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Sexual and Dating Violence in Adolescents and Young Adults in Chile: A Review of Findings from a Survey of University Students

Jocelyn A. Lehrer, Sc.D.

Bixby Center for Global Reproductive Health

University of California, San Francisco

Evelyn L. Lehrer, Ph.D.

Department of Economics

University of Illinois, Chicago

Mary P. Koss, Ph.D.

Mel and Enid Zuckerman Arizona College of Public Health

University of Arizona

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ABSTRACT

This article synthesizes and discusses results from the 2005 Survey of Student Well-Being, a closed-ended questionnaire administered to students attending general education courses at a major public university in Santiago (n = 484 women, 466 men). The survey included questions on sexual violence (SV) and dating violence (DV) in adolescents and young adults - public health problems that have received little attention in Chile and other Latin-American countries. This paper highlights key findings from a series of articles based on these data, noting lessons learned in the Chilean context that may be useful for other Latin-American countries. Important gaps in the international literature on SV and DV are also discussed. A central finding is the high prevalence of SV and DV in this sample of university students, warranting further public health attention to these problems. Potentially, the findings will contribute to changes in awareness, policy and practice along similar lines to efforts that transformed the U.S. landscape regarding SV and DV on college campuses in the 1980s.

Keywords: sexual assault, sexual violence, dating violence, intimate partner violence, college student health, Chile

Introduction

Violence against women has come to be widely recognized as a violation of human rights, a public health concern, and an obstacle to economic development. In 2000, the United Nations General Assembly resolved to "combat all forms of violence against women" and included "the promotion of gender equality and empowerment of women" among the Millennium Development Goals (Ellsberg 2006; World Health Organization (WHO) 2005a). The WHO has provided comparable data on violence against women for ten countries representing diverse cultures and stages of economic development, with a focus on intimate partner violence (IPV) experienced by women in marital or common-law relationships (WHO 2005b); this work contributes to a growing literature that finds a high prevalence of IPV in countries around the world (Perilla et al. 2011; WHO 2010). Further impetus for research in this area has come from evidence that IPV can play a significant role in the transmission of HIV and other sexually transmitted infections (STI) (Dunkle et al. 2006; Guedes 2004; Luciano 2008).

Numerous studies have documented other adverse consequences of IPV, including impacts on physical, mental and reproductive health (Campbell 2002; Ellsberg, Jansen, Watts, and García Moreno 2008), and related direct costs of medical, social and judicial services to assault survivors (National Center for Injury Prevention and Control, 2003). Other research has examined indirect economic costs in the form of negative labor market outcomes (e.g., absenteeism, decreased productivity and earnings) and the barriers that IPV may pose to women's achievement and maintenance of economic self-sufficiency (Max et al. 2004; Morrison and Orlando 1999; Yodanis, Godenzi and Stanko 2000). Many IPV prevention and response initiatives have been developed but few programs, particularly in poor countries, have been rigorously evaluated (Heise 2011; WHO 2010).

Until the 1980s, little research and practice attention was paid around the world to violence earlier in the life course - in particular, sexual violence (SV) and dating violence (DV) against adolescent girls and young adult women. The WHO (2002, p. 149) has defined SV as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using

coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work." Perpetrated by a casual date or more committed partner, DV has been defined as capturing "three forms of violent behavior that may occur in dating relationships: emotional/psychological, physical, and sexual aggression" (Teten et al. 2009, p. 923).

The emergence of research and practice regarding DV in the U.S. began with a quantitative study of male and female students' DV victimization on a college campus (Makepeace 1981), which found a high prevalence among its sample. This study led to a critical mass of further studies and the resultant recognition of DV in U.S. youth as an issue of public health importance, which in turn led to the development and evaluation of DV prevention programs – an area of research which continues to be developed. A parallel first quantitative study of women's SV victimization on a college campus (Koss and Oros 1982) led to a similar trajectory, and in 1994, colleges receiving federal funds were mandated to provide SV prevention programs (NASPA 1994).

