Hitting Back: Women's use of physical violence against violent male partners, in the context of a violent episode

J Interpers Violence published online 11 November 2014
(DOI: 10.1177/0886260514555010)

Janet L Fanslow, Social and Community Health, School of Population Health, University of Auckland, Auckland, New Zealand.

Pauline Gulliver, New Zealand Family Violence Clearinghouse, School of Population Health, University of Auckland, Auckland, New Zealand.

Robyn Dixon, School of Nursing, Faculty of Medical and Health Sciences, University of Auckland, Auckland, New Zealand.

Irene Ayallo, Social and Community Health, School of Population Health, University of Auckland, Auckland, New Zealand.

Postal Address:
University of Auckland
Private Bag 92019
Auckland, New Zealand 1142

Corresponding author:
Janet L Fanslow
Social and Community Health
School of Population Health
University of Auckland
Private Bag 92019
Auckland, New Zealand 1142

Phone: + 64 9 923-6907
Fax: + 64 9 303-5932
Email: j.fanslow@auckland.ac.nz

Hitting Back: Women's use of physical violence against violent male partners, in the context of a violent episode

Abstract

This paper explores women's use of physical violence in the context of experiencing intimate partner violence. Data were drawn from the New Zealand Violence Against Women Study, a cross-sectional household survey conducted using a population-based cluster sampling scheme. Multinomial logistic regression was used to identify factors associated with women's use of physical violence against their partners when they were being physically hurt. Of the 843 women who had experienced physical violence perpetrated by an intimate partner, 64% reported fighting back at least once or twice while 36% never fought back. Analyses showed that women's use of violence more than once or twice was associated with experience of severe IPV, IPV that had 'a lot of effect' on their mental health, and with children being present when the woman was being physically abused. Women's use of physical violence only once or twice was associated with both partners having alcohol problems and both having been exposed to violence as a child. Of the women who fought back, 66% reported that this did not result in the violence stopping.

Key words: intimate partner violence, women's use of violence, factors associated with women's use of violence

Intimate partner violence (IPV) describes any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. IPV occurs across all socioeconomic, religious and cultural groups (World Health Organization, 2013; World Health Organization/London School of Hygiene and Tropical Medicine, 2010). The overwhelming global burden of IPV is borne by women, with approximately 30% of women experiencing physical or sexual IPV (World Health Organisation, 2013). However, there is a body of research that suggests symmetry in the perpetration and experience of IPV by both men and women (see (Dobash & Dobash, 2004) for a review of the debate in this area).

Respondents that took part in the WHO Multi-Country study of Violence Against Women (2005) were asked how they had responded to the physical IPV they had experienced. Of those women who reported that their partner had been physically violent to them, between 6% (in Ethiopia and Bangladesh provinces) and 79% of women (in Brazil city) reported that at some time they had fought back against their partner. Women who had experienced severe physical violence were more likely to "hit back" than women who experienced moderate violence (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005).

A number of motivations for using violence have been identified within the international literature, including self-defence, fear, defence of children, control and retribution (see Swan and Snow, 2006, for a comprehensive exploration of the literature in this area). Women who live in socio-economically deprived areas are more likely to experience violence from an intimate partner as well as being more likely to use violence (Benson, Fox, DeMaris, & Van Wyk, 2003). Indeed, once socio-economic differences are accounted for, the majority of the difference in prevalence of violence between cultural groups is also accounted for (S. C. Swan & Snow, 2006).

In 2002, Worcester challenged the research community to take the issue of women's use of violence seriously, and to be open to the concept that women and girls are learning that violence is *"an effective way to have power in a society that often limits their opportunity for healthy control in their own lives"* (Worcester, 2002). Swan and Snow's seminal paper on the development of a theoretical understanding of women's use of violence highlights the importance of understanding this phenomenon within the context of women's victimisation by male partners as well as the historical context of women's experiences of childhood trauma. They highlight the need to study women's violence within social, cultural and historical contexts, also acknowledging the potential impact of mental health disorders (S. C. Swan & Snow, 2006).

