were isolated acts, thus admittedly obtaining only an incomplete picture of the incidence, patterns and nature of violence victimisation for men and women, as well as in relation to health.

The questions on sexual abuse were also relatively conservative. While avoiding the use of loaded terms such as 'abuse', 'rape' or 'assault', the measure used was broad and it could be suggested that reporting would have been highly contingent on respondents' perceptions of 'force' as well as of 'sexual activity'. For example, it is not known whether sexual assault that did not involve penetration would have been consistently reported. Thus, it is assumed that the prevalence of physical and sexualised violence in the present study was likely underreported, rather than overestimated.

In theorising the link between gender and violence, the thesis compared men and women's experiences of victimisation. The gender-specificity of men and women's experiences of violence in this case means that in essence, the analysis compared male-on-male violence with male-on-female violence. This raises the question of whether this is a methodologically valid comparison, as different relations as well as contexts were analysed. The premise of the theo-

retical analysis was that normative understandings of gender posit masculinity as innately connected to violence – whether perpetrated against men or women – and that constructions of gender and sexuality shape the way in which victims are 'recognised' differentially in relation to types of violence, as well as the way in which victimisation is subjectively experienced. Therefore, it is maintained that rather than attempting to conflate two distinct analyses, the thesis proposed a cyclical argument, in which different forms of violence were seen as interrelated and as unified by their base in gendered power relations. Naturally, qualitative distinctions need to be made between the types of violence men may experience and the types of violence women predominantly are subjected to; these differences have implications for the ways in which victimisation is experienced, as well as for the way in which victims are constituted.

A further and related caveat to be mentioned is that the interrelation between material victimisation and discursive victimisation is not conceptualized as causal. The logical conclusion of the argument presented here is naturally not that either women should stop being viewed as victims and violence would not have as great an impact on their health, or that men should be viewed as victims, but then they would be worse off from experiences of victimisation. Rather, the thesis constitutes victimisation as gender-specific on distinct but interrelated levels: at the level of material experiences of violence and at the level of discourse/representation and subjectivity. It is argued that as men's gender-specific violence towards men and women is anchored in and perpetuated by constructions of gender, which in turn have implications for the constitution of victims, that the two levels cannot be separated out entirely.

6. Perspectives

6.1 Implications for future research

Violence is an issue of concern for both men and women. Men are overwhelmingly the perpetrators of violence and they appear to be victimised by physical violence at least as much as women, two evident reasons for why violence must be acknowledged also as a problem for men. The present project also found that while a significantly smaller proportion of men than women experience sexual victimisation, poor well-being among male victims was comparable to that of female victims on a number of indicators. This warrants that attention be paid to sexual victimisation among men in future research, including ways to address underreporting among male victims. The present analysis sought to draw attention to the potential for seeing men's lives as gendered and men as disadvantaged by hierarchical relations of gender and power. In so doing, the study aimed to disrupt the naturalisation of gender (the naturalisation of men as the norm) and of the link between gender and violence. So how may this investigation bring us forward in preventing violence?

It is hoped that the findings may give us pause for thought about future violence research, as well as policy and practical initiatives. The result that physical and sexual victimisation are indeed prevalent among women and are associated with a range of negative health outcomes indicates the continued need to build upon our evidence-based knowledge, as well as to fulfil a collective obligation to eliminate violence against women, as set out in the Convention on Elimination of all Forms of Discrimination Against Women (1979) and the Beijing Declaration and Platform for Action (1995). National Action Plans on Violence should persist in calling for improved data on violence against women, based on which public as well as professional awareness may be raised and upon which effective prevention measures may be developed. The WHO has amongst others, noted the enduring need for heightened knowledge on health problems displayed by female victims of violence by doctors and other health personnel (WHO 2005).

Future research might also explore the changing meanings attributed to violence by women, in order to clarify the types of experiences that are captured through concrete survey questions. A recent Nordic study (Piispa 2004) has shown that young women's understandings of violence are substantially different to those of preceding generations. More detailed or varied questions may therefore need to be included in future studies with a view to capturing and thus understanding the types of experiences women in different age groups define as violent more accurately. This may be one step towards minimising underreporting of violence. Further, in a longer-term perspective, this knowledge may show us how attitudes towards and

how attitudes towards and tolerance of violence are shifting among women.

The project also found that not only is sexual victimisation not absent among men, but it is associated with a number of poor health outcomes in a way that physical violence is clearly not. This points to the necessity of further research to gather improved evidence on the prevalence and consequences of sexual victimisation for men. Also, more qualitative research could be undertaken to elucidate the differential meanings of physical and sexual violence for this group and the factors shaping these. While health surveys are useful instruments with which to obtain information on health problems associated with violence, future research could consider illuminating the impact of physical violence for men in alternative ways. Health may not be the most accessible outlet for men to express trauma or distress and it is argued in the present thesis that physical violence might have a different impact on men's subjective experiences of gender identity and of victimisation than sexual assault. Future studies may thus need to look at other indicators with which to measure the relationship between physical victimisation and negative outcomes for men. These could include longitudinal studies of social outcomes for men who experience different levels of physical victimisation, or mixed-methods research to investigate how men make sense of their experiences of physical violence, including what types of experiences (relational dynamic, context) may be characterised as 'just a fight' as differentiated from a truly victimising experience. Further, questions on the sexual orientation of the victim, as well as the gender of the perpetrator should also be included in order to distinguish different types of sexual assault towards men (and women).

Attitudinal changes towards violence are extremely important to prevention. In this regard, education is of utmost importance. Schools could cover themes of gender, equity and violence as an integral component of their curriculums, for example in social studies classes. This might be implemented also in gender-segregated lessons in order to facilitate discussions of gender-specific views on and experiences of violence. It is important that hegemonic myths of gender be broken down, specifically in relation to violence, in order that violence towards both genders comes to be seen as undesirable and potentially harmful. In order to achieve this though, more information on young people's current views and attitudes is needed. Mixed-methods research in schools or in youth clubs may be a useful and appropriate way of obtaining this knowledge.

The continued reiteration of egalitarian conceptualisations of gender relations throughout young people's schooling could be argued to have a potentially profound impact on future generations' understandings of gender overall, and attitudes towards violence specifically. Additionally, the disruption of normative gender categories may hold potential for altering girls

and women's self-perceived power and ability for resistance in relation to physical and sexualised violence. Naturally, self-respecting girls and women who are fully aware of their rights also experience violence, just as boys and men raised in societies that espouse gender equality use violence and education can only be one (cross-cutting) aspect of reducing men's violence (e.g. Hearn 2001). However, the greater young people's familiarity with equal gender and power relations, and the less legitimate gender-based discrimination in all its forms is, the more likely violence will be rejected and its perpetrators ostracized at a societal level.

At the level of social and political discourse, physical violence is often still seen as a normal aspect of male adolescence, or marginalised as anti-social behaviour that delinquent youth or otherwise socially deprived groups participate in, and therefore as an exclusive concern of the criminal justice system. A task for violence prevention is then to emphasise the pervasiveness of violence, mainly among young men – as evidenced by the present study - all of whom obviously cannot be categorised as delinquent, aggressive or even as perpetrators of violence. Campaigns aimed at adults which stress the potentially harmful nature of violence among men as well as among women, while clearly emphasising their differing distributions, contexts, relational dynamics and so on could also contribute to bringing about attitudinal changes.

6.2 Theoretical perspectives

Greig (2001) has argued for the need to locate violence not within constructions of masculinity, but within a context of social injustice in the world, which affects the lives of both men and women. He argues that by situating men's role to challenge and help end violence solely in the context of gender constructions, we may be encouraging an old model of 'masculinity' to be replaced by a new one, thus doing nothing more but reinforcing the inherent violence of an existing gender hierarchy.

In order to make effective (political) connections between masculinity and violence, we need therefore to focus on the "structural violence of gender" itself (Greig 2001: 07). As has been suggested in this thesis, the binary logic of gender creates social hierarchies and legitimises unequal power relations, along lines of sexuality, ethnicity, class among other divisions. The construction of masculinity as that which is 'not feminine' positions the definition of the self as negation of the 'other'- thus shaping our logic about social relations as relations of superiority and inferiority (Greig 2001: 10). The definition of a 'new masculinity' for men is thus not an acceptable solution to involving men in violence prevention, as this would only reinforce the violence that is inherent to constructions of gender; it perpetuates the notion that men are necessarily something 'other' (opposite) to women, or in reality, the reverse. Greig (2001:11) thus argues that we need to make a connection between the violence of the gender construction and the vio-

lence of oppressive social relations that are structured by gender, class, ethnicity and so on. The continued deconstruction of gendered power relations in research, practice and education is thus advocated.

Interventions to include and interest men in violence prevention have sometimes reinforced existing gender constructions and hierarchies. Scheel, Johnson, Schneider et al. (2001) commenting on rape education for men argue that it has been most accessible to constitute men in one of three roles in relation to violence: as perpetrator, victim or protector. Programmes have thus aimed to gain the 'sympathy' of men by alternately demonising perpetrators of violence; constructing violence as an issue of importance to men because 'men are victimised too'; or appealing to the 'innate' protector in men to defend women from violence. It is argued here that each of these categorisations perpetuates (or obscures) the very gender hierarchy that underlies violence in social relations.

The perpetrator model not only reinforces a construction of masculinity and violence as intricately connected, it is ineffective in its categorisation of all men as abusers, and thus in its lack of appeal to the majority of men who are not (or who do not view themselves as) abusers. The victim approach to preventing violence obscures the gendered basis for violence, representing violence as a phenomenon that affects men and women equally, in all senses. Thus, it is redundant as a model for violence prevention, as it does not even recognise the differential power relations in which gender is rooted. The categorisation of men as protectors not only reinforces the gender hierarchy in notions that women need to be protected from men by other men; it has also been shown to elicit more violence. Scheel et al. (2001) found that among the men whom the rape education initiatives were trying to recruit, immediate responses to a hypothetical rape scenario were a desire to harm the abuser. Women were thus constituted as a medium through which competing masculinities could be produced and reproduced.

This suggests that while theoretical perspectives that exclusively position men as victims clearly cannot form the basis for violence prevention initiatives, making the gender of men explicit is vital to locating men as allies to women in violence prevention. This entails elucidating the disadvantage also posed to men by the existing gender hierarchy and the diverse relationships men have to patriarchy and power (Kaufman 2003). By definition, the mainstreaming of gender and so the struggle for gender equality, will only be effective when men and women take equal responsibility for naming, challenging and eventually rejecting rigid gender constructions and practices.

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Appendices 1-3

English translation of the original questions in the Danish National Health Survey 2000.

Translation by the author.

Appendix 1

Have you as an adult, experienced one or more of the following forms of physical violence? (Tick one option in each line)

Being pushed, shaken or lightly struck (*Yes, within the past year Yes, earlier No*)

Being kicked, struck with a fist or an object

Being thrown against furniture, walls, down stairs or similar

Being strangled, assaulted with knife or firearm

a. Other form of violence, specify

II. Who subjected you to the violence?

a. Current spouse/partner
b. Former spouse/partner
c. Current or former boyfriend/girlfriend
d. Other family member/relative
e. Friend or acquaintance
f. Colleague/other person at workplace
g. Stranger
h. Other person

Appendix 2

Have you ever been forced or attempted forced to participate in any form of sexual activity? Tick as many as apply

Yes, as a child (under 13 years)

Yes, as an adolescent (13-17 years)

Yes, at age 18 or older

No

If yes to forced or attempted forced sexual activity at age 18 or older

Did it happen within the past year? Tick only one option.

Yes

No

Who subjected you to the forced or attempted forced sexual activity?

Current spouse/partner

Former spouse/partner

Current or former boyfriend/girlfriend

Parents/foster parents

Other family member

Friend or acquaintance

Playmate (under 18 years)

Colleague/other person at workplace

Stranger

Other person

Appendix 3

I. **The following questions relate to sexual experiences that occurred before you were 15 years old and with a person who was much older than yourself. You should answer yes or no to each question. Have you:**

a. Been encouraged to perform a sexual act, without it actually taking place
b. Been photographed partly or completely nude by an older person
c. Watched an older person masturbating
d. Looked at pornographic magazines or watched pornographic movies with an older person
e. Been kissed or caressed against your will by an older person
f. Been touched in a sexual way on the breasts or elsewhere on your body – but through your clothes
g. Been touched on the genitals through your clothes by an older person
h. Touched the older person's genitals through his/her clothes
i. Had your clothes removed by the older person in an attempt to touch you
j. Experienced the older person removing their clothes in order to have sexual activity with you
k. Been caressed and touched by an older person while you were naked
l. Touched and caressed an older person who was naked
m. Had attempts at intercourse with an older person
n. Had completed intercourse with an older person

Had attempts at anal intercourse (in your bum) with an older person

Who was the older person?
Stranger/person not known to you
Someone you knew, but not very well
Friend or acquaintance
Scout leader
Sports coach
School teacher
Caregiver at after-school youth centre or kindergarden
Person at your work
Friend or acquaintance of your parents
Babysitter or other person, who has taken care of you in your home
Cousin
Uncle or aunt

Grandparents

Brother or sister

Half-brother or half-sister

Father

Stepfather, mother's boyfriend

Mother

Stepmother, father's girlfriend

Papers 1-3

Paper I

Physical violence, self rated health, and morbidity:
is gender significant for victimisation?

V Sundaram, K Helweg-Larsen, B Laursen and P Bjerregaard
Journal of Epidemiology and Community Health 2004; **58**: 65-70

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RESEARCH REPORT

Physical violence, self rated health, and morbidity: is gender significant for victimisation?