Research conducted with samples of adolescent and young adult women in industrialized countries over the past three decades shows that a wide range of health risk behaviors and adverse physical, sexual and mental health outcomes are associated with both DV (Fletcher 2010; Silverman et al. 2001; Teten et al. 2009) and SV (Gidycz et al., 2008; Rickert et al. 2003); early, unwanted pregnancies and an elevated risk of revictimization are other costs of SV in young women (Martin, Macy, and Young 2011; Ullman and Najdowski 2011). Although reductions in DV and SV in youth are not listed in the Healthy People 2020 goals for the U.S., the need to better understand these problems and related prevention strategies is noted in the document (U.S. Department of Health and Human Services 2010).

To date, few studies on SV and especially DV have been conducted with adolescents and young adults in less-developed economies. Findings from a multinational study of university students, gathered in over 30 sites around the world, show variable, generally high prevalence of DV and SV (Straus 2004; Hines 2007).[1] These results are consistent with findings from studies conducted in individual low- and middle-income countries (Contreras et al. 2010; Jejeebhoy, Shah, and Tapa 2005; Jewkes and Abrahams 2002; Philpart et al. 2009). However, the development of prevention and response

programs has received little priority. The case of Chile, among the more advanced Latin-American economies, is no exception - social discourse and public health research and practice regarding DV and SV in youth in Chile are notably limited.

The Survey of Student Well-Being

The Survey of Student Well-Being (SSWB) was administered in 2005 to students enrolled in General Education courses at a large public university in Santiago. This research initiative was the first quantitative examination of SV and DV in a sample of college students in Chile -- following the example of the early studies described above which ultimately helped transform the U.S. college landscape in the 1980s. The survey was compiled by the first author of the present article, based on scales already validated in the U.S. Chilean students and faculty provided feedback on the survey items to ensure cultural relevance and preservation of meaning upon translation to Spanish. Key survey items addressed experience since age 14 of (a) SV victimization, measured with items adapted from Straus, Hamby and Warren (2003) and Koss et al. (2007); and (b) DV victimization involving physical aggression, measured with items adapted from Foshee (1996). Henceforth in this paper, DV refers to *physical* DV. Items regarding the participants' economic and demographic background were included, as were items regarding experience with two forms of violence in childhood: unwanted sexual experiences and witnessing domestic violence before age 14. At the time of survey administration, 1,193 students were present in class and 970 completed the questionnaire, reflecting an 81% response rate. After deleting 20 cases with invalid data, the sample included 484 women and 466 men.[2]

Six publications based on these data have reported findings on various aspects of DV and SV. Two articles present descriptive statistics on prevalence and contexts of DV and SV, making comparisons between men and women (Lehrer, Lehrer, and Oyarzún 2009; Lehrer, Lehrer, and Zhao 2009). Other articles based on the female sample present multivariate analyses of risk factors for DV and SV (Lehrer et al. 2007; Lehrer, Lehrer, and Zhao 2010), and an examination of the role of religion in DV at the individual and societal levels (Lehrer, Lehrer, and Krauss 2009). The most recent article examines prevalence, contexts, and risk factors for SV in men (Lehrer, Lehrer, and Koss 2012).

The present paper synthesizes key findings described in these articles, with an emphasis on victimization in women, and discusses lessons learned in the Chilean context that may also be useful for other Latin-American countries. In addition, the paper identifies important gaps in the international literature on DV and SV in adolescent and young adult populations.

Main Findings and Implications: Victimization in Women

Prevalence of DV and SV since age 14

A primary finding in our sample of urban college women is that there is a high prevalence of DV and SV since age 14, indicating a need to collect further data on these topics with representative youth samples in college contexts in Chile, as well as other urban and rural contexts in Chile and other Latin-American countries where data are similarly limited. Specifically, 21% of female participants reported at least one incident of DV with no physical injury since age 14, and another 5% reported at least one incident with injury. Approximately 31% reported at least one incident of SV in this time period; the most serious forms experienced were forced sex and attempted forced sex, respectively, for 9% and 6% of female participants. There was a substantial prevalence of joint experience of DV and SV (not necessarily by the same aggressor or in the same incident): 52% of female participants who reported DV also reported SV, indicating an augmented risk of HIV/STI, unwanted pregnancy and other adverse consequences of SV among women who had experienced physically violent relationships. In addition, one fourth of female participants who reported DV also reported coerced condom nonuse. These findings lend support to recent U.S. research that calls for more comprehensive examination of the co-occurrence of physical and sexual aggression (Koss, White, and Kazdin 2011; Smith, White, and Holland 2003; White, Koss, and Kazdin 2011).