Dobash and Dobash (2004) also highlight the need to understand women's use of violence in the context of violence they have experienced by men. From their investigation of IPV reported by couples, Dobash and Dobash documented that the violence experienced by men generally (although not always) had inconsequential emotional impact, resulted in less severe injuries, and was experienced in the context of self-defence or self-protection. The violence rarely affected the men's sense of safety or well-being. The authors suggested that their findings made it impossible to construe *"the violence of men and women as either equivalent or reciprocal"* (Dobash & Dobash, 2004).

This investigation of women's use of violence occurs within the context of research on intimate partner violence (IPV) perpetrated by men over their female partners (García-Moreno, et al., 2005; Walters, et al., 2013; World Health Organization/London School of Hygiene and Tropical Medicine, 2010). In this study we sought to develop an understanding of the factors associated with women's use of violence in the context of a violence situation. By focussing on women who were currently experiencing violence, we sought to contextualise this use of violence in an acknowledgement that the use of violence when confronted with the reality of experiencing violence is likely to have

different determinants than the use of violence outside of a violence situation. Using data from a population-based sample of New Zealand women, the current study sought to identify factors associated with the likelihood that a woman will use physical violence in response to IPV.

METHODS

Study Design

The data reported is from the New Zealand Violence Against Women Study, a cross-sectional survey conducted by the School of Population Health at the University of Auckland. This study replicated the WHO Multi-Country Study on Women's Health and Domestic Violence (García-Moreno, et al., 2005).

Setting and sampling strategy

A population-based cluster-sampling approach with a fixed number of dwellings per cluster was used. The interviews were conducted in the Territorial Local Authorities (TLA) of: Auckland City, Manukau City, Waitakere City, North Shore City (Auckland), Hauraki, Matamata-Piako, Waikato and Waipa Districts (Waikato). Meshblocks were the primary sampling unit within each TLA. Within each meshblock a randomly selected street and street number was used as the starting point for interviews. Interviewers approached 10 households within each meshblock. In Auckland, interviewers approached every 4th house; in the Waikato, interviewers approached every second household.

Recruitment and Participants

The study population for the current investigation was women aged 18-64 years, who were usually resident in Auckland or North Waikato and who resided in private homes. Recruitment took place over the period March to November, 2003.

In selected households with more than one eligible respondent, one woman was randomly selected. If the woman selected was available to talk, consent was sought and an interview arranged, otherwise contact details were obtained and further attempts made to set up an interview. To maximise the chance of obtaining an interview, a minimum of three return visits were made to each household at different times and on different days. The interview was conducted in the woman's home in a room without where no other people over 2 years of age were present. If the interview was interrupted the interviewer switched to a neutral subject (such as nutrition) to ensure the safety of the study participant.

In total 2,855 women agreed to be interviewed. This study uses the data from 843 women who reported they had experienced physical violence by an intimate partner sometime in their lifetime and who provided useable information in response to the question about use of violence in the context of IPV (see *Measures and variables* below).

Questionnaire development

The base questionnaire was developed by the Core Technical Team of the WHO Multi-country study on Women's Health and Domestic Violence (Core Technical Team, 2003). Minor modifications were made to increase the appropriateness to the New Zealand context, and the revised questionnaire was pilot tested for acceptability. The questionnaire was produced in English and Chinese, as Mandarin/Cantonese speakers were the largest group that could not complete the questionnaire in English. Multi-lingual interviewers were used to conduct the Chinese interviews.

The questionnaire was administered as a face-to-face interview, in the participants own home, or other private location. The study received approval from the University of Auckland Human Subjects Ethics Committee (Ref 2002/199).

Measures and variables

Consistent with definitions from the WHO Multi-Country Study (2005), intimate partners included male current or ex-partners that the women were married to or had lived with, or current male sexual partners. Where the respondent was divorced or separated from her partner, she was asked to consider the most recent or last partner when responding. Information on the variables was collected from the respondent only. All information gathered about the partner, intimate partner violence experienced and use of violence in the context of experiencing violence were related to the respondent's current or most recent partner (if they were no longer with their partner).