V Sundaram, K Helweg-Larsen, B Laursen, P Bjerregaard

J Epidemiol Community Health 2004;**58**:65–70

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Study objective: To analyse gender differences in associations between physical violence and self rated health and self reported morbidity among a random sample of adults in Denmark.
Design and setting: Two questions on self rated health and self reported morbidity respectively, were obtained from a cross sectional national health interview survey conducted among 12 028 adults (16 years +) in Denmark in 2000. A question on six different forms of physical violence was obtained from a supplementary self administered questionnaire given to the same sample. The reporting period for experienced physical violence was the past 12 months and for morbidity symptoms, the past 14 days.
Main results: Men aged 16–24 years were significantly more likely to have experienced violence than women (OR = 3.2, 95% CI = 2.3 to 4.2). Female victims of physical violence were significantly more likely to rate their health as poor (OR = 2.02, 95% CI = 1.41 to 2.89) and to report anxiety (OR = 2.14, 95% CI = 1.35 to 3.37), depression (OR = 2.36, 95% CI = 1.55 to 3.60), and stomach ache (OR = 1.58, 95% CI = 1.01 to 2.47) than female non-victims. Male victims of physical violence were only significantly more likely to report stomach ache (OR = 1.73, 95% CI = 1.03 to 2.89) than male non-victims.
Conclusions: Associations between physical violence and poor self rated health and self reported morbidity were found to be significant for women, but not for men. It is probable that gender differences in experiences of violence, as well as gender differences in health related self perception, contribute to a gender specific process of victimisation. Improved knowledge about the relation between gender specific violence and victimisation as a gender specific consequence is essential for targeting violence prevention.

Violence is increasingly being recognised as a public health problem that has long term human and economic costs.[1 2] An increasing amount of research is beginning to offer a global picture of the extent of violence. The magnitude, nature, and health impact of violence differ greatly for men and women. Men and women's respective experiences of violence are characterised by widely differing power and gender relations, inherent in the different settings, contexts, mechanisms, and perpetrators of violence.[3 4]

Most violence experienced by men is perpetrated by men and primarily occurs in public spaces.[5 6] Violence usually occurs as isolated incidents, rather than repeated, ongoing abuse and men's violence towards each other is accepted and normalised as a "natural" aspect of socially constructed masculine behaviour.[7] Importantly, the perpetrator-victim relationship among men is much more rarely an intimate one, compared with violence against women.[5 8] Consequently, the likelihood of a dependence relationship between the victim and abuser is less. However, it should be noted here that intimate partner violence is presumably underreported by men, particularly in homosexual relationships.[9–11]

Violence against women comprises a wide range of abuses, including collective violence, interpersonal violence perpetrated by strangers, and intimate partner violence.[2 12] Violence against women has been distinguished from other forms of violence as "gender based violence",[13] rooted in gender inequality and the perpetuation of male power and control.[14] WHO estimates that at least one in five women has been physically or sexually assaulted by a man at some time in their lives.[15] Interpersonal violence against women is primarily perpetrated by a male intimate partner and occurs within the confines of the home.[3 16] The violence is "hidden" from public view and when it becomes visible, it is often dismissed as a private, family affair.[17] Intimate partner violence is often repeated, continuous, and used as a means by which to control the woman's actions and behaviour.[17] The physical abuse coupled with social and economic inequalities often render the woman "powerless" and dependent and the male abuser powerful. Women in violent relationships may also have responsibility for children, which may further prevent them from leaving their abuser. Additionally, societal and legal norms often render it difficult for the woman to seek and obtain help and support to leave her abuser.[18]

Interpersonal violence against women has numerous physical and mental health effects, ranging from immediately visible lesions and severe physical injuries to long term effects such as poor health status and poor quality of life, including loss of social networks and diminished ability to work.[19 20] Violence is estimated to be responsible for one of every five healthy days of life lost to women of reproductive age.[1] Both the physical and the mental stress caused by violence can lead to chronic health problems that persist long after the abuse has ended,[21–24] including chronic headache and back pain, fainting, seizures, cardiac symptoms and chest pain.[19] Choking and severe blows to the head can also have critical neurological consequences.[19 22] The negative physical and psychological effects of physical violence are also salient when violence is low severity—that is, pushing and grabbing or threats, as compared with hitting, slapping or choking.[25] Women with current violence of any severity are more likely to have a history of substance misuse and to have a substance misusing partner, thereby putting them at an increased risk for physical and mental health problems.[25]

A few studies have researched the health consequences of interpersonal violence among men. Experienced intimate partner violence and stalking have both been associated with poor health for men, including depression, injury, substance misuse, and chronic mental illness.[26 27] Additionally, experienced violence among men has been associated with

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depressive symptoms, increased alcohol use and diminished social support.[28] The association remained significant and constant regardless of the perpetrator relation, indicating that victimisation by persons other than a partner is also associated with poor health. Sexual abuse has also been associated with mental health problems for both genders and is associated with increased alcohol consumption, substance misuse, and self harm particularly among men.[29–31]

A recent Greenlandic study analysed associations between physical and sexualised violence and health for both genders. The study found that women were significantly more likely to report experiencing violence and sexual abuse and the associations between violence and poor health were stronger for women than for men.[32] No similar Scandinavian studies have been conducted.

The overall aim of this study was to examine the gendered process of health related victimisation as a consequence of violence. Victimisation is related both to self perception and to external imposition of victim identity. The social constructions of gender and sexuality that define masculinity as necessarily dominant, aggressive and powerful and femininity as weak, passive and subordinate are integral to the gendered labelling of victims.[33] If men are expected to be masculine and thereby powerful, dominant, and in control, they cannot be discursively produced as victims—the antithesis of masculinity.

Therefore, it can be argued that the gendering of victimhood discursively produces women as victims in relation to men. In terms of interpersonal violence, women are named as victims. This status defines the woman as object of the man's actions, as weak, powerless. Men are named as actors, ''doers'' in relation to their violence against women and towards each other. Gender specific forms of violence and the gendered imposition of victim status presumably interact and differentially influence men and women's self perception. This may relate to assessment and perception of own vulnerability, capabilities and resources consequent to violence, as well as own wellbeing and health status.

The specific aim of this study is therefore to examine whether gendered victimisation as a consequence of violence manifests itself in gender differences in self perceived poor health and morbidity among survivors of violence. We recognise that health related victimisation is one of many facets of gendered victimisation.

METHODS

The health data used in this study were obtained from the Danish national health interview survey, conducted among the adult population (16 years +) in 2000. The data primarily describe the incidence and distribution of health and morbidity in the adult population. This includes factors that are of significance to health status, such as health behaviour, life style, health risks at work, and external health resources, such as social networks or healthcare services.

The survey was implemented by face to face interview, conducted by trained interviewers in the respondents' homes. Additionally, the survey encompassed a self administered questionnaire with questions about violence and sexual abuse that were to be answered by the respondent following the interview, and then to be returned by mail. The questions on violence, including perpetrator information were identical to those included in the Greenlandic study.[33] The study was approved by the Danish Central Scientific Ethical Committee and written informed consent was obtained from participants. The sample consisted of 16 684 adult persons randomly selected from the Central Population Register in Denmark. Of these, 12 028 (72%) participants were interviewed and given the self administered questionnaire.

The question about physical violence asked about five different forms of violence,[34] previously tested in the Canadian Violence Against Women survey[35]—experienced during the past 12 months and ever. The original question (English translation) was:

- Have you as an adult, experienced one or more of the following forms of physical violence within the past 12 months or ever?

(a) Being pushed, shaken or lightly struck
(b) Being kicked, struck with a fist or an object
(c) Being thrown against furniture, walls, down stairs or similar
(d) Being strangled, assaulted with knife or firearm
(e) Other form of violence, specify

The questionnaire included separate questions on the perpetrator of both physical and sexualised violence. The questionnaire also included separate questions on sexualised violence, which were not included in this study.

In this study, the five measures of physical violence were dichotomised to a single variable: experienced violence within the past 12 months—yes or no. A positive response to one or more of the violence measures and to having experienced violence during the past 12 months thus defined a violence victim.

Two indicators of health from the interview survey were used in this study: self rated health as a broad indicator of self perceived wellbeing, and four measures of self reported morbidity. Respondents were asked the following question about their own health:

- How would you rate your health in general? (excellent/good/fair/poor/very poor).

This measure of self assessed health was dichotomised to indicate *good* (excellent-good) versus *poor* (fair-poor-very poor).

The question regarding morbidity was:

- Have you experienced any of the below mentioned symptoms of pain or discomfort within the past 14 days?

The symptoms were limited to those that have been empirically associated with experienced physical abuse.[36–38] They were (a) anxiety/nervousness/restlessness/uneasiness, (b) melancholy/depression/unhappiness, (c) stomach ache, (d) headache.

Statistical analysis

Statistical analysis was performed using SPSS software version 11.0 for Windows and SAS System version 8.2. Using SPSS, gender disaggregated cross tabulations for violence and age groups were performed. Using SAS, odds ratios (OR) were calculated to estimate associations between violence, poor self rated health and morbidity for both genders. Potential confounders were identified on the basis of biological or behavioural interference with the associations between violence and health. OR were thus adjusted for age, socioeconomic status and marital status in logistic regression models. Statistical significance was determined using the 95% confidence interval (CI) level.

RESULTS

The self administered questionnaire was answered by an approximately equal number of men (n = 4975) and women (n = 5483) yielding an overall response rate of 87% of those that had received the questionnaire (85% for men, 88% for women). This constituted 62% of the original random sample. Table 1 shows gender differences in reported

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Table 1 Reported incidence of physical violence in the past 12 months

Age groups	Male victims % (95% CI)	Female victims % (95% CI)
16–24 years	28.4 (24.8 to 32.1) n=171	11.1 (8.9 to 13.8) n=75
25–44 years	5.7 (4.6 to 6.9) n=95	4.6 (3.8 to 5.7) n=92
45 years and above	1.4 (1.0 to 2.0) n=37	1.4 (1.0 to 1.9) n=38

Victims of violence, by gender and age groups. Crude prevalence percentages. Danish National Health and Morbidity Survey 2000.

experience of physical violence by age groups. Men aged 16–24 years were significantly more likely to have experienced violence than women. Table 2 presents the prevalence of poor self rated health and morbidity for victims of physical violence and non-victims by gender and age groups. Table 3 presents the odds ratios (OR) for correlations between experienced physical violence, poor self rated health, and morbidity for both genders. Common cold, a comparatively widespread disease, was tested as a control for its prevalence among victims of violence, compared with non-victims. Adjusted OR show that overall, associations between violence and poor self rated health and morbidity were significant for women for all conditions except headache and common cold. Male victims of violence were only significantly more likely to report stomach ache than male non-victims.

DISCUSSION

Two important results were found in this study. Firstly, men aged 16–24 years were significantly more likely to have experienced violence than women. Secondly, the associations between physical violence and poor self rated health and morbidity were significant for women, but not for men. Only stomach ache was significantly associated with violence among men. This manifestation of gender specific victimisation is presumably in large part attributable to the gender specific nature of violence against women, including the intimate perpetrator relation and private, isolated context of violence.

The questionnaire used in this study did include a separate question on the perpetrator of physical violence and violent threats. However, the response rate on this question was too low for valid conclusions to be drawn. This is an important limitation of the study. However, data indicate that women primarily report being abused or threatened by a former spouse, while for men the perpetrator is primarily a stranger or in the category ''other''.

An association between violence and headache was not found for either gender, possibly because headache is already a comparatively common symptom in the general adult population.[39 40] Reporting frequency may not increase significantly after experienced violence. There was no association between violence and depression among men, possibly because certain feminised illnesses such as depression are reported less among men generally[41 42] and experienced

Table 2 Prevalence of poor self rated health and morbidity for victims of physical violence and non-victims, by gender and age groups

Men	Poor self rated health % (95% CI)	Anxiety % (95% CI)	Depression % (95% CI)	Stomach ache % (95% CI)	Headache % (95% CI)
16–24					
Victims	9.4 (5.5 to 14.8) n=16	1.8 (0.4 to 5.2) n=3	2.9 (0.9 to 6.6) n=5	4.1 (1.7 to 8.3) n=7	18.1 (12.6 to 24.7) n=31
Non-victims	7.4 (5.1 to 10.3) n=32	2.1 (1.0 to 3.9) n=9	3.7 (2.1 to 5.9) n=16	4.4 (2.7 to 6.8) n=19	16.0 (12.7 to 19.8) n=69
25–44					
Victims	22.1 (14.2 to 31.8) n=21	6.3 (2.3 to 13.2) n=6	7.4 (3.0 to 14.7) n=7	9.5 (4.4 to 17.3) n=9	17.9 (10.8 to 27.1) n=17
Non-victims	13.6 (11.9 to 15.4) n=214	3.2 (2.4 to 4.2) n=50	4.1 (3.2 to 5.2) n=65	4.0 (3.1 to 5.1) n=63	16.5 (14.7 to 18.4) n=260
45+					
Victims	27.0 (13.8 to 44.1) n=10	10.8 (3.0 to 25.4) n=4	13.5 (4.5 to 28.7) n=5	13.5 (4.5 to 28.7) n=5	16.2 (6.2 to 32.0) n=6
Non-victims	24.4 (22.7 to 26.1) n=621	3.7 (3.0 to 4.5) n=95	4.4 (3.6 to 5.3) n=113	4.6 (3.8 to 5.5) n=117	9.7 (8.6 to 10.9) n=246
Women					
16–24					
Victims	21.3 (12.7 to 32.3) n=16	10.7 (4.7 to 20.0) n=8	17.3 (9.5 to 27.8) n=13	17.3 (9.5 to 27.8) n=13	37.3 (26.4 to 49.3) n=28
Non-victims	9.6 (7.4 to 12.3) n=57	6.7 (4.8 to 9.0) n=40	6.4 (4.6 to 8.7) n=38	9.2 (7.0 to 11.8) n=55	32.8 (29.0 to 36.4) n=196
25–44					
Victims	21.7 (13.8 to 31.5) n=20	12.0 (6.1 to 20.5) n=11	13.0 (6.9 to 21.6) n=12	9.8 (4.6 to 17.8) n=9	39.1 (29.1 to 49.8) n=36
Non-victims	14.3 (12.7 to 16.0) n=269	5.3 (4.3 to 6.4) n=99	6.5 (5.4 to 7.7) n=122	6.8 (5.7 to 8.0) n=129	31.1 (29.0 to 33.2) n=588
45+					
Victims	39.5 (24.1 to 56.6) n=15	15.8 (6.0 to 31.3) n=6	13.2 (4.4 to 28.2) n=5	7.9 (1.7 to 21.4) n=3	18.4 (7.7 to 34.3) n=7
Non-victims	28.8 (27.1 to 30.6) n=758	7.1 (6.1 to 8.2) n=186	7.2 (6.2 to 8.3) n=190	6.2 (5.3 to 7.2) n=163	15.8 (14.4 to 17.3) n=416

Crude percentages. Danish National Health and Morbidity Survey 2000.