Risk factors for DV and SV since age 14

Approximately 21% of female participants reported some form of unwanted sexual experience before age 14, and this factor was a strong predictor of subsequent SV (AOR = 5.09, 95% CI 3.20-8.09) and DV (AOR = 1.89, 95% CI 1.14-3.12). Witnessing domestic violence in childhood, reported by slightly over one third of female participants,

was also associated with increased vulnerability to subsequent DV and SV. The above findings are consistent with those of numerous studies conducted with adolescents and young adults in industrialized countries, which show that various forms of experience with violence in the childhood environment are risk factors for future DV and SV victimization (Arriaga and Foshee 2004; Maniglio 2009; Vézina and Hebert 2007). These findings have led to calls for prioritizing prevention programs that target young age groups (WHO 2010).

In contrast, current understanding of the role of low socio-economic status (SES) as a risk factor for DV and SV during young adulthood is limited. Mixed findings have been reported in earlier research, reflecting differences in SES measures as well as in study samples, methodologies, and the sets of other variables included in the models (Spriggs et al. 2009; Vézina and Hébert 2007). In the SSWB, childhood experiences with violence were a better predictor of SV and DV than low SES. The importance of paying more attention to SES became clear, however, when noting that across our studies, the findings are highly suggestive of a mediating role: low SES was significant in regressions examining risk factors for DV and SV outcomes, but in both cases declined in magnitude and lost significance after variables for violence in the childhood environment were added. Additional research on links between SES in the family of origin, violence in the childhood environment, and subsequent DV and SV would be desirable.[3]

Other factors that were found to be associated with an increased likelihood of DV were being raised in an urban area, having a mother who did not work in the labor market, and having initiated voluntary sexual activity. In addition, there was some evidence that living outside the parental home during the college years was associated with heightened risk of SV and DV, suggesting that it may be helpful to include content on safe independent living in risk reduction programs for college students in Chile.

The findings described above, parallel to those in the literature for the U.S. and other developed countries, identify characteristics and experiences of adolescent girls and young adult women that are linked with increased vulnerability; such factors of course do not cause men's perpetration of violence against women. Further research is needed to expand our understanding of the mechanisms behind these associations (Foshee et al.

2004; Ullman and Najdowski 2011). In the meantime, information on factors associated with heightened vulnerability can help inform pragmatic risk-reduction efforts.

Incident of Victimization since Age 14 Considered Most Severe by Participant: Contexts and Disclosure

Approximately 79% of female participants who reported DV since age 14 identified a steady dating partner as the perpetrator in the most severe incident, consistent with U.S. evidence of a higher prevalence of partner violence in more committed relationships (Luthra and Gidycz 2006). The perpetrator of the most severe SV incident was identified as an acquaintance/friend or casual date/dating partner by 37% and 40%, respectively, of women who reported SV - consistent with findings in countries around the world that the assailant in sexual assault is most frequently someone known to the victim (Black et al. 2011; WHO 2010). Yet at present there are no commonly-used terms in Chilean parlance for "acquaintance rape" or "date rape." In light of the well-understood importance of language to reflect social realities and help people interpret their experience (Searle 1995), these findings suggest that it would be beneficial for the Chilean public health community to create/adopt such terms in Spanish (e.g., "violación por conocido," "violación en cita").

One third of female participants who indicated DV told no one about the most severe incident. Among those who told someone, 85% told a friend, 8% told a health professional, and no one notified the police. One fourth of women who indicated SV told no one about the most severe incident. Among those who told someone about it, 84% told a friend, 11% told a psychologist or social worker, 3% told a doctor, and 2% reported it to the police (among other nonexclusive options). In the cases of police non-report by participants who indicated experience of forced sex or attempted forced sex, the most commonly-stated reasons were a belief that what happened was not sufficiently serious or a crime (35%), and not being sure that the perpetrator had meant to harm them (27%). In a review of studies for Latin-America and the Caribbean, Contreras et al. (2010) report that only about 5% of adult survivors of SV in the region report the assault to the police. Overall, these findings indicate a need to educate young people about what they can

rightfully expect from healthy romantic and sexual encounters, definitions of DV and SV, and protections provided by the law.