Main outcome measure

To identify variables that were associated with the respondent using physical violence when she had experienced IPV, participants were asked the following questions: "During the times that you were hit, did you ever fight back physically or to defend yourself?" Participants who answered YES were then asked: "How often? Would you say once or twice, several times, or most of the time?" For the purposes of the current investigation those who responded *several times* or *most of the time* were grouped together. *Don't know* or *can't remember* were treated as missing data (n=114, 12%).

Associated measures

For the purposes of the current investigation, the age of the respondent was dichotomised to those who were under 25 years and those who were 25 years or older. Respondents also reported the ethnic group/s they identified with. For the purposes of analysis, reported ethnicity was prioritised as (i) Maori; (ii) Pacific Island; (iii) Asian; (iv)Other; (v) European.

Duration of the relationship: Respondents were asked to report how long they had been in a relationship with their current (or most recent) partner. Responses were categorised as <1 year; 1-5 years; >5 years.

Severity of physical IPV: Violence was categorised as moderate or severe. Moderate IPV was defined as: having been slapped or had something thrown at them which could hurt them; having been pushed, shoved, or had their hair pulled. Severe physical IPV was defined as: having been hit with the fist or something else that could hurt them; having been kicked, dragged, or beaten up; having been choked or burnt on purpose; or having been threatened with or had used against them a gun, knife or other weapon.

Children present during abuse: If women indicated that they had children, they were asked: "For any of these incidents, were your children present or did they overhear you being beaten". Those who answered YES were asked: "How often? Response options were "once or twice", "several times" or most of the time?"

Effect on mental health: Women were asked to denote the impact of their partner's violent behaviour on their mental health as either "it has had no effect", "a little effect" or "a lot of effect".

Alcohol problems: Respondents were asked whether, in the past 12 months, they or their partner had experienced any of the following problems related to their drinking: money problems, health problems, conflict with family or friends, problems with authorities or other problems. Response options were coded as: neither had problems, respondent only, partner only, both had problems.

Exposure to IPV in childhood: Exposure to violence as a child was assessed by the question: "When you were a child, was your mother hit by your father (or her husband or boyfriend)?" And "As far as you know, was your (most recent) partner's mother hit or beaten by her husband?" Based on the responses to both of these questions, exposure to IPV in childhood was categorised as "your mother", "his mother", "both mothers", or "neither mother".

Analysis

All analyses were conducted using StataSE 11.2., which allows for specification of the survey sampling units and strata. As responses were similar in the two locations, data for the two regions was combined. *Don't know*, *don't remember*, refused and no answer responses were considered 'missing data'. Missing values were excluded from the analyses.

In the first instance descriptive statistics were generated. In order to identify factors associated with use of physical violence when controlling for age and ethnicity, multinomial logistic regression was conducted. Multinomial logistic regression is an extension of binary logistic regression (used for binary outcome variables), allowing more than two categories for the outcome measure. Odds ratios were considered significant where the confidence interval did not pass through 1.

RESULTS

Overall prevalence of women fighting back in response to physical IPV

Of the 843 study members who had experienced physical IPV and reported whether they had used violence in the context of IPV, 307 (36%) reported that they never fought back, 257 (31%) reported that they fought back once or twice, while 279 (33%) reported that they fought back more than once or twice. The relationship between each associated variable and the number of times respondents reported fighting back in response to physical IPV are presented in Table 1. Odds ratios for each of these variables are presented in Table 2.

At the bivariate level, women who were older than 25 years were less likely than younger women to report hitting back once or twice. Compared to women who were Maori, those who were European or of 'Other' ethnicities were less likely to report hitting back more than once or twice (Table 2).