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Table 3 Correlations between physical violence, poor self rated health, and morbidity

	Men		Women	
	Crude		Crude	
	OR (95% CI)	Adjusted	OR (95% CI)	Adjusted
Poor self rated health	0.78 (0.57 to 1.07)	1.31 (0.91 to 1.89)	1.23 (0.89 to 1.70)	2.02 (1.41 to 2.89)
Anxiety	1.28 (0.72 to 2.29)	1.53 (0.81 to 2.87)	2.04 (1.33 to 3.15)	2.14 (1.35 to 3.37)
Depression	1.34 (0.80 to 2.23)	1.40 (0.80 to 2.44)	2.33 (1.56 to 3.48)	2.36 (1.55 to 3.60)
Stomach ache	1.63 (1.03 to 2.60)	1.73 (1.03 to 2.89)	1.91 (1.24 to 2.95)	1.58 (1.01 to 2.47)
Headache	1.50 (1.11 to 2.05)	1.16 (0.83 to 1.61)	1.73 (1.29 to 2.32)	1.27 (0.94 to 1.72)
Common cold	1.61 (1.18 to 2.19)	1.25 (0.89 to 1.74)	1.55 (1.08 to 2.21)	1.12 (0.78 to 1.62)

Victims of violence compared with non-victims as baseline (crude odds ratios (OR) and OR adjusted for age, socioeconomic status, and marital status). Danish National Health and Morbidity Survey 2000.

violence does not change this pattern. We can assume that most violence experienced by women in this study was perpetrated by known men and that most violence against men was perpetrated by male strangers or acquaintances. The power imbalance and abuse that characterises intimate partner violence probably has a far more severe psychological impact than group violence or public, socially normalised violence. Male abusers have the physical, and often financial and emotional power to control and confine the woman, isolate her from her social networks, her family, and other resources. This immense power differential does not characterise public, male violence and may therefore largely explain the lacking association between violence and depression for men in our study.

The 12 month prevalence of violence reported particularly by women aged 25–44 years, was relatively low compared with other studies.[2 19 43 44] The wide range in prevalence estimates[45–48] may be attributable to difference in levels of violence between settings, as well as differences in study design,[19] including the definitions of abuse used, interviewer training, and cultural differences in respondent's willingness to disclose sensitive information.[2 16] Moreover, abused women frequently invalidate and normalise their experiences of violence.[49 50] Many prevalence studies now include emotional, physical and sexualised violence in their definitions of partner abuse to reflect the complexity of the abuse.[19 49] This difference in inclusiveness may explain differences in prevalence between studies, and the relatively low prevalence in our study.

This study did not include sexualised violence in its analysis of interpersonal violence. We note that rape and other forms of sexual abuse rarely occur on their own in the context of intimate partner violence, they are often coupled with physical abuse and vice versa.[2 16 19] The prevalence of violence for women in this study would likely be higher, had physical and sexualised violence been analysed as part of the same phenomenon. Additionally, it must be acknowledged that a complete picture of the violence-health association will not be obtained for those persons that have experienced both forms of violence.

It can be assumed that the self reported morbidity symptoms are specifically correlated to experienced violence as adjusted OR show no associations between violence and the control symptom, cold. However, causation between experienced violence and poor health cannot be shown by cross sectional data. Victims of violence may, at baseline, present other health problems than persons who have not experienced violence.[23] This may present a significant bias to the correlation between experienced violence and poor health.[51] However, studies have shown that risk factors for exposure to, and injury from intimate partner violence hinge on characteristics of the perpetrator, rather than the abused woman. These include unemployment, history of arrest, and substance misuse.[52 53]

A strength of this study was that it used nationally representative data, covering all ages ⩾16 years and it achieved a comparatively high response rate. Generally, there has been a decreasing response rate in most European health interview surveys.[54 55] Recent surveys on violence against women based upon self administered questionnaires have achieved comparatively low response rates.[56 57] Of those who answered our self administered questionnaire, 98% of male respondents and 97% of female respondents answered the violence questions.

A recent study found that even a two month time lapse has an effect on recall bias, such that prevalence rates are significantly underestimated.[58] In our study, the effect of recall bias was greatly reduced, as we focused on physical violence experienced within the past year and morbidity symptoms experienced within the past 14 days.

However, this study relied on self perceived health and morbidity symptoms as an outcome measure. The measures have been previously tested.[59 60] The validity of self rated health, in terms of objectivity and predictive value has been questioned. Self rated health is often equated with subjective health, in contrast with medically defined health.[61] However,

Key points

- Violence is increasingly being recognised as a public health problem. The magnitude, nature and health impact of violence differ greatly for men and women. Research on the gender specific process of victimisation among survivors of violence is limited. This study examined how health related victimisation is gendered among survivors of physical violence.
- Young men were significantly more likely to experience violence than women.
- Associations between physical violence, poor self rated health and self reported morbidity were significant for women, but not men.
- It is probable that gender specific experiences of violence and gender differences in health perceptions interact and contribute to a gender specific process of victimisation. Future work should address the relation between violence, power, and gender in relation to victimisation as a gender specific process. This knowledge could be used in developing gender specific and prevention strategies, for example, psychological self defence tactics for women, which deconstruct oppressive power gender relations—that is, male equates to powerful, female equates to weak.

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Policy implications

- The results of this study strengthen the importance of improving knowledge about the relation between gender specific experiences of violence and victimisation as a gender specific consequence.
- The results can be implemented in developing evidence based violence prevention strategies that account for the gender specific mechanisms underlying violence, including its form and function. The following initiatives, which follow WHO's recent recommendations* could be implemented by the Ministries of Health, Education and Gender Equality:
- Implementation of screening for violence victims at hospitals and general practices, as female victims of violence are significantly more likely to report poor health and morbidity than non-victims.
- Public awareness campaigns and education targeted at young men and women about the damaging consequences of using and accepting violence, as well as risk factors for exposure to violence.
- General education starting at primary school level, based on gender aware initiatives teaching self reliance, self awareness, and self respect to children and young adults, which may prevent gendered patterns of exposure to physical and sexualised violence.

as has been pointed out, doctors' evaluations of health are rarely objective as they rely upon the personal perceptions of the doctor in question.[61] The concept of objectivity postulated and defined by quantitative research has been criticised by feminist researchers and sociologists.[50 62 63] They have argued that the notion of objectivity has been based on male experiences and definitions of what constitutes worthy research. Similarly, the use of surveys to obtain universal knowledge has been criticised, as surveys treat all people as being equal actors and therefore do not reflect the patriarchal reality in which data are gathered.[50 64] This has often obscured women's experiences in quantitative, ''objective'' data.[65 66]

Sen has criticised self reported morbidity as being an extremely misleading measure of ill health, as self perception may be influenced by the subject's social experience.[66a] Social experience is inevitably gendered and therefore, we can presume that gender differences may exist in perceptions of health and illness, which are determined by and interact with gender specific experiences and socially imposed gendered identifications, including masculinity/femininity and victim status. Just as gender specific life events[67 68] differentially influence women and men's frames of reference,[61] so will gender specific experiences of violence. Studies show that women do rate their health as worse than men in corresponding age groups.[67 68] Self rated health has been reported as a valid predictor of morbidity and future health care use.[69–72] We therefore view social experience and self rated health as especially relevant for analysing health related victimisation as a gendered process, because background factors for men and women will differ greatly and influence the frame of reference in which they rate their own health and perceive their own wellbeing.

This study found associations between physical violence, poor self rated health, and self reported morbidity for women, but not men. It is probable that gender differences in experiences of violence and health related self perception, contribute to a gender specific process of victimisation. Improved knowledge of the mechanisms underlying violence is essential for developing gender specific prevention strategies.[73] Future work should address the mechanisms of violence that lead to gender specific victimisation, including gender specific forms and functions of violence, and the role of social gender constructions in experiences of violence, power, and victimisation.

*Resolution WHA56.24 ''Implementing the recommendations of the World report on violence and health'', 28 May 2003.

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Paper II

Is sexual victimisation gender-specific? Prevalence of forced sexual activity among men and women in Denmark, and self-reported well-being amongst survivors.

V Sundaram, B Laursen and K Helweg-Larsen

Under second review in Journal of Interpersonal Violence

Is sexual victimisation gender-specific? The prevalence of forced sexual activity among men and women in Denmark, and self-reported well-being among survivors.

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Abstract

The present study investigated the prevalence of sexual victimisation, and correlations between sexual victimisation and indicators of poor health in two representative samples of men and women in Denmark. Specifically, we explored the prevalence of self-reported victimisation among adolescents (N=5829) and adults (N=3932) and analysed differences in self-reported health outcomes between male and female victims and corresponding controls. Gender differences were found in the reported prevalence of sexual victimisation. Significantly more females than males reported forced sexual experiences in both samples. Associations between sexual victimisation and poor health outcomes were found for both genders. Comparable patterns of association for men and women were found on a number of variables, particularly those pertaining to risk behaviour.

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Keywords: Sexual victimisation, gender, health, risk behaviour, Denmark

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Biographical statements

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Is sexual victimisation gender-specific? The prevalence of forced sexual activity among men and women in Denmark, and self-reported well-being among survivors.

Experiences of sexual abuse and assault are relatively prevalent in Western societies (Ackard & Neumark-Sztainer, 2002; Garnefski & Arends, 1998; Shrier, Dwyer, Emans & DuRant, 1998). While the reported prevalence differs between studies depending on the methodology used, the exact questions asked about the abuse, and the physical as well as temporal context in which the questions are presented to the respondents, it is well-accepted that sexual abuse and assault experiences are more prevalent among women than among men (Dube, Anda, Whitfield et al. 2005; Harrison, Fulkerson & Beebe, 1997; Finkelhor, 1993). Among women, the prevalence of childhood sexual abuse has been found to range between 7% and 36% (Anda, Croft, Felitti et al. 1999; Bendixen, Muus & Schei 1994; Finkelhor 1994), while reported sexual assault in adulthood ranges from 11% to 27% (Making Sense of Rape in America 2002; WHO 2002; Edgardh & Ormstad 2000; NVAW Survey 1996; National Women's Study 1991). Among men, the self-reported prevalence of sexual abuse in childhood and adulthood (2%-29%) is consistently lower (Ackard & Neumark-Stainzer 2003; Edgardh & Ormstad 2000; Finkelhor 1994). Women appear to be equally at risk of sexual assault in childhood and adulthood, while the reported prevalence of sexual victimisation by men is greater for childhood sexual abuse than for adult experiences of assault. Accordingly, previous research on the social and health-related consequences of abuse has primarily focused on female victims and available knowledge about the sequels of abuse is based, in the main, on this group.

Among women, sexual abuse in childhood and adolescence has been associated with binge drinking, fighting, suicide ideation and sexual risk behaviours (Garnefski & Arends, 1998; Erickson & Rapkin, 1991) among survivors. Sexual assault in adulthood has been linked to poor subjective health (Golding, Cooper & George, 1997), multiple sexually transmitted diseases (Ohene, Halcon, Ireland, Carr & McNeely, 2005), panic and depression (Dube, Anda, Whitfield et

al. 2005; Leserman, Li, Drossman & Hu, 1998), alcohol disorders (Lown & Vega, 2001; Caetano, Cunradi, Clark & Schafer, 2000), smoking (Hathaway et al. 2000; Anda, Croft, Felitti et al. 1999) and increased subsequent hospital admissions and surgical procedures (Helweg-Larsen & Kruse, 2003; Salmon & Calderbank, 1996).

Increasingly, as academic and media attention has discerned and recognised the relatively prevalent sexual victimisation of young and adolescent boys, a growing body of work has also begun to take seriously sexual assault among adult men, including risk factors for victimisation and health outcomes among male survivors. Early and existing studies on sexual abuse among men have primarily been based on specific or clinical samples e.g. sexual assault experiences among homeless youth (Johnson, Rew & Sternglanz 2006), substance users or HIV-positive men (Hyman, Garcia & Sinha 2006). Correlations between sexual abuse and anxiety and affective disorders (Shack, Averill, Kopecky, Krajewski & Gummattira 2004), substance use (Johnson, Ross, Taylor, Williams, Carvajal & Peters 2005), and self-harm (Edgardh & Ormstad 2000) have been shown among men.