In 57% of the cases of most severe SV reported by the female participants, the victim and/or perpetrator had consumed alcohol and/or other drugs, and 55% of incidents of forced sex occurred when the victim had consumed alcohol and/or other drugs and was unable to stop what was happening - consistent with U.S. findings that substance use is commonly part of the context in which SV against young women takes place (Vézina and Hébert 2007). Related research has emphasized the importance of integrating substance use prevention content into SV prevention programs (targeted to potential aggressors) and interventions to reduce risk (targeted to potential victims) (Brecklin and Ullman 2010; Ullman 2003; WHO 2010).

Religious, socio-economic and legal landscape

A large literature based on individual-level U.S. data shows that participation in religious activities is generally associated with beneficial outcomes in a wide range of health and socioeconomic domains (Waite and Lehrer 2003). However, recent research has suggested the possibility of non-linearities in the effects of such participation, with the influence becoming negative at very high levels of involvement (Chiswick and Huang 2008). Analyses of SSWB data found that while low and moderate levels of religious participation at age 14 are associated with decreased odds of DV since age 14 among adolescent girls and young women (as compared to no participation), the protective effects disappear at high levels of participation and the influence may even become adverse. Related research has shown that conservative theological concepts in many religions have the potential to be interpreted to condone or tolerate violence (Nason-Clark 2004). At the societal level, conservative religious beliefs have kept abortion illegal in Chile including in cases of rape**,** and divorce was legalized in 2004, making it the last Western society to do so (Blofield and Haas 2005).

Several other aspects of the conservative social environment in Chile foster fertile ground for violence against adolescent girls and women - including cultural norms supporting machismo and marianismo, and widespread permissive attitudes regarding violence against women (Ceballo et al. 2004; Cianelli, Ferrer, and McElmurry 2008).

SSWB analyses found that substantial minorities of participants (with a greater proportion among the men) expressed adherence to traditional gender ideologies and adherence to female rape myths. For example, 14% of women and 32% of men agreed with the statement that "economic support of the family should largely be the responsibility of the husband," and 28% and 36% of women and men, respectively, agreed with the statement that "the degree of resistance that a woman presented should be the main factor in determining whether what happened was a rape." [4] In addition to the aforementioned laws regarding abortion and divorce, the legal landscape in Chile has reflected and reinforced the social forces described above: the first law against workplace sexual harassment was passed in 2005, and the first law mandating equal pay for women and men who perform equal work was passed in 2009.

In international comparisons, Chile ranks as 48th among 134 countries on the overall Gender Empowerment Index, reflecting the relative status of women in the areas of health, education and participation in government (Hausmann, Tyson, and Zahidi 2010). However, the country ranks in the 108th place in the sub-index of economic opportunity, in part because of a wide male/female wage gap and an unusually low rate of female labor force participation. While the role of women's economic empowerment is receiving increasing attention in the IPV literature (Heise 2011), the extent to which economic inequality between men and women fosters an environment that increases the vulnerability of adolescent and young adult girls to DV and SV has not been studied to our knowledge and merits attention in future investigations.

Main Findings and Implications: Victimization in Men

Thirty-eight percent of male SSWB participants indicated experience of DV since age 14, as compared to 26% of female participants. Other studies using similar DV measures based on the Conflict Tactic Scales have found that victimization prevalence tends to be as high or higher in young men as in young women; many studies have also found that female victims are far more likely to experience physical injury and severe psychological consequences, including fear and anxiety (Lewis and Fremouw 2001, Straus 2004). These findings underscore the importance of using a gendered approach in research on DV (Smith et al. 2009; White 2009), including examination of dynamics

within same-sex and opposite-sex couples. Future investigations should also use scales that include a wide range of forms of aggression in dating relationships (White et al. 2000; White 2009).

SV in adolescent girls and young women has received more public health attention than SV in adolescent boys and young men because studies around the world have found the overall prevalence of victimization to be substantially greater for the former (Mirsky 2003). Yet substantial minorities of male youths are affected. Among SSWB participants, 31% of women and 20% of men reported SV since age 14; the respective percentages for the period before age 14 were 21% and 9%. As was true for their female counterparts, there was a substantial prevalence of joint victimization in male SSWB participants: among those who indicated forced sex or attempted forced sex since age 14, 56% also indicated DV victimization and 30% reported coerced condom nonuse.