Compared with those who experienced moderate violence, those who experienced severe violence were more likely to report hitting back either once or twice or more frequently. When there were children present during the abuse, there was an increased likelihood of a woman reporting that she had hit back more than once or twice. There was also a significant relationship between the woman's perceived effect of the abuse on her mental health – when she reported that the abuse had a lot of effect there was increased likelihood of hitting back either once or twice or more frequently (Table 2).

Compared with women who had not experienced IPV in childhood, those who had (either independently or if their partner had also experienced IPV in childhood) were more likely to report that they hit back more than once or twice (Table 2).

Table 1: The number and percentage of women who experienced physical IPV by the number of times they fought back, as a function of demographic, health and family variables

	Never		Once or twice		More than once or twice	
	N	%	N	%	N	%
Age (n=843)						
< 25 years	11	21	24	45	18	34
>= 25 years	296	37	233	29	261	33
Ethnicity (n=843)						
Maori	46	24	58	30	87	46
Pacific Island	15	29	22	42	15	29
Asian	5	33	7	47	3	20
European	198	46	140	29	150	31
Other	43	44	30	31	24	25
Length of relationship (n=843)						
< 1 year	13	36	8	22	15	42
1-5 years	39	30	46	35	46	35
>5 years	255	38	203	30	218	32
Severity (n=839)						
Moderate	143	48	100	34	54	18
Severe	159	30	156	29	224	42
Children present during abuse (n=665)						
Never	121	41	99	34	75	25
Once or twice	67	42	57	36	36	23
Several times	24	22	21	19	63	58
Many/most of the time	23	23	21	21	58	57
Effect of abuse on mental health (n=839)						
No effect	126	46	81	29	68	25
A little	96	39	75	31	74	30
A lot	85	27	99	31	135	42
Alcohol problems (n=843)						
Neither	236	39	177	29	191	32
Her only	14	26	18	33	22	41
Him only	49	33	47	32	52	35
Both	8	22	15	41	14	38
Exposure to IPV in Childhood (n=843)						
Neither	190	41	133	28	146	31
Her only	50	29	54	31	70	40
Him only	44	35	45	36	35	28
Both	23	30	25	33	28	37

Table 2: Univariate analyses - showing factors associated with the women's use of physical violence in response to physical IPV by an intimate partner

	Never	Once or twice		More than once or twice	
	OR	OR	95% CI	OR	95% CI
Age					
< 25 years	Ref				
>= 25 years	Ref	0.4	0.2-0.9	0.6	0.3-1.6
Ethnicity					
Maori	Ref				
Pacific Island	Ref	1.16	0.5-2.7	0.51	0.2-1.2
Asian	Ref	1.11	0.3-3.9	0.31	0.1-1.5
European	Ref	0.51	0.3-1.0	0.32	0.2-0.6
Other	Ref	0.54	0.3-0.9	0.40	0.3-0.6
Length of relationship					
< 1 year	Ref				
1-5 years	Ref	1.8	0.7-4.9	1.3	0.5-3.2
> 5 years	Ref	1.1	0.4-2.5	0.7	0.3-1.6
Severity					
Moderate	Ref				
Severe	Ref	1.4	1.0-2.0	3.8	2.6-5.8
Children present during abuse					
Never	Ref				
Once or twice	Ref	1.0	0.6-1.6	0.9	0.5-1.6
Several times	Ref	1.2	0.6-2.3	4.9	2.8-8.7
Many/Most of the time	Ref	1.0	0.5-2.0	4.5	2.5-8.4
Effect of abuse on mental health					
No effect	Ref				
A little	Ref	1.2	0.8-1.9	1.6	1.0-2.5
A lot	Ref	1.9	1.2-2.9	3.3	2.1-5.0
Alcohol problems					
Neither	Ref				
Her only	Ref	1.4	0.6-3.3	1.5	0.7-3.3
Him only	Ref	1.5	0.9-2.4	1.4	0.9-2.3
Both	Ref	3.2	1.3-8.0	2.1	0.8-5.3
Exposure to IPV in Childhood					
Neither	Ref				
Her only	Ref	1.5	0.9-2.5	1.9	1.2-3.0
Him only	Ref	1.5	0.9-2.4	1.2	0.7-2.1
Both	Ref	1.6	0.9-3.1	2.1	1.1-4.0

Factors with significant, independent relationship with women fighting back in response to physical IPV

We sought to control for the effect of age and ethnicity in the logistic regression because of the association between these variables and the experience of IPV, which, in turn, is strongly associated with likelihood of fighting back. The multinomial logistic regression is presented in Table 3 (adjusting for age and ethnicity).