A relatively smaller number of cross-sectional studies have analysed gender differences in risk behaviours and health problems associated with sexual abuse (e.g. Garenfski & Arends, 1998; Garnefski & Diekstra, 1997; Bendixen, Muus & Schei 1994). Sexual victimisation has been associated with immediate and long-term health problems for both genders. Male victims of sexual abuse have also varyingly been found more likely than females to engage in drug use (Watts & Ellis, 1993), binge drinking (King, Flisher, Noubary, Reece, Marais et al. 2004) and suicide attempts (Garnefski & Diekstra, 1997). Bendixen et al. (1994) found that sexual abuse was not correlated with anxiety, depression or suicidal ideation among men in their study, while it was for women. Generally, it has been argued that sexually abused males tend to exhibit more externalising behaviours, such as frequent alcohol consumption (Garnefski & Arends, 1998; Ratner et al. 2003), violence (Watkins & Bentovim, 1992) and suicide attempts (Chandy, Blum & Resnick,

1996), while female victims are more likely to display internalising behaviours such as depression, anxiety, suicide ideation and somatic symptoms and risk behaviours such as smoking (Nørlev, Davidsen, Sundaram & Kjøller, 2005; Tomori, Zalar, Kores, Ziherl & Stergar, 2000; Acierno et al. 2000; Finkelhor, 1994; Rozario, Kapur, Rao & Dala, 1994). Gender appears to be an important factor in exposure to sexual abuse and assault. There is less clarity regarding the gender-specificity of health outcomes among survivors. Relatively recent, large-scale research such as the Adverse Childhood Experiences (ACE) study have established no gender differences in a range of health outcomes among survivors of childhood sexual abuse (e.g. Duba, Anda, Whitfield et al. 2005). Abuse was associated with suicide attempts, alcohol problems, affective disorders and family problems among men and women, and the increased risk was similar for both genders. Different measures of risk behaviour with varying degrees of specificity have been used across studies; this causes considerable variation in the observed assocations between abuse and health. Further research in this area is therefore warranted, in relation to obtaining empirical evidence as well as optimising research design.

In order to draw attention to the continuing widespread abuse of girls and women, as well as to increase awareness about sexual abuse and assault experienced by men, further knowledge about gender-specific risk behaviours associated with abuse, the prevalence of abuse among women and men, respectively, and the subsequent health and well-being of survivors of abuse must be obtained. This knowledge is also essential in relation to developing evidence-based, gender-specific prevention and intervention strategies. If such research can contribute to males and females with, and without, a history of sexual abuse being distinguished based on the types of emotional, physical and behavioural problems they present with, this information may also be important in terms of screening for sexual abuse by general practitioners and school nurses. The classification of differing, and generally dichotomous ‘male’ and ‘female’ patterns of health/risk behaviour among survivors of sexual abuse based on specific, small and non-representative samples

may impede accurate identification of at-risk or exposed men and women by health personnel, caregivers and other relevant actors.

To the authors' knowledge, no such study has been conducted in Denmark at the time of writing. Further, due to the sensitive nature of the issue, both for participants and researchers, sample sizes are often very small. The present study includes two samples in order to assess whether observed patterns can be substantiated in two independent samples. It should be noted already at this stage, that we are by no means attempting to draw direct comparisons between the two populations, differing in nature and composition as they do. However, we do find it relevant, and a strength, to be able to corroborate (or counter) the observed results given the relatively small samples available to us.

AIM

The aim of the present study is to explore gender differences in sexual victimisation, specifically in terms of exposure and in self-perceived health status among survivors. The present study analyses health status based on a range of parameters, broadly defined as morbidity, illness behaviour, and risk behaviour. It is hypothesised that gender differences will exist in exposure to sexual assault and that victims of both genders will report poorer health outcomes than non-victims. Further, gender differences in associations between abuse and health will exist.

MATERIAL AND METHOD

The present study draws on two, independent population samples - adults (aged 16 years and over) and adolescents (14-16 years) - to investigate associations between sexual abuse and health status. Because most sample sizes in this field of enquiry tend to be relatively small due to the nature of the topic, as well as ethical and methodological difficulties surrounding disclosure, the authors collectively made the decision to explore the health status of sexual abuse survivors in

two separate samples, in order to assess whether the findings were incidental or whether they could be confirmed in both populations. As briefly reviewed above, previous research has shown that sexual assault and abuse in childhood, adolescence and adulthood are all associated with subsequent poor health outcomes. We therefore felt reasonably confident to assume that any similar (or dissimilar) findings would not be spurious or due solely to the differential characteristics (adult vs. adolescent) of the samples.

Danish National Health and Morbidity Survey 2000

The main objective of the national health interview survey was to describe the incidence and distribution of health and morbidity in the adult population (16+), including factors associated with poor health such as sexual abuse and assault. The themes included in the health survey have been described in detail elsewhere (Sundaram, Helweg-Larsen & Laursen, 2001). All participants were asked about health status, health/illness behaviour and risk behaviours in a face-to-face interview in the respondents' homes. Questions on forced sexual activity were included in a self-administered questionnaire, which was given to respondents following the interview. Participation was voluntary and answers were confidential. The study was approved by the Danish National Committee on Biomedical Research Ethics.

Subjects

The original random sample comprised a nationally representative cross-section of 16,648 Danish citizens. A total of 12,333 adults were interviewed about their health status and were offered the self-administered questionnaire containing separate questions on physical and sexualised violence; of these 12,028 people agreed to answer the questionnaire. Of the 12,208 respondents, a total of 10,153 (84%) answered at least one question about lifetime and past-year experiences of sexual abuse and assault (4857 men and 5296 women), corresponding to 61% of the original random sample. The present investigation focused only on lifetime experiences of sexual assault in childhood, adolescence and adulthood, as the prevalence of past-year assault reported in this study

was relatively low, thus hampering statistical analysis. In order therefore, to diminish potential retrospective memory bias of lifetime reporting, the present study focused on those adults aged between 16 and 39 years, only. This sub-sample comprised 1798 men and 2134 women.

Measurements

Sexual abuse and assault history was assessed by three questions on forced, or attempts at forced sexual activity as a child, adolescent or adult (Figure 1). A question regarding the perpetrator of sexual abuse was also included.

Health status was defined by self-rated health, emotional and physical symptoms of morbidity, stress, and feeling well enough to accomplish what you want to. Illness behaviour was covered by amount of annual sick leave, use of sleeping medication and tranquillisers, contact to general practitioner and contact to psychologist within the past 3 months. Risk behaviour was covered by experiences of physical violence, movement in deserted urban areas, suicide ideation, suicide attempts, exceeding the recommended alcohol limit within the past week (defined as 14 + units for women and 21 + units for men, where 1 unit is equivalent to a single glass of wine, pint of beer, or measure of spirits) and smoking behaviour.

Statistical analysis

In order to compare sexually abused men and women with non-abused counterparts, male and female control groups were created by selecting 2 non-abused persons for each case - matched for age and socio-economic group. Prevalence estimates of health outcomes among victims and non-victims and 95% confidence intervals were calculated using the FREQ procedure (SAS version 8, SAS Institute, 2001). The significance of difference in health status between victims of abuse and non-victims was tested using Pearson's chi-square test, and Fisher's exact test when numbers were small ($N<5$) (FREQ procedure, SAS version 8.02, SAS Institute 2001).

Due to the relatively small number of male cases in particular, no analyses were conducted to ascertain the relation between perpetrator of abuse and health outcomes, although we acknowledge that this would have been pertinent.

Danish Youth Survey 2002

The main objective of the survey was to describe the overall well-being of young people in Denmark, with a particular focus on early and illegal sexual experiences. All subjects were personally interviewed about their health status, recent illness and risk behaviours in the interview survey. Other themes included in the survey have been described elsewhere (Helweg-Larsen & Bøving-Larsen, 2003). The interview was conducted using the multimedia computer-assisted self-interview method in the students' respective schools. The questions were presented in text form on the computer screen and were accompanied by a voiceover in a set of headphones connected to each individual computer. The questions on sexual experiences were included in the main survey, however each student had the option of skipping any question or theme he/she did not wish to answer. Data were anonymised and individual answers could not be identified. The study was approved by the Danish National Committee on Biomedical Research Ethics.

Subjects

The original random sample comprised a nationally representative cross-section of 324 schools with 9th grade classes in Denmark. Of these, 183 schools (56%) comprising 7,241 students aged 14-16 years participated in the youth survey. A total of 6,203 students (86%) were present on the day of the study and were asked about sexual experiences with older persons before the age of 15 (the age of sexual consent in Denmark). The sample comprised 3,142 boys and 3,043 girls. We did not pre-define a lower age limit for 'older persons' as we were aware that age is a relative concept. To a 14 year-old, someone only two years older might be perceived as being 'significantly older'. We were concerned that by setting a lower boundary on the age of someone significantly older, we might omit the experiences of adolescents who had experienced

acquaintance or friend assault by someone closer to their own age. The potential implications for underestimation of the true prevalence in this population are discussed later in the paper.

Measurements

Sexual experiences were assessed by 13 questions about different forms of sexual activity, ranging from non-physical actions to completed intercourse (Figure 2). Respondents were asked to indicate whether they currently perceived the sexual experience(s) to be abusive. A positive answer to one of the 13 actions, as well as to perceiving the experience as abusive, defined a sexually abusive experience in the present study. We recognise that using this conservative definition of abuse may have consequences for obtaining the 'true' prevalence of abuse in this population. A balance had to be achieved between permitting the young person to define their own sexual experiences with the awareness that abuse is normalised and invalidated by many victims (e.g. Kelly, Regan & Burton 1992). However, neither did we want to create a 'false' picture of the prevalence of abuse among young people by including experiences that we, as researchers, defined as abusive but which genuinely were not perceived as such by the respondents. However, the ethical and practical implications of using this approach to establish the prevalence of abuse have to be acknowledged. These will be discussed in some detail later in the paper. A question on the victim-perpetrator relationship was included also in this part of the survey.

Health was illuminated by questions on self-rated health, emotional and physical symptoms of morbidity, feeling that everything is overwhelming and illness during the past 2 weeks. Risk behaviour was described by experiences of violence, daily alcohol intake over the past week, and smoking behaviour.

Statistical analysis

Students reporting at least one incidence of sexually abusive activity, using the definition given above, were compared with students reporting no sexual abuse, using gender as a matching criterion. Prevalence estimates of health outcomes among victims of abuse and non-

victims and 95% confidence intervals were calculated using the FREQ procedure (SAS version 8, SAS Institute, 2001). The significance of associations between sexual abuse and well-being was tested using Pearson's chi-square test, and Fisher's exact test when numbers were small (N<5) (FREQ procedure, SAS version 8.02, SAS Institute 2001).

As with the adult sample, the number of male cases was considered too small to analyse the relation between the perpetrator of the abuse and self-perceived health status, although results about the proportion of abuse perpetrated by known and unknown actors are presented and discussed.

RESULTS

The results are reported separately for the adult sample (Table 1) and the adolescent sample (Table 2). The response rate for interviewees who had been presented with questions on forced sexual activity was high in both samples, 86% among adults and 94% among adolescents, with no major gender differences in response rate.

Adults: 16-39 years (Table 1)

Among 16-39 year-olds who answered questions on sexual abuse, 8% reported at least one lifetime incidence of forced sexual activity; 294 were women and 39 were men. This represents 14% of women (N=2134) and 2% of men (N=1798) in the total sub-sample, and 6% and 1% of all women and men who answered questions on sexual victimisation. Among women, the perpetrator was a person known to the victim in 50% of cases: a friend/acquaintance (19%), family member other than a parent (12%), boy/girlfriend (11%), former spouse/partner (8%) or parents (5%). A stranger perpetrated the abuse in 10% of cases. Despite the relatively few male cases available, we were able to ascertain that here also, the majority of abuse was perpetrated by a person known to the victim: friend/acquaintance (18%), family member other than a parent (10%), a playmate/friend >

18 years (10%), or parents (5%). However, abuse experiences involving a stranger were reported by 10% of men.

Just over half of the abusive experiences reported by women occurred in childhood, or adolescence. Among men, three-quarters of abuse experiences reported had occurred under the age of 18, of which the majority took place in childhood (<13 years).

Health

Poor self-rated health was not associated with abuse among either women or men. However, indicators of poor health, such as rarely feeling well enough to accomplish what one wants to, often feeling stressed, and emotional and somatic symptoms of morbidity were significantly associated with abuse among women ($p<0.05$) Among men, the reported prevalence of these indicators were consistently higher for survivors than for controls, although the difference was significant only for stomach ache ($p<0.05$). The estimated prevalence differences between cases and controls were comparable for men and women on the majority of health parameters.

Illness behaviour

Indicators of illness behaviour were not reported significantly more among female survivors compared to gender-matched controls. However, a single significant difference was found for men on measures of illness behaviour: survivors of abuse reported high annual sick leave (16 days +) significantly more than did controls. It must be emphasised that the number of cases was small; a variation of only a few cases (or controls) can represent a large difference in percentage points.

Risk behaviour

Risk behaviour was significantly associated with sexual assault, on a number of parameters, for both genders. Only male cases were significantly more likely to report avoiding deserted urban areas than matched controls. However, it should be noted that the estimated prevalence among male controls was equal to 0, so this finding is arguably spurious. While

experienced violence/threats of violence and smoking were associated with abuse among women only ($p<0.05$), heavy drinking (exceeding the recommended alcohol limit within the past week) and suicidal tendencies were significantly associated with abuse among both genders.

Suicide ideation was reported significantly more among both male and female cases compared with controls. One-third of male cases reported suicide ideation compared to 11% of controls, while nearly one quarter of female cases reported suicide ideation compared to 9% of controls. Attempted suicide was also significantly associated with abuse among both genders; the prevalence difference between cases and controls being greater for men (26%) than for women (12%). Exceeding the recommended alcohol limit within the past week was reported by over ¼ of male cases, while a lower proportion of 2/5 of abused women reported the same.

Adolescents: 14-17 years (Table 2)

A total of 137 persons (2 %) of those who answered questions on sexual experiences reported at least one abusive sexual experience (Table 2); 110 were girls and 27 were boys. This represents 4% of girls (N=3043) and 1% of boys (N=3142) who answered questions about early sexual experiences. Among girls, abusive sexual experiences primarily involved a friend (20%) or an acquaintance (25%), although many cases involved a family member other than a parent (e.g. grandparents, cousins or siblings) (16%), a friend of the parents (10%), or fathers/stepfathers (10%). Fourteen percent of girls reported an abusive experience involving a stranger. Among boys, abusive sexual activity involved a stranger in over a quarter of cases (26%), however many cases involved an acquaintance (15%) or friend (12%). Fathers perpetrated the abuse in 7% of cases. A relatively large share of boys also reported an abusive sexual experience with a school teacher (15%), although these percentages should be interpreted with some caution considering the small number of cases involved.

Collectively, the majority of abusive experiences involved known persons. Among girls, the figure was 80%; this was slightly lower among boys with 67% of reported abuse being perpetrated by an older person known to the respondent.

Health

Poor self-rated health and feelings of being overwhelmed were associated with sexual abuse only among girls ($p<0.05$). However, the indicator covering emotional and somatic morbidity symptoms was reported significantly more by male and female cases than by controls. Illness during the past 2 weeks was not associated with abusive experiences among either gender.

Risk behaviour

Experienced violence during the past year and daily drinking were correlated with sexual abuse among both boys and girls ($p<0.05$). Close to 5% of sexually abused girls reported daily drinking compared to 0.5% of controls. Among boys, almost a quarter of cases reporting daily drinking compared with 4% of controls. Smoking was associated with abuse only among girls, although the prevalence difference between male cases and controls was relatively large. Due to the small sample size, there was a real risk of committing a Type II error, and assuming no differences existed where they did. This is a general caveat for male cases in both samples.

DISCUSSION

The present study had three main findings: Firstly, there were gender differences in the reported prevalence of abusive sexual experiences. In both sub-samples, significantly more women than men reported experiences of forced sexual activity. Secondly, sexual abuse was significantly associated with poor health, illness behaviour and risk behaviour among both men and women. Thirdly, the same associations were found for men and women on a number of indicators.

Prevalence

Adults

Our study confirms previous findings that forced sexual activity is reported significantly more frequently by adult women than by adult men. However, the prevalence was slightly lower than that found among women in previous studies (e.g. Elliot, Mok & Briere, 2004; Watts & Zimmerman, 2002; Thakkar, Gutierrez, Kuczen & McCanne, 2000; Newton-Taylor, DeWit & Gliksman, 1998). Our question on sexual abuse was incorporated into a large, nationwide health survey that focused primarily on describing the distribution of health and morbidity in the general population, including risks to health such as violence and sexual abuse. This rendered it difficult to include multiple or detailed measures of sexual abuse.

It could be argued that respondents may have been reluctant to perceive themselves as victims of sexual abuse, and therefore would not report forced sexual activity that was not specifically asked about (Walby & Myhill, 2001). This contention is supported by research on physical violence measures (DeKeseredy & Schwartz, 1998). Further, the present study analysed sexual violence in isolation from physical abuse. Numerous studies have shown that sexual violence against women is almost always accompanied by some form of physical and verbal aggression (Jewkes, 2002; Campbell, 2002). Previous studies may have employed more inclusive measures of abuse (covering physical as well as sexual violence) and this may account for the higher reported prevalence of abuse found in previous studies. This may also explain our finding that among adults, physical violence was associated with sexual assault only among women.

Additionally, our sample only included women less than 40 years of age, even though we excluded a relatively large number of cases using this delimitation. We defined our population stringently in order to reduce retrospective reporting bias, as our study analysed lifetime prevalence of forced sexual activity. Some evidence shows that underestimation of abuse over the lifecourse is likely (e.g. Dube, Anda, Whitfield et al. 2005), although this is variable. Perhaps more importantly,

as we did not control for the effects of age on health, we could be more certain of discerning a 'true' abuse-health correlation by limiting the age group in the way that we did.

The Making Sense of Rape in America study (2002) shows the prevalence of reported abuse to vary between studies depending on the sources of data, definitions of abuse used, and the methodology employed to elicit responses, but emphasises that different source have particular strengths in informing us about aspects of violence. In the National Violence Against Women Survey (1996) 15% of adult women (>18 years) reported at least one lifetime experience of rape, while the National Women's Study (1991) showed that the lifetime prevalence of rape was slightly lower at 13%. Victimisation studies based on criminal statistics are also prevalent (e.g. International Crime Victim Survey 2001); the prevalence of sexual assault tends to be underestimated, as the data depend on the victim's inclination to report crime and the willingness of the police to record it. This unreliability could be expected to be particularly relevant for violent and sexual crimes, which as Walby (1999) points out, are subject to moral and social judgement. This does indicate that while the prevalence of sexual victimisation of women in the present study might have been relatively low due to the reasons (amongst others) mentioned above, the rates are comparable with those found in other national contexts, using different (often more specific) measures.

Among adult women in the present, the prevalence of sexual abuse and assault was approximately evenly distributed over childhood (28%), adolescence (29%), and adulthood (32%). A total of 11% of women reported sexual abuse in several periods of their lives. Accordingly, a recent Danish study based on data from the National Centre for Rape Victims (Boegh, Helweg-Larsen & Sidenius 2005) showed that sexual abuse in childhood and adolescence was a strong predictor of sexual victimisation in adulthood. The clear majority of abuse against adult women overall was perpetrated by a person known to the victim; however this varied according to the type of abuse reported (childhood, adolescent or adulthood). Women who reported childhood abuse overwhelmingly identified the perpetrator as a family member other than their parents (30% of this

group, N=83). Adolescent abuse was reported to be perpetrated by a friend or acquaintance as the biggest category (26% of this group, N=87), while the most frequently identified perpetrator of adult sexual victimisation was a former spouse/partner (22% of this group, N=93). This confirms previous evidence that women are most at risk from sexual victimisation by people known to them, and that adult women are primarily assaulted by intimate partners (e.g. Dobash & Dobash 1992; WHO 2002).

While just over half (58%) the cases of abuse against women were perpetrated under the age of 18 years, a clear majority of abuse against men (74%) was perpetrated in childhood (<13 years) or adolescence (13-18 years). 56% (N=39) of cases were perpetrated in childhood, while the number of cases reported in adolescence and adulthood were equal (18% in each group). Boegh et al. (2005) recently reported that among men attending a state hospital rape centre, the prevalence of adult sexual victimisation was low. However, among those adult men that did present following sexual assault, a high proportion indicated having been sexually abused as a minor, suggesting that childhood/adolescent abuse is also a risk factor for re-victimisation among men. While adult men in the present study primarily report childhood abuse, they are also more likely to report risk behaviours and poor health than men who have not reported any abuse, leading us to cautiously suggest that the abuse may account for a large portion of the variance in health status. It must naturally be considered that there may be other behaviours that characterise this population, and that have an independent effect on health status.

The reported prevalence of sexual violence among adult men in the present study was low. It could be argued that there is a great deal of underreporting among male victims; however, the underlying reasons for this are not well illuminated. Existing studies on sexual violence among men have found the prevalence to range from 0.3% to 24% depending mostly on the definition used and the type of abuse (childhood, adolescence, adulthood) investigated (e.g. NVAW 1996; Elliot, Mok & Briere, 2004; Briere & Elliot, 2003; Dunne, Purdie, Cook, Boyle & Najman, 2003; Ratner

et al. 2003; Sariola & Uutela, 1994). Again, methodology will undoubtedly influence reporting, and the majority of studies have precluded anonymity for the respondent, or have been conducted by telephone – leading to unsurprisingly low reporting rates. As most previous research on physical and sexual violence has been conducted among women, very little knowledge exists on the ways in which men respond to questions on abuse. The present study does not shed further light on this particular problem; however it does contribute to the evidence on gender-specific victimisation, and thereby highlights the problems inherent to future research design which does not incorporate this gender-specificity.

It has been suggested that gendered socialisation may encourage men to be non-disclosing and self-reliant, as opposed to women who are raised to be expressive and help-seeking (Canetto, 1997; Wellman, 1993; Rice, 1990). Recent research on gendered victim identities argues men may be constructed as 'victims' of sexual assault in a specific, and gendered way that differs from the way in which female victims of sexual abuse are perceived. The hegemonic, Western construction of (heteronormative) masculinities may position a man as being 'emasculated' through the act of sexual subordination. This may be argued to be reflective of the way in which male sexuality has been constructed as being dominant, in control (Connell 2001), or indeed, the conceptualisation of diverse masculinities, that nonetheless have virtues such as fortitude and resilience in common. (Sundaram & Jackson, forthcoming). If male-on-male sexual assault is analysed as a form of emasculation, we may better understand why men may be unwilling to disclose the abuse or perceive themselves as 'classic' victims, but at the same time may be profoundly affected by the experience.

Adolescents

In the adolescent group, the prevalence of sexual abuse (according to the definition given earlier in the paper) reported by girls was 4%, which is considerably lower than the rates reported in much previous research (e.g. Bendixen, Muus, Schei 1994; Dube, Anda, Whitfield et al.

2005) which has found the lifetime prevalence of childhood sexual abuse to be reported at approximately 20%. Here, the majority of perpetrators were identified as acquaintances or friends of the victim (44%), with 10% of girls (N=11) reporting abuse by a parent or step-parent. The prevalence of abuse among boys was similarly lower than in previous studies (e.g. Dube et al. 2005; Sarielo & Uutela 1994). Among boys, the biggest perpetrator sub-category was stranger assault (27%), although acquaintances, friends and teachers were also reported as perpetrators. Using the pre-determined definition of abuse, 8% of boys reported abuse involving a parent (father); however this figure was equivalent to only two cases. Close to one quarter of all cases reported by girls and boys were perpetrated by a family member, a category that included all first-order blood relations, and step-siblings/parents.

There may be several explanations for the discrepancy between the prevalence found in the present study and that reported in previous research. A primary factor might be the conservative definition used to identify cases of abuse in the present study. We chose to include only those respondents as cases where a positive answer was given to at least one sexual action before the age of 15, and the experience was identified as clearly abusive (in the view of the respondent) at the time of completing the survey (‘at present’). Numerous studies have shown that young and adult survivors of sexual - and physical - victimisation frequently invalidate, deny, or normalise abuse (Westmarland 2000; Kelly et al. 1992). It could therefore be argued that by selecting only those young people that indicated that they definitely perceived the experience as abusive, we would be eliminating a number of cases of abuse from our sample, and subsequently biasing the reported prevalence of sexual abuse in the study. Following careful consideration we decided that as a means of reducing the number of false positives which might exist in the sub-sample that met the legal criteria for sexual abuse, we would use the more conservative definition of abuse. This decision had to be weighted against the knowledge that we might be excluding and

silencing real cases of abuse. However, we did not want to create an exaggerated picture of abuse by including 'false' cases in our sample.

In separate analyses of the representative sample (Sundaram, Laursen & Helweg-Larsen, forthcoming) we examined those responses that met the legal definition for sexual abuse of a minor, but which were labelled as clearly non-abusive by the young person themselves (N=385 girls, N=174 boys). It was found that among girls, the vast majority of cases (73%) were identified as sexual experiences with a friend or acquaintance, who was aged 15-17 years. We were able to identify whether the sexual experience(s) were isolated or recurring events, and whether it was ongoing. Questions about the use of force, alcohol and/or drugs in relation to the sexual experience were included in this expanded and detailed analysis. On this basis, we loosely identified these cases as potential heterosexual partnerships, specifically considering the fact that they answered negatively to a question about the experience being clearly abusive, and to the experience having affected them negatively at the time, and at present. Among boys, 67% of cases involved a friend or acquaintance aged 15-17 and the same considerations as to their perception of the experience were taken.

Among girls, 5% of cases (N=20) involved a family member, including parents. The corresponding figure for boys was 7% (N=13). A detailed analysis of these cases found that many of the situations involving parents were photographs being taken of the young person between the ages of 0 and 1 year, which suggested that the question might have been inappropriately formulated, and thus susceptible to easy misinterpretation by the respondent, who in these cases primarily seemed to be 'reporting' that their parents had taken nude photos of them as babies.

The reactions given to these incidents by the respondents was overwhelmingly 'of no importance' or 'don't know', the latter suggesting that there might have been problems understanding the essence of the question. In other cases, the young person reported watching pornographic movies or reading pornographic materials with an older sibling (<15 years) and the

majority of these respondents indicated that this was of no importance to them at the time, or at present.

There were some obvious cases in which the young person had answered – deliberately or otherwise – the question 'incorrectly'. In one case, the respondent had reported watching pornography with his father between the ages of 2 and 5, and reported that it had affected him positively at the time, and currently. A total of 7 out of the 34 cases involving family members (31%) could be identified with relative certainty as possible instances of abuse that had not been defined as such by the respondent. As the survey was confidential, voluntary and carried out using a personalised and sensitive methodology, we can only hope that we created an environment in which the young people felt comfortable in telling us about any abusive experiences they had. We aimed to reduce underreporting by some degree. Post-hoc analysis of excluded responses therefore strengthened the assumption that the risk of including false positives outweighed the risk of exclusion – however, it should be stressed that we do not endorse this strategy as problem-free.