Women's use of violence against her partner on one occasion was associated with the severity of the abuse experienced (OR (severe) = 1.4, 95%CI 1.0-2.0), the effect of her partner's behaviour on her mental health (OR (a lot) = 2.0, 95%CI 1.3-3.1) and both partners having alcohol problems (OR (both) = 3.2; 95% CI 1.3-8.0).

Women's use of violence more than once or twicewas associated with the severity of IPV she experienced ('severe' compared with 'moderate': OR = 3.5; 95% CI 2.3-5.3), the presence of children during the abuse (OR (many/most of the time) = 4.7, 95%CI 2.5-8.8) and the effect of their partner's behaviour on their mental health (OR (a lot) = 3.5, 95%CI 2.2-5.5).

Table 3: Multivariate analyses (adjusting for age and ethnicity) - showing factors that had a significant, independent relationship with the women's use of physical violence in response to physical violence by an intimate partner

	Never	Once or twice		More than once or twice	
	AOR	AOR	95% CI	AOR	95% CI
Length of relationship					
< 1 year	Ref				
1-5 years	Ref	2.1	0.7-6.1	1.2	0.5-2.9
> 5 years	Ref	1.6	0.6-4.4	0.8	0.4-1.8
Severity					
Moderate	Ref				
Severe	Ref	1.4	1.0-2.0	3.5	2.3-5.3
Children present during abuse					
Never	Ref				
Once or twice	Ref	1.0	0.6-1.7	0.9	0.5-1.6
Several times	Ref	1.2	0.6-2.5	5.1	2.9-9.0
Many/Most of the time	Ref	1.1	0.5-2.1	4.7	2.5-8.8
Effect of abuse on mental health					
No effect	Ref				
A little	Ref	1.3	0.8-1.9	1.7	1.1-2.8
A lot	Ref	2.0	1.3-3.1	3.5	2.2-5.5
Alcohol problems					
Neither	Ref				
Her only	Ref	1.4	0.3-3.3	1.5	0.7-3.3
Him only	Ref	1.5	0.9-2.4	1.4	0.9-2.3
Both	Ref	3.2	1.3-8.0	2.1	0.8-5.3
Exposure to IPV in Childhood					
Neither	Ref				
Her only	Ref	1.3	0.8-2.2	1.6	1.0-2.6
Him only	Ref	1.3	0.8-2.1	1.1	0.6-1.8
Both	Ref	1.4	0.7-2.6	1.7	0.9-3.3

Effects of women fighting back in response to physical IPV

Of those who reported that they had used violence in response to being physically abused, 38% indicated that the violence they suffered had subsequently become worse, while 32% indicated that the violence stopped. Only 9% of respondents indicated that the violence decreased, while the remainder indicated that there was no change in the violence they experienced (19%).

DISCUSSION

This study provides information on factors associated with women's use of violence against their male partner or ex-partner, in the context of a violent episode (when he was perpetrating violence

against her), using data from a large cross-sectional study of women in New Zealand. This information contributes to our understanding of the variables most strongly associated with women's use of violence in response to physical violence by their male partner.