Another possible explanation for the lower prevalence of sexual abuse reported in this study might be the relatively vague denotation of a 'significantly older person' in the preamble to the list of sexual actions presented to the respondent. As described earlier, we wanted to use an open description of the 'counterpart' as age is naturally a relative, context-specific construct. To a 14 year-old, a 17 year-old might be perceived as being significantly older, whereas an age-gap of two years may be less meaningful to someone in early adulthood. However, it is entirely possible that the reverse happened, and the young people thought that 'significantly older' could apply only to someone defined, for example, as legally much older e.g. 18 years or older. Some cases of unwanted sexual experiences with a person aged below the arbitrary limit set in the young person's mind might then have gone unreported. Alternatively, if we had asked about unwanted sexual experiences with contemporaries or peers, the reported prevalence might also have been higher.

The victim-perpetrator relationship has not been well illuminated in the few existing studies of sexual abuse among men. A recent study based on ACE data examined the relationship between perpetrator (male/female) and adverse outcomes among men; no differences were found in health outcomes according to the gender of the perpetrator. Severity of abuse (intercourse vs no intercourse) predicted greater variance in health (Dube, Anda, Whitfield et al. 2005). The present findings thus give us pause for thought in relation to gender differences in contexts of sexual abuse. In relation to women in particular, the findings challenge the widespread myth that sexual assaults are predominantly stranger assaults and are therefore necessarily 'unpreventable' or unpredictable. They also challenge the misconception that boys/young men do not become victims of stranger/sexual assault.

Sexual abuse and well-being

The present study was based on cross-sectional data and caution must therefore be exercised when interpreting associations between sexual abuse history and poor well-being as causal relations. We cannot determine with certainty that victims of sexual abuse at baseline do not have worse health or exhibit riskier behaviour than the reference population. Factors that may be regarded as likely consequences of abuse may equally be argued to 'predict' unwanted sexual experiences, such as low self-esteem, depression (Kaltiala-Heino, Kosunen & Rimpela, 2003), self-harming behaviour and alcohol disorders (Spak, Spak & Allebeck, 1997; Edgardh & Ormstad, 2000). Further, we must acknowledge factors that might contribute to (perceived) poor health independently of abuse, such as poverty (Mead, Witkowski, Gault & Hartmann, 2001) and low sense of coherence (Honkinen, Suominen, Valimaa, Helenius & Rautava, 2005). We did not control for these factors in our model due to the small sample size; there was a concern that the amount of data would be reduced to an unacceptable degree. It is with these stipulations that we present our results.

The present study found that sexual abuse was significantly associated with poor well-being among males and females in both samples. Further, the same associations were found for men and women on a number of parameters, particularly in relation to risk behaviours. The overall rating of health did not appear to be associated with abuse, indicating that concrete risk behaviours and (gender-specific) symptoms may be aspects of health in which the impact of victimisation is most reflected – and this, particularly for men.

Among adults, sexual abuse was significantly associated with indicators of poor health, heavy drinking, and suicidal tendencies among both genders. Physical health was not associated with abuse for men. The size of the sample is likely an explanation for potential differences not being observable. However, it could also be argued that health is a less accessible 'outlet' for men to express trauma or distress, than for women. A similar pattern was observed for adolescents. Comparable associations were observed for boys and girls with regard to experienced violence and drinking, as well as selected emotional and somatic symptoms of morbidity. While associations between abuse and well-being were found on more indicators for adolescent girls than boys, similar prevalence differences between cases and controls were found for both genders on all parameters. Among adolescent boys, physical health was not correlated with abuse, although here too, the sample size was small. Much gender-aware and sociological research has noted that women are more concerned with, and informed about their own (and others') health compared to men. Perhaps this gendered knowledge is manifest already at this early age. Further and more detailed research is needed to substantiate this hypothesis.

Our results could not definitively support the gendered pattern of behaviour previously observed among survivors of sexual abuse, whereby men are argued to engage in overtly self-destructive behaviour, such as binge drinking or substance abuse and self-directed as well as interpersonal violence, while women are thought to turn their self-harm inwards, in the form of disordered eating, suicide attempts and anxiety disorders.

If the impact of victimisation is reflected in more concrete risk behaviours and symptoms, than in survivors' overall rating of their health, this may have important implications for detecting at-risk adolescents and adults. More specific questions about health and health/illness-related behaviour may need to be asked by the actors in health care, education, and social fora that potential victims will come into contact with at different stages of their lives.

Again, it should be emphasised that we were not attempting to draw a direct comparison between the adult and the adolescent samples in this study. However, an association between abuse and selected health/risk indicators was confirmed in both samples, despite the relatively small number of boys and men. As discussed, the likelihood of a type II error being committed in relation to a number of parametres was probably high in these small samples.

Other, co-occuring forms of child maltreatment have not been taken into account, or controlled for. Previous research based on the Adverse Childhood Experiences (ACE) Study has shown that adverse childhood experiences are correlated and that exposure to one or more ACE significantly increases the risk of later suicide attempts, substance abuse and mental illness (Dube, Anda, Whitfield et al. 2005; Dube, Anda, Felitti et al. 2001). We did not control for family form, adverse family/school experiences or other factors that might render a young person more vulnerable to abuse and subsequent re-victimisation. These covariates may be similar in many instances, to those factors that influence early, and risky sexual behaviour.

Despite design limitations, associations were found between sexual abuse and a number of health indicators for men, as well as women. This indicates that while the prevalence of sexual assault is undoubtedly higher among women, sexual abuse among men and well-being among male survivors is indeed a relevant and distinct issue for research. A potential shortcoming of quantitative research is a limited scope for understanding which factors might influence reporting and disclosure of abuse among men, as well as women. These may include the differing contexts in which violence and abuse can occur, as well as societal taboos surrounding sexual abuse among

adult men in particular. Further research is thus needed to uncover reasons underlying gender differences in reporting of abuse, in order to improve our overall knowledge of gender-specific victimisation and its consequences.

The present study did, however, contribute to an emerging body of evidence that sexual abuse is experienced by men and women, and that different contexts/relationships characterise the abuse for both genders. Furthermore, to the authors' knowledge the present study was one of the few and certainly the first in Denmark to look both at adolescents' and adults' gendered experiences of sexual victimisation within the same study.

CONCLUSION

The present study found that while the reported prevalence of sexual abuse is much higher among women than men, abuse appears to be associated with poor well-being among both men and women. The pattern of association was similar for men and women on a number of variables. However, further research is needed to shed light on potential gender differences in reporting of sexual assault experiences, as well as gender-specific 'outlets' for the impact of victimisation. The knowledge gained about emotional, somatic and behavioural problems among sexually abused men and women may be used in screening by health care providers, while knowledge about risk behaviours associated with sexual assault may be valuable to educational/awareness-raising material aimed at primary prevention among young people, as well as at adults.

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Figure 1. Measure of forced sexual activity. The Danish National Health and Morbidity Survey 2000.

- Have you ever been forced or attempted forced to participate in any form of sexual activity? Tick as many as apply

a. Yes, as a child (under 13 years)

b. Yes, as an adolescent (13-17 years)

c. Yes, at age 18 or older

d. No

Figure 2. Measures of sexual experiences. The Danish Youth Survey 2002.

- The following questions relate to sexual experiences that occurred before you were 15 years old and with a person who was much older than yourself. You should answer yes or no to each question. Have you:

1. Watched an older person masturbating
2. Looked at pornographic magazines or watched pornographic movies with an older person
3. Been kissed or caressed against your will by an older person
4. Been touched in a sexual way on the breasts or elsewhere on your body – but through your clothes
5. Been touched on the genitals through your clothes by an older person
6. Touched the older person's genitals through his/her clothes
7. Had your clothes removed by the older person in an attempt to touch you
8. Experienced the older person removing their clothes in order to have sexual activity with you
9. Been caressed and touched by an older person while you were naked
10. Touched and caressed an older person who was naked
11. Had attempts at intercourse with an older person
12. Had completed intercourse with an older person
13. Had attempts at anal intercourse (in your bum) with an older person

Table 1. Associations between lifetime experiences of forced or attempted forced sexual activity and well-being. Survivors compared to non-victims as controls. Prevalence (P), 95% confidence intervals (95% CI). Danish National Health and Morbidity Survey 2000.

	Men,survivors N=39 P, 95% CI	Men,controls N=78 P, 95 % CI	Women,survivors N=294 P, 95 % CI	Women,controls N=588 P, 95% CI
Poor self-rated health	23(11-39)	10(5-19)	17(13-21)	12(10-15)
Rarely feel well enough to accomplish what you want	21(10-37)	8(3-16)	19(15-24)*	12(10-15)
Often stressed	15(6-31)	8(3-16)	18(14-23)*	10(7-12)
Headache	28(15-45)	26(16-37)	38(33-44)	35(31-39)
Anxiety/sleeping problems/depression	23(11-39)	10(5-19)	25(20-30)*	15(12-18)
Stomach ache	13(4-27)*	1(0-7)	12(8-16)	8(6-11)
Annual sick leave (+16 days)	25(11-45)*	6(1-15)	17(12-22)	11(8-15)
Sleeping medication	3(0-14)	4(1-11)	1(0-4)	1(0-2)
Tranquillisers	8(2-21)	3(0-9)	2(1-5)	1(1-3)
Contact to GP (3 months)	33(19-50)	31(21-42)	46(40-52)	43(39-47)
Psychologist (3 months)	8(2-21)	3(0-9)	4(2-7)	3(2-5)
Avoidance of deserted areas due to fear (often)	8(2-21)*	0(0-5)	21(17-26)	20(17-23)
Violence/threats of violence (past year)	23(11-39)	15(8-25)	14(10-19)*	6(4-8)
Suicide ideation	33(19-51)*	11(5-20)	22(17-27)*	9(7-12)
Suicide attempts	27(14-44)*	1(0-7)	15(11-19)*	3(2-5)
Alcohol consumption (exceeding recommended limit)	26(13-42)*	9(4-18)	11(7-15)*	6(4-8)
Smoking	54(37-70)	39(28-50)	53(47-59)*	33(29-36)

***) Significantly different from the control group (p< 0.05)**

Table 2. Associations between abusive sexual experiences and well-being. Survivors compared to non-victims as controls. Prevalence (P), 95% confidence intervals (95% CI). The Danish Youth Survey 2002.

	Boys, survivors N=27 P, 95% CI	**Boys,controls N=2958 P, 95% CI**	**Girls, survivors N=110 P, 95% CI**	**Girls,controls N=2721 P, 95% CI**
Poor self-rated health	19(6-38)	11(10-13)	34(25-43)*	17(16-18)
Feeling that everything seems overwhelming	35(16-57)	18(17-20)	53(43-63)*	35(33-37)
Depressed/melancholy/lost interest/sleeping problems (almost every day)	75(53-90)*	44(42-46)	85(76-91)*	60(58-62)
Illness (past 2 weeks)	30(14-50)	21(20-23)	32(23-41)	31(29-33)
Experienced violence (past year)	48(28-69)*	12(10-13)	34(25-44)*	8(7-9)
Daily drinking (beer/wine/liquor)	22(9-42)*	4(3-5)	5(1.5-10)*	0.5(0.3-0.8)
Smoking	33(9-42)	17(19-22)	41(32-51)*	20(19-22)

***) Significantly different from the control group (p< 0.05)**

Paper III

Upholding the myth of masculinity: The gendered production of violence victims

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Manuscript submitted to Violence and Victims

Upholding the myth of masculinity: the gendered production of violence victims.

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Abstract

This paper seeks to explore why, although men experience significantly more physical violence than women, they are less likely to be constructed as 'victims' of violence. The paper takes root in recent research findings that violence victimisation is gender-specific in terms of the reported prevalence of violence, as well as associations found between victimisation and health. However, the quantitative nature of this research allowed us to explore victimisation only at the level of material experiences of violence. Thus, it was not possible to explore connections between gender, violence and victimisation. The present paper wishes to draw attention to the ways in which gendered understandings of violence may impact upon the construction of victims. By framing the construction of victims in terms of normative understandings of masculinity and femininity, we considered how physical and sexualised violence might be differentially experienced by men and women. Further, how men's violence might in fact be perpetuated by gendered constructions of victimhood.

Keywords: sexual and physical victimisation, gender, social construction, subjectivity

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Main text: 5.630 words

The aim of this paper is to re-examine the gendered production of victims of violence in relation to male violence, gender and sexuality. Of particular interest are the reasons why men, although they may be 'actual' victims of physical violence are less likely than women to be discursively produced as victims.

Recent survey-based research reports that gender differences in violent victimisation do exist, in terms of the reported prevalence of physical and sexualised violence and in terms of health outcomes associated with victimisation (Sundaram, Helweg-Larsen, Laursen, Bjerregaard, 2004; Sundaram, Laursen & Helweg-Larsen, forthcoming). The findings confirmed previous research (e.g. Newburn & Stanko 1994; Stanko 2002) that men experience more physical victimisation than women. It is widely acknowledged that men and women experience gender-specific types of violence and that the former is characterised by isolated incidents of 'public' violence, whereas the latter is typically repeated and often escalating violence perpetrated by a person known to the woman (e.g. Kelly 1987; Dobash & Dobash 1992; Heise, Pitanguy & Germain 1994; Krantz 2002). Much research has thus concentrated on obtaining information about the risks violence against women poses to the physical, emotional and social well-being of its victims (see Jewkes 2000; Krantz & Ostergren 2000; Campbell 2002; Watts & Zimmerman 2002). The findings of the empirical research on which the present paper is based confirmed that violence was indeed associated with a number of physical and emotional illness symptoms and poor perceived health amongst women. However, the same association between victimisation and health was not seen among men (Sundaram et al. 2004).

While previous studies have pointed out that the specific context, relational dynamic and form of violence against women can explain the severe impact it has on victims' well-being, less research has explored why the context and form of violence that men experience should not

impact upon men's well-being. It is argued in the present paper that this academic void reflects understandings of violence that are shaped by hegemonic constructions of gender, and which in turn impact upon the way in which we construct and view victims of violence.

Studies of masculinity and violence have tended to focus on men primarily as perpetrators of violence, so that the relationship between victimhood and masculinity remains relatively unexplored. Yet men are not only violent towards women, but also towards other men. The present paper sought to problematise this relationship, to consider how constructions of gender (specifically masculinity) inform the production of violence victims. In considering men as 'victims', the paper was neither attempting to downplay the significance of men's violence against women or its consequences, nor saying 'but men suffer violence too'. Rather, the intention was to strengthen the critique of male violence by making the gender of men explicit, by emphasizing that men's violence is a gendered phenomenon whether its victims are men or women.

Feminists have been keen to contest the ideological construction of women as helpless, passive, perpetual victims of male violence. It is argued here that such claims might be more successfully challenged by also analyzing men's violence against other men as gender-based. This way, we can begin to problematise the current construction of victims by revealing how a predominantly gender-blind analysis of men's violence towards men has shaped our understandings of violence, and by implication, of victims. Specifically, how male-on-male violence is legitimated and male victims are subsequently 'unrecognised'.

Men's violence towards other men cannot be seen as existing outside hierarchical gender relations. It is argued that the constructions of masculinity that sustain the gender hierarchy

are bound up with men's violence towards other men, as well as women. As Kimmel (1994) has argued men's violence towards women and towards other men are mediated by, and are constitutive of hegemonic notions of masculinity. Since men are gendered subjects and the primary perpetrators of violence towards other men, it should be self-evident that men's violence towards other men is rooted in existing gender relations. Yet where men are cast as victims of other men this is rarely seen as male violence per se, but as some other form of violence. Thus gay men may be victims of homophobic violence and black men may be victims of racist violence, but it is less often recognised that this is also typically male violence – that racist and homophobic violence are gendered.[3]

Exploring the reasons for and the consequences of this gendered construction of victimhood may help us to resolve the tension between taking violence against women seriously while contesting their inevitable victim status. We may also illuminate the potentially detrimental effects of male violence towards other men by making explicit the constructed nature of victim identifications. It was our contention that victim status is contradictory to dominant understandings of masculinity and this is central to the non-production of men as victims. Conversely, oppositional and hierarchical constructions of gender produce women as inescapable victims. Salient constructions of appropriate sexuality are also integral to the allocation of victim status. We were interested in how norms for (hetero) sexuality variably legitimate and deny victim status to men and women in relation to sexual violence.

The paper thus proposed a cyclical model in which the gendered construction of victims might be understood. Discursive constructions of gender shape our understandings of violence and these logically impact upon our recognition of victims in relation to different types of

[3] Although intersections between sexual, racialized and gendered identities are recognized when women are victimized.

violence. Further, the subjective experience of victimisation may be shaped by the internalisation of scripts for appropriate masculinity and femininity. The gendered construction of victims upholds hegemonic understandings of gender (or the content of gender categories), which in turn may be seen to perpetuate men's violence. In order to explore this argument, we must clarify our position on gender – and its interrelation with sexuality and violence.

Gender and (hetero) sexuality

Gender is understood as a constructed, hierarchical division between men and women that is 'embedded in both social structure and social practice' and is also 'lived and embodied' in terms of cultural understandings of masculinity and femininity (Jackson & Scott 2002: 1-2). The paper wished to examine how the content of oppositional and hierarchical gender categories may produce specific social truths about appropriate (normal) ways of being a man and being a woman.[4] These are in turn understood as impacting upon our views of violence(s) and our thinking about who may be 'recognised' as victims. Furthermore, gender is seen as intersecting with sexuality, which is practiced at the level of individual, subjective experience, but which is also conceptualised as encompassing constructions of normal sexual behaviour, desires and identities for men and women under current gender norms.

Following Jackson (1999; 2006; Jackson & Scott 2002), gender and sexuality were thus seen as being constituted at a number of levels: the structural and institutional, the level of meaning (both discursive and representational), that of everyday interaction and practices and finally, at the level of subjectivity at which we construct ourselves as gendered and sexual beings through our own experiences (Skeggs 1997). At the level of hegemonic cultural discourses,

[4] In this context, the 'normal' is conceptualized as normative, rather than natural (Jackson 2005: 02).

appropriate masculinity is constructed oppositionally to appropriate femininity as being active, dominant, and assertive. Femininity is thus associated with passivity, submissiveness and acquiescence. Thus, the links between gender and (hetero) sexuality across these intersecting levels of construction cement understandings of men and women, masculinity and femininity as binary, hierarchical and oppositional.

The paper acknowledges that while gender may be conceptualised as a binary and relatively 'fixed' division, it does not produce homogenous or static categories of 'man' and 'woman' or 'masculinity' and 'femininity'. As numerous theorists have pointed out, gender intersects with a multitude of social divisions (Kimmel 1994; Ramazanoglu & Holland 2002; Jackson 2006) which inform one's gendered experience, including the experience of power (or lack thereof). In making explicit the power relations that characterise masculinity (Hearn & Collinson 1994) it has to be acknowledged that masculinity is neither static nor timeless and men and masculinities have different meanings and power within different discourses and in relation to one another (Kimmel 1994). Thus, material and discursive representations of masculinities form social divisions within, as well as between societies and cultures.

However, it must acknowledged that unities may also be formed by men practicing various types of masculinity, and that these reflect and reinforce other social divisions (Hearn & Collinson 1994: 105). As Kimmel (1994) has argued, being a man in Western culture is defined 'in opposition to a set of 'others'…and above all, women.' Thus, while some men and masculinities may be subordinated in relation to and by other men and masculinities, it should be acknowledged that some form of collective power may be practiced and enjoyed in relation to less powerful social groups, namely 'women'. The recognition of diverse and historically

shifting masculinities need not be seen as problematic to the analysis however; rather, '…[it gives us] agency, the capacity to act.' (Kimmel 1994: 120).

Previous analysis of gender and heterosexuality has largely been in terms of men's use of violence against women and the function it serves in maintaining male domination over women and sexual access to their bodies. Feminist theorists have analyzed men's violence towards women as serving to confine and control women's movements, and have illuminated the ways in which naturalized gender division and institutionalized heterosexual relations are reinforced and reproduced through men's violence against women (Hanmer & Maynard 1987; Dobash & Dobash 1998).

Relatively little research has been done on how the same gender relations are reproduced and reinforced through men's violence towards other men. It could be argued that this gap reflects a construction of 'men' and 'masculinity' as the norm, against which 'others' are defined and judged. The constructed content of masculinity as part of 'gender' has not been made explicit. The persistence and severity of men's violence against women and its consequences, coupled with the naturalisation of the link between masculinity and violence has thus resulted in a dearth of critical analysis of male on male violence. This, it is argued has obscured the gendered constructions of violence that shape our recognition (or non-recognition) of victims.

Male violence: a 'victimless' crime?

Non-gendered analyses of men's violence (and victimisation) produce and reproduce hegemonic notions of men/masculinity as powerful, active and dominant over another subject. This is evident in much existing research on physical violence, where men's violence towards other men has been constructed as honourable (Walinski-Kiehl 2004), as constitutive of and

signifying masculinity (Kimmel 1994; Hearn 1998; Messerschmidt 2000; Totten 2003). Research on violence in gangs and subcultures, such as juvenile delinquency and hooliganism has analyzed the ways in which this behaviour has reproduced hegemonic 'masculine' values, despite their historical construction as deviant or as a threat to mainstream society (Matza 1964; Pearson 1983). As Matza (1964) pointed out, there was a convergence between pervasive norms of masculinity and the specific qualities valued by gang members such as toughness, courage, defence of and loyalty to one's friends and 'turf.

A relatively recent report on existing knowledge about violence (Stanko 2002) addressed men's violence towards other boys/men. Violence was framed in terms of homophobic violence, violence towards children and racist violence, but not made explicit as gender-based violence. Men were named as 'victims' only in relation to specific forms of abuse, where 'victims' were identified not by gender but in relation to their departure from the norm. Stanko (2002) pointed out that there is a glaring gap in research on male-on-male violence, despite it being the most prevalent form of violence. However, the report did not explicitly problematise men's violence towards other men as a specifically gendered phenomenon or suggest the need to relate current understandings of violence to the 'non-production' of male victims. Further, the way in which men's violence towards other men is labelled (in popular discourse as well as in crime reports), for example drunk lads fighting, football hooliganism and so on, obscures the interrelation of different forms of violence and obscures the gendered basis for the violence occurring (Stanko 2002; Kaufman 1997). Male violence has also primarily been addressed in criminological discourse and theories, which tend to focus on the documentation and prevention of individually located acts of violence committed by individual (non-gendered) actors (Stanko 1994: 33). The present paper argues that this serves to conceal the patterning of violence and its base in specifically gendered social relations.

Relatively more studies have addressed male violence in the context of sexual assault. Many have focused on the characteristics, pathology and motivations of the perpetrator(s) (e.g. Romans & Martin 1997; Messerschmidt 2000; Cohen, Nikiforov, Gans et al. 2002; Stanko 2002; Denov 2003), but increasingly research is being conducted into the consequences of sexual assault for male victims (e.g. Watts & Ellis, 1993; Garnefski & Diekstra, 1997; King, Flisher, Noubary et al. 2004; Shack, Averill, Kopecky et al. 2004; Johnson, Ross, Taylor et al. 2005). Sexual abuse has been linked with severe emotional, behavioural and physical problems among men, indicating that further research on sexual victimisation among men is relevant and necessary. While much feminist work on the reasons for male sexual violence against women has been conducted (e.g. Brownmiller 1975; Kelly 1987; Dworkin 1981), to the authors' knowledge, no analysis of the specifically gendered nature of male on male sexual assault has been done. In other words, how masculinity may be constituted and derided through male sexual victimisation. The very fact of having been assaulted by another male appears to speak for itself, and apparently, little further analysis has been considered necessary. The greater attention to male sexual assault relative to physical victimisation could be argued to reflect the very constructions of violence that this paper sought to problematise – one of physical violence as so legitimated among men (Morgan 1987) that its impact does not warrant academic attention, versus a converse understanding of male sexual assault as abnormal, as indicative of homosexual behaviour and thus as indisputably victimising.

Masculinity, femininity and violence

Heterosexuality as an ideology and as a set of relations only 'works' if men and women conform to prescribed constructions of masculinity and femininity. Thus, being a 'man' only holds social meaning in relation (in opposition) to being a 'woman'. Drawing on Richardson

& May's (1996) concept of 'deserving' and 'less deserving' victims, the project sought to examine how constructions of gender shape our understandings of violence and by implication, of the discursive and subjective constructions of victims. Further, using Simon and Gagnon's (1986) notion of sexual scripts, the paper wished to explore the production of gendered victims in terms of 'scripts' of physical and sexual violence, in which thought and behaviours are gendered and mediated by oppositional constructions of gender, which are institutionalised at the level of discourse and internalised at the level of everyday practices and subjectivity (Marcus 1992; Jackson 2005). It was argued that this conceptualisation would offer great potential for deconstructing social 'truths' about men and women's given positions and self-perceptions in violence scenarios.

In conceptualising oppositional constructions of gender, Kimmel (1994) notes that we tend to think of 'manhood' as static, eternal and innate. As noted earlier in this paper, masculinity however, means different things to different men at different times. Dominant and subordinate masculinity types are formed through practices that perpetuate stratified relationships between men and between men and women (Totten 2003). Masculinities are constructed not only at level of discourse and representation, but are negotiated and internalized through everyday interaction and practice (e.g. Connell 1995). Connell points out that many boys and men have a divided, tense or oppositional relationship to a 'hegemonic masculinity' (Connell 1987, 2000). This is an important fact that is often concealed by the enormous attention given to a stereotype of hyper-masculinity e.g. in the media and popular culture. Alternative practices of masculinity are often culturally discredited or denigrated as wimps, fags, cowards and so on.

The oppositional character of 'gender' implies that subordinate and dominant masculinities are defined more by what one is *not*, than what/who one is, 'leaving masculine gender identity

tenuous and fragile' (Kimmel 1994: 127) and in need of continuous reaffirmation as dominant, in control and powerful relative to 'others' placed lower in the hierarchy. It is argued that an integral aspect of practicing masculinity as it is constituted discursively, as well as through interaction and subjective experiences, is the display of endurance - sometimes conflated with ´toughness´ - the capacity to defend one's bodily integrity. As far back as 1958, Sykes noted in his classic study of prison culture (including prison rape) that 'fortitude and endurance, self-restraint and emotional balance have long been seen as the virtues of the [masculine] hero in a multitude of cultural traditions.' (Sykes 1958: 98). The myth of 'masculinity' as an innate quality of 'men' may thus render a subjugated identification as victim less accessible for men.

The gender construct shapes 'femininity' in opposition to masculinity as relatively powerless, irrational and defenceless. For example, a woman may be regarded as strong and generally receive approval for being capable of physically defending herself, yet she is not necessarily constituted as 'feminine' for this. Normative understandings of 'femininity' position women as being in 'need of protection' from men by other men. Emotional discourses predicated on the essentialised vulnerability and innocence of women have frequently been invoked by men in relation to protecting women and thereby their own honour, which is often connected to a woman's adherence to appropriate norms for gendered behaviour (Lutz & Abu-Lughod 1990). Men have positioned themselves as being the only ones capable of protecting women from other men, thus reinforcing the competitive display of dominance that is constitutive of masculinity(ies). The discursive and material positioning of women as 'naturally' similar to or connected to children has also served to imbue appropriate femininity with connotations of childlike innocence and has served to infantilize women – also in relation to potential violators. It is argued that women are thus idealised into discursive and material

powerlessness, which may impact upon their selfhood as an experienced loss of agency and empowerment.