S Overall, just over one third of women who experienced physical violence by an intimate partner, reported that they never used physical violence against him. Almost one third reporting using violence in the context of a violent episode once or twice, and one third indicated that they had used physical violence against their violent partner more than once or twice.
Relative to respondents who described themselves as being of Maori ethnicity, women from European and 'Other' ethnic groups were less likely to report having fought back more than 'once or twice' occasion (Table 2). Compared with other countries, the proportion of New Zealand women who had experienced IPV and fought back at least once was mid-range, (64% compared with other countries surveyed in the WHO Multi-Country Study; range 6% in Ethiopia and Bangladesh provinces to more than 80% in Brazil and Peru).

Factors that increased the likelihood that a women would use of violence more than once or twice against their partner during a violent episode include the severity of the violence she had experienced, with those who had experienced more severe violence more than three times more likely to fight back. This finding is comparable to international data (García-Moreno, et al., 2005), and is consistent with the finding that one of the most common motivations for women's use violence is for the purpose of self-defense (Swan & Snow, 2006; Swan et al 2008). .

The presence of children also strongly influenced the woman's likelihood of fighting back, with women five times more likely to use violence against her male partner more than once or twice if the a child was present (Table 3), suggesting that the woman may be using violence in defense of her children, a finding also reported by others in the literature (Swan & Snow, 2006; Swan et al 200). .

This perception of threat is not exaggerated. The National Survey of Children's Exposure to Violence (NatSCEV) (a nationally representative telephone survey of the victimization experiences of 4,549 youth aged 0-17 living in the contiguous United States) found a strong connection between IPV and abuse of children by the same perpetrator. Children living with an abused mother were 12 to 14 times more likely to be physically and sexually abused than children whose mothers were not abused (Hamby, Finkelhor, Turner, & Ormrod, 2010).

Understanding a woman's increased likelihood of using violence against her partner when he is hurting her requires consideration of her history of violent experiences, across several consecutive relationships, including if she was exposed to violence as a child (Dasgupta, 1999). These experiences are likely to have influenced her perception of danger and response to danger. As such, her actions of fighting back are triggered by the memory of abuse and / or fear for her children (Dasgupta, 2002). In an investigation into woman's use of violence in intimate relationships, Watson (2000) reported that all of the women in her study had been victims of abuse as a child, and the majority had been exposed to IPV between their parents. Seamans et al. (2007) reported that women who have been victims of childhood abuse and of subsequent intimate partner violence vividly remembered their own mother's exposure to violence and vowed not to be anything like their mothers, "and most of all, not to be a victim" (p. 55).

Respondents in the current investigation who indicated that their partner's behaviour had 'a lot' of effect on their mental health were more likely to report fighting back. Previous studies have widely recognised mental health problems such as depression, stress-related syndromes, chemical dependency and substance (ab)use, and suicide as important primary outcomes of abuse rather than precursors (Ehrensaft, Moffitt, & Caspi, 2006; Fischbach & Herbert, 1997; García-Moreno, et al., 2005). Although it was not possible in this cross-sectional survey to demonstrate causality between violence and mental health problems or other outcomes, the findings give a strong indication that mental health outcomes are associated with women's use of violence in intimate partner

relationships. In-depth analysis into the complex relationship between violence and mental health is required in order to develop relevant services and responses to abused women with co-occurring problems (Hager, 2011).

Our findings on the relationship between problem alcohol consumption and likelihood of hitting back were complex. We identified no significant relationship if only the respondent or her partner experienced problems related to their alcohol problems. However, if both the respondent and her partner experienced problems, there was an increased likelihood that she would have hit back once or twice, but not more frequently. Alcohol consumption makes it harder to resolve conflicts peacefully by enhancing the likelihood of verbal and non-verbal cues being misinterpreted (Hoaken, Assaad, & Pihl, 1998; Klostermann & Fals-Stewart, 2006). We hypothesise that when exposed to alcohol-related violence, alcohol consumption may enhance the likelihood of a woman hitting back, but that this may result in further violence being experienced, and therefore reducing the likelihood that the woman will react this way again in the future. As highlighted by Heise, several inter-related pathways are likely to exist about how alcohol increases the risk of partner violence, and despite difficulties understanding the relationship between alcohol consumption and violence exposure, evidence exists concerning the effectiveness of treatment for alcohol problems in reducing the frequency and severity of abuse (Heise, 2011).