We now go on to consider how hegemonic constructions, expectations and enactments of gender may shape men and women's subjective experiences of (potential) victimisation, as well as our understandings of violence - which in turn impact upon our identification/recognition of victims.

The script of physical violence

The empirical findings upon which the theoretical argument is based found that physical victimisation was prevalent among men, but was not associated with risks to health. Among women physical victimisation was less prevalent, but significantly associated with a number of illness symptoms. The present analysis suggests that gendered constructions of violence legitimate – and so do not recognise – male on male violence as 'violence' and therefore do not position men as victims in the script of physical violence. Further, hegemonic sexual and gender scripts may be internalised by men, making a relatively powerless identification less operative for male victims.

Kaufman (1994) has argued that men's violence against other men is commonly used as a very visible and direct expression of the need to dominate and show power. Men's violence towards each other and the ever-present potential for using violence reinforces the reality that relations between men are relations of power, of competing masculinities. Violent and aggressive masculinity will rarely be the only form of masculinity present. The hierarchy of masculinities may itself be a source of violence, since force is used in defining and maintaining hierarchy e.g. gay bashing. Kaufman argues that the potential for being subjected

to violence creates an unspoken fear, particularly amongst heterosexual men, that all other men are potential humiliators, competitors in their ability to tear away the façade of manliness. There is therefore a marked and consistent effort to produce and reproduce a narrowly defined hegemonic masculinity both at the level of discourse and representation and at an institutionalized organizational level (Connell 2002). Physical violence may thus be viewed as productive of masculinity even for subordinated men, as their victimisation constitutes them as men, in a hierarchy of masculinities.

However, while the myth of 'masculinity' may dominate the story of men's physical violence towards each other, some men do experience assault and violence without an 'equal' part in the exchange. Men who are assaulted walking home from a night out, mugged, or men who experience random, 'non-consensual' victimization in other, similar scenarios cannot be said to be participating as equally motivated or positioned social actors in a mutually-agreed upon violence script. The victims may suffer extensive injuries and be affected emotionally and psychologically by the assault. However, these men do not come to be discursively produced as, or treated as victims, nor is it encouraged for them to perceive themselves as such.

It is important to consider that victim status defined as weak, powerless or vulnerable, may be a relative concept that is variable depending on the context of the violence and the relative status of the perpetrator to the victim. This has also been suggested by a large body of feminist research on violence against women (e.g. Dobash & Dobash 1980; Edwards 1987; Kelly 1987). It should be noted that naturally, there are multiple ways in which men and women live and experience gendered social lives and just as there may be relatively powerful men, there may also be comparatively powerless men. Some women may experience more social power than some men, across divisions of ethnicity, age, disability, class and so on.

However, the classic connotations of the term victim, such as vulnerability and passivity (Stringer 2001) in many ways parallel the content of socially constructed femininity, and following the oppositional gender divison, it thus stands in contradiction to the content of appropriate 'masculinity'. On a discursive/symbolic level, a 'woman' is thus produced as a natural victim, whereas a 'man' is produced as the antithesis of a victim. The physical and mental consequences of men's violence for male victims may thus be obscured or downplayed by institutionalized and internalized heterosexual norms.

Further, the naturalisation of the link between masculinity and violence legitimates physical violence between men (Morgan 1987), thus rendering it 'unrecognised' as a particular form of violence – and thus, as productive of victims. Moreover, the content of constructed 'masculinity' in opposition to 'femininity' may be argued to impact upon men's subjective recognition of themselves as 'victims'. They may then make sense of their experience in terms of 'crime' or 'fighting' rather than in terms of corporeal victimisation.

Conversely, men's violence towards women is constructed as 'violence' – it is named as such. It is argued that when male violence is framed in relation to an 'other' to the white, heterosexual male norm, the violence is recognised. Thus, the institutionalisation of a hierarchical gender division and of heterosexual relations as the norm is emphasised. However, men's violence towards women may not be universally condemned by men or by women despite its recognition as violence. Drawing on Richardson & May's (1996) conceptualisation of 'deserving' and 'less deserving' victims, it is argued that in some contexts male violence against women may be constituted as 'understandable' and female victims as thus 'less deserving' of their victim status. This construction is also intimately

bound up with notions gender which apply to both the perpetrator and the victim. Thus, violence may be constructed as understandable if 'men' are constructed as being innately more aggressive than women, or as having uncontrollable violent impulses. Violence may also be construed as explainable if the victim is seen as having transgressed the norms of 'her' gender category, for example if she was a 'nag', if she disobedient, if she was drunk and so on. If so, her claim to legitimacy as a victim would be doubted and she might be represented as somehow culpable in the violence perpetrated against her.

Paradoxically, the discursive construction of 'feminine' women positions women as helpless and rather vulnerable to assault by men. Thus, women are simultaneously positioned as being in constant need of men's protection from assault while variably being denied victim status when they are assaulted.[5] As Stanko (1990) has noted, "if people frequent places that are known to be dangerous or they do not follow exactly the rules for precaution, we implicitly hold them responsible for whatever happens to them (Stanko 1990: 49 in Richardson & May 1996: 312). Thus, while female victims of physical violence may be recognised as violence victims, they are not always constituted as 'deserving' of this recognition.

The script of sexual violence

Under notions of masculinity fostered by compulsory heterosexuality, men can only be constructed as 'legitimate' victims in relation to sexual violence by other men[6]. Male sexual assault deviates from the norm both in terms of gender (norms for masculine behaviour) and

[5] It is notable that most violence prevention campaigns focus on reducing 'risky' behaviour among victims, teaching them to be aware of their 'signals' and body language, rather than focusing on the violent behaviour of the perpetrator.

[6] It should be acknowledged that male sexual assault of other men has widely differing meanings depending on the context e.g. within gay male relationships, gay-bashing by heterosexual men, prison rape etc. Here, we focus on the subject of discourse in Western, patriarchal society – the heterosexual male, as it is his fears, interests and perspective that inform the production of legitimate male 'victims' within the rape script.

in terms of sexuality (institutionalisation of heterosexuality as the natural order) – and it may thus be recognised and named as violence. The empirical analysis showed that while women reported a greater prevalence of sexual victimisation, sexual abuse was clearly associated with poor health and risk behaviours, such as heavy drinking and suicide attempts for both genders, in a way that physical violence was not. The present paper argued that sexual victimisation has a different meaning for men and therefore a different impact - and that this difference is gendered and sexualised. Thus, the salience of heterosexual norms for sexual desires and practice renders homosexual behaviour deviant, whether engaged in willingly or not. Binary and oppositional constructions of gender and sexuality discursively position men who are 'done-to' by other men, as 'women'. The sexual assault of men by other men is therefore not viewed as 'understandable' and victims are not viewed as culpable in their victimisation.

The sexual victimisation of men may thus be seen as a specific devaluation of manhood, through the discursive, symbolic and embodied positioning of the victim as a 'woman' by another man. Further, if hegemonic constructions of 'masculinity' are seen as contingent on physical capability to protect one's bodily integrity (using violence is necessary), then male sexual assault may be seen as robbing a man of his physical and discursive power as a man. In a culture shaped by binary constructions of gender, this failure to perform 'masculinity' discursively positions him as a woman. Sykes (1958) found a parallel construction of manhood amongst the prison population. Those inmates that 'failed to be men' participated more or less willingly in homosexual sex, either by preference or in exchange for certain advantages. These men 'turned [themselves] into wom[en]…by the very act of submission' (Sykes 1958: 97). This construction is upheld amongst current male prison populations, as supported by recent research (Robertson 2003).

Interestingly, in Sykes' study, the men that were constructed as 'masculine' despite engaging in homosexual behaviour used the relationship as little more than a 'casual, mechanical act of physical release.' (Sykes 1958: 97). The naturalization of male sexual attraction to women renders homosexual behaviour perverse, unless the men are acting on their 'natural' male 'impulses' to penetrate and ejaculate – here, they use male bodies since they are cut off from female bodies in the prison world. The construction of heterosexual masculinity as active and dominant over 'feminine', passive sexuality allows heterosexual men to engage in an 'active' role in consensual homosexual behaviour without their heterosexuality - or masculinity - being questioned.

Male sexual violence towards other men is not constructed as gendered (male) violence and has not often been analyzed in terms of the production and upholding of hegemonic masculinity and correspondingly, the derision of the feminine. Rather, the violence is constructed as inexplicable and as deviant, and is thus viewed as productive of 'deserving' victims. The raped party can thus also be produced as the victim of an 'abnormal' situation, unlike in the script of physical violence.

Conversely, the language of rape and of an all-encompassing, powerful masculinity calls for women to position themselves as helpless, violable and fearful in relation to a potential attacker. Correspondingly, women are constructed as inescapably vulnerable to potential assault, even before the rape has occurred. Thus, discursive constructions of sexuality structure physical action and responses, as well as words and thoughts in the woman's feelings of powerlessness and helplessness in relation to a potential attacker, as well as the would-be rapist's feelings of power (potency) vis a vis his victim (e.g. Scully 1990).

Masculine power and feminine powerlessness neither exist as inherent characteristics of men and women, nor simply cause or precede rape (or any other form of violence). The rapist does not simply possess the power to rape, but the discourse of gender and of victims help to create the rapist's power. This is not to diminish the material fact of being victimized by the real experience of rape or sexual assault. Rather, we draw attention to the discursive, pre-emptive positioning of women as victims, which has material effects on their self-perception and perceived ability for resistance and subversion of the 'prewritten' script.

As Richardson & May (1996) suggest, constructions of violence are also sexualised. Thus, the transgression of norms for appropriate sexual practice, desires and identities may warrant punishment by violence. As the violence is perpetrated towards a sexual 'other' to the heterosexual male norm, it is therefore named as violence. However, victims of sexualised violence may still be constituted as culpable in the violence towards them if the abuse is constructed as understandable in relation to their deviance from gendered and sexualised norms. Again, the contradictory positon of female victims may be illustrated – they are simultaneously constituted as inevitably vulnerable, and as 'undeserving' of their status as non-culpable victims. The dualistic construction here also hinges on gendered perceptions of the characteristics of the perpetrator (the myth of an uncontrollable male sex drive or the man's right to sex if a woman has been 'leading him on') and the perceived characteristics of the victim (she was sexually assertive, flirting, intoxicated, walking in a deserted area on her own and so on). These perceptions are obviously intimately connected to prevailing constructions for appropriate femininity and masculinity, which are institutionalised at the level of structure as well as in discourse, and in people's everyday interactions.

Conclusion

The paper has argued that violence victimisation may be constituted as gender-specific on two levels: that of material victimisation and that of the construction of victims. Taking root in empirical analysis of the former, the present paper has argued that the latter is both contingent on, and perpetuates oppositional and hierarchical constructions of gender and of appropriate sexuality.

It has been proposed that 'gender' is salient in shaping our understandings of violence and of some forms of violence as more or less understandable or explainable. These constructions in turn impact upon our recognition of 'victims' in relation to different violences. Further, it has been proposed that prevailing constructions of masculinity and femininity impact on the construction of 'victims' itself, as well as on men and women's self-perceptions in relation to victim identification. It is suggested that the gendered (and sexualised) construction of victims may be one way in which to understand the differential outcomes seen among male and female victims of violence, as well as gendered outcomes observed in relation to specific types of violence. The empirical findings suggest that sexual victimisation is not characterised by an identical relational dynamic among men and women. Similar power differences between perpetrator and victims among men and women cannot therefore wholly explain the similarities seen in the associations between abuse and health, as has previously been suggested could explain the difference seen for physical victimisation (e.g. Dobash & Dobash 1992).

While surveys are useful instruments with which to obtain information on health problems associated with violence, future research could consider illuminating the impact of physical violence for men in alternative ways. Health may not be the most accessible outlet for men to

express trauma or distress and the present paper argues that physical violence might have a different impact on men's subjective experiences of gender identity and of victimisation than sexual assault. Future studies may thus need to look at other indicators with which to measure the relationship between physical victimisation and negative outcomes for men, as well to investigate the factors that differentiate experiences characterised as 'just a fight' from truly victimising ones.

It is argued that current constructions of masculinity as the norm must be disrupted and challenged in order to contribute to violence prevention. Gender analysis needs to be applied to men and to their violences towards each other, as well as towards women. Failing this, current constructions of gender will continue to be upheld and men's violences will be perpetuated. We have aimed to explore the ways in which the gendered construction of victims may continue to perpetuate oppressive gender and power hierarchies, which in turn legitimate and deny different forms of men's violence and obscure its potential consequences. Additionally, we have wished to contribute to the deconstruction of social 'truths' about women's and men's positions in relation to physical and sexual violence, questioning the inevitable vulnerability and defencelessness of women in the face of assault and their subsequent abiding identification as damaged and traumatized. Similarly, the positioning of men as victimised only in relation to sexual assault perpetuates notions of 'normal' masculinity and men as dominant and physically invincible and of heterosexual relations as the norm. If femininity as a weak and subjugated identity only has meaning in opposition to masculinity, then it is our current constructions of masculinity that must be disrupted and challenged in a strategy for change.

The gendered process of violence victimisation on a structural level may thus be illuminated through quantitative evidence. However, these findings cannot fully explain the discursive and representational construction of victims in relation to different and gendered forms of violence. More systematic research is needed to elaborate these ideas further, not only quantitative work, which we took as our starting point, but qualitative research exploring the gendered meanings of violence as it is experienced and practiced in everyday life.

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