In line with previous research that indicates that in most of cases the use of violent strategies has little to no effect on the violence perpetrated (Downs, Rindels, & Atkinson, 2007), half of the women who reported fighting back indicated that violence did not stop. A possible explanation for this is provided by Bair-Merritt et al., (2010) who argue that, in Western societies (including New Zealand), IPV occurs in a societal context in which men generally have more physical and social power than women, and women are socialised to assume a more passive role than men. Women,

therefore, are unlikely to be successful in changing their partners' violence, even with the use of physical violence.

Strengths and Limitations of Study

There are several limitations which need to be considered with respect to the reported findings. In the first instance, the cross-sectional design does not permit causal attributions to be made, such as between violence by an intimate partner and the reported outcomes. A second limitation is that, like any study based on self-report, there may be recall bias on some issues as well as biases in disclosure. Finally, all the women in this study experienced physical IPV by an intimate partner, so this study does not provide information on women's use of violence in situations where her male partner has not used any violence.

Despite these limitations, the present study's findings provide new information on women's use of violence in the context of IPV victimization. Furthermore, the robust strategy and high response rate obtained by the New Zealand Violence Against Women Study provide confidence that the results are representative of women who use violence in response to physical IPV by an intimate partner. The replication of questions from the WHO Multi-Country Study also attests to the study's rigour, and allows international comparisons to be made.

Implications

Information from the present study contributes to our understanding of factors associated with women's use of physical violence while experiencing physical IPV. Exploration of these factors reminds us not to unfairly shut out these women from services due to their apparent 'abusiveness', and points to the need to develop appropriate services and policies in response. Specifically, it is important to understand that because the woman's violence occurred within the context of her own victimization, she is unlikely to cease her own use of violence until her partner's violence towards

her stops. She also requires treatment for the physical, psychological, and mental injuries suffered, and assurance that her children are safe (Campbell, 2002; Hager, 2011; Hamby, et al., 2010; Hamby, Finkelhor, Turner, & Ormrod, 2011; Suzanne C. Swan, Gambone, Fields, Sullivan, & Snow, 2005). Additionally, given the overlap between violence against women and child abuse, there is a need for increased efforts to integrate and coordinate policies and services responding to abused women and their children (who witness or experience actual abuse) (Hamby, et al., 2010). Fragmenting these services and policies will limit their ability to provide adequate safety to all survivors of violence in a family.

Practitioners working with women use violence need to be aware of their vulnerability. Although their fighting back has been found to be a strategy for coping and 'escaping' violence by their intimate partner (García-Moreno, et al., 2005), such actions have also been found to have limited effect on the violence, and it may actually increase their vulnerability, as the male partner is likely to respond with an escalation of his violence (Dowd & Leisring, 2008). Practitioners can support women by ensuring appropriate organisational support and safety is provided and by helping women develop non- violent protective strategies which target their safety and that of their children.

References

Benson, M., Fox, G., DeMaris, A., & Van Wyk, J. (2003). Neighborhood disadvantage, individual economic distress and violence against women in intimate relationships. *Journal of Quantitative Criminology, 19*, 207-235.

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*(9314), 1331-1336.

Core Technical Team. (2003). *WHO Multi-country study on violence against women, Questionnaire, version 10*. Geneva: WHO: Gender and Health Department.

Dasgupta, S. D. (1999). Just like men? A critical view of violence by women. In M. F. Shepard & E. L. Pence (Eds.), *Coordinating community responses to domestic violence: Lessons from Duluth and beyond* (pp. 195-222). Thousand Oaks, CA: Sage.

Dasgupta, S. D. (2002). A framework for understanding women's use of nonlethal violence in intimate heterosexual relationships. *Violence Against Women, 8*(11), 1364-1389.

Dobash, R. P., & Dobash, R. E. (2004). Women's violence to men in intimate relationships. *British Journal of Criminology, 44*, 324-349.

Dowd, L., & Leisring, P. A. (2008). A Framework for Treating Partner Aggressive Women. *Violence and Victims, 23*(2), 249-263.

Downs, W. R., Rindels, B., & Atkinson, C. (2007). Women's Use of Physical and Nonphysical Self-Defense Strategies During Incidents of Partner Violence. *Violence Against Women, 13*(1), 28-45.

Ehrensaft, M. K., Moffitt, T. E., & Caspi, A. (2006). Is Domestic Violence Followed by an Increased Risk of Psychiatric Disorders Among Women But Not Among Men? A Longitudinal Cohort Study *Am J Psychiatry, 163*, 885-892.

Fischbach, R. L., & Herbert, B. (1997). Domestic violence and mental health: Correlates and conundrums within and across cultures. *Social Science & Medicine, 45*(8), 1161-1176.

García-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO Multi-country Study on Women's Health and Domestic Violence against Women: Initial results on prevalence, health outcomes and women's responses*. Geneva: World Health Organization.

Hager, D. (2011). *Finding safety: provision of specialised domestic violence and refuge services for women who currently find it difficult to access mainstream services: disabled women, older women, sex workers and women with mental illness and/or drug and alcohol problems as a result of domestic violence*. Wellington, NZ: Winston Churchill Memorial Trust. Retrieved from

http://www.communitymatters.govt.nz/vwluResources/WCMFReport10Hager/$file/WCMFReport10Hager.pdf

Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2010). The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth. *Child abuse & neglect, 34*(10), 734-741.

Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2011). *Children's exposure to intimate partner violence and other family violence*. Washington, DC: U.S. Government Printing Office. (CV197).

Heise, L. (2011). *What works to prevent partner violence? An evidence overview*. London: London School of Hygiene and Tropical Medicine. Retrieved from http://strive.lshtm.ac.uk/system/files/attachments/Heise%20Partner%20Violence%20evidence%20overview_0.pdf

Hoaken, P. N. S., Assaad, J. M., & Pihl, R. O. (1998). Cognitive functioning and the inhibition of alcohol-induced aggression. *Journal of Alcohol Studies, 59*, 599-607.

Klostermann, K., & Fals-Stewart, W. (2006). Intimate partner violence and alcohol use: Exploring the role of drinking in partner violence and its implications for intervention. *Aggression and Violent Behaviour, 11*, 587-597.

Swan, S. C., Gambone, L. J., Fields, A. M., Sullivan, T. P., & Snow, D. L. (2005). Women Who Use Violence in Intimate Relationships: The Role of Anger, Victimization, and Symptoms of Posttraumatic Stress and Depression. *Violence and Victims, 20*(3), 267-285.

Swan, S. C., & Snow, D. L. (2006). The development of a theory of women's use of violence in intimate relationships. *Violence against women, 12*(11), 1026-1045.

Walters, M. L., Basile, K. C., Breiding, M. J., Smith, S. G., Merrick, M. T., Chen, J., et al. (2013). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 findings on victimization by sexual orientation*. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/ViolencePrevention/pdf/NISVS_SOfindings.pdf

http://www.cdc.gov/ViolencePrevention/NISVS/SpecialReports.html

Worcester, N. (2002). Women's use of force: Complexities and challenges of taking the issue seriously. *Violence against women, 8*(11), 1390-1415.

World Health Organisation. (2013). Intimate partner violence and non-partner sexual violence: Intimate partner violence prevalence by GBD region Retrieved from http://apps.who.int/gho/data/view.main.IPVGBDREGION?lang=en

World Health Organization. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*. Geneva: World Health Organization. Retrieved from http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf

http://www.who.int/reproductivehealth/publications/violence/9789241564625/en/index.html

http://www.nzfvc.org.nz/node/1341

World Health Organization/London School of Hygiene and Tropical Medicine. (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. Geneva: World Health Organization