The limited available evidence suggests that SV in boys under 19 years of age (Holmes and Slap 1998) and adult men (Choudhary et al. 2010; Elliott et al. 2004) can have important sequelae with regard to physical and mental health and sexual function; initiatives to prevent and respond to such violence are clearly essential per se. In addition, it has been hypothesized that sequelae of boys' childhood sexual abuse and/or SV in adolescence "may contribute to the evolution from young victim to older perpetrator," (Holmes and Slap 1998, p. 1860) suggesting that efforts to provide support to male survivors may decrease the likelihood of their becoming perpetrators of IPV and SV. This hypothesis has received little research attention; if supported, it would provide further reason to work to prevent and respond to SV against male youths.

As SV in adolescent boys and young men has begun to receive more research attention, it has been noted that this is a highly under-reported, under-treated and misunderstood public health problem (Holmes and Slap 1998; Peterson et al. 2011). Two-thirds of male SSWB participants who experienced SV since age 14 told a friend, and 3% told a psychologist or social worker; no one told a physician. No cases of forced sex or attempts were reported to the police; the most frequently cited reasons for nonreport were thinking that what happened was not sufficiently serious or a crime (50%), shame (14%) and not being sure that the aggressor had meant to harm them (14%). These results are

consistent with earlier U.S. findings indicating that salient barriers to men's SV disclosure include male rape myths, fear of being judged to be gay, and gender norms that call for men to be strong and self-reliant (Sable et al. 2006). Public health initiatives to promote healthy masculinities should include acknowledgement that men can indeed be legitimate victims of SV and DV, and promote men's seeking of health care, psychological support and legal recourse when needed (Courtenay 2000).

With regard to research methods, the SSWB assessed SV in men with a small set of questions (the same as those used for women), which lacked behavioral specificity as to whether a penetrative act was unwillingly performed vs. sustained by the respondent. While this limitation is also present in most earlier studies (e.g., Choudhary, Coben, and Bossarte 2010; Elliott, Mok, and Briere 2004; Hines 2007), it has received little attention in the literature. Future research should assess SV in men with a tool such as the Revised Sexual Experiences Survey (Koss et al. 2007); these scales contain items with behavior-specific wording that permit less subjective interpretation by respondents as to what "forced sex" means.

Gaps in the International Literature and Directions for Future Research

DV as a precursor to more severe IPV

Most IPV against women in cohabiting and marital unions occurs behind closed doors and is "hidden" - unreported and unknown to others except in more extreme cases (WHO 2010). Such cases are unfortunately not rare in Chile, where approximately one woman is killed by an intimate partner per week (Donoso 2007). In the case of violence between dating partners, U.S. evidence shows that although incidents may be frequent - one dimension of seriousness - most do not result in physical injury (Follingstad et al. 1999). Thus DV in young people tends to be even less visible than partner violence in cohabiting/married couples, likely accounting in part for the lack of attention DV has received in Chile and other Latin-American countries.

Yet as noted in the Introduction, there is ample evidence that DV is a critical issue in its own right - for the harm it causes in the present. Moreover, it may lead to the establishment of violent patterns of interaction and conflict resolution, and trajectories of adverse long-term consequences. The hypothesis that DV may be a precursor to more

severe IPV in the subsequent context of marriage was first advanced in Makepeace's aforementioned 1981 investigation. Early studies with small samples provided some evidence suggestive of continuity of DV perpetration (Roscoe and Benaske 1985) and victimization (O'Leary et al. 1989) into marital relationships. More recently, analyses based on a longitudinal survey addressed to students at the University of North Carolina found that young women who experienced physical DV victimization in adolescence were at higher risk of physical DV victimization in college (Smith, White, and Holland 2003). Another prospective study based on the National Longitudinal Study of Adolescent Health found that among both women and men, physical DV victimization in adolescence was predictive of higher odds of IPV victimization and perpetration in young adulthood (Manchikanti Gómez 2011). Further research with such prospective data would be desirable, using methods that permit examination of causal effects of DV on subsequent IPV (Rees and Sabia 2011).

Given the high prevalence of DV in less developed countries found in the small international literature on this subject, including our SSWB analyses, further longitudinal research is needed in these contexts so as to understand the nature of the relationship between DV and IPV. If such research confirms that DV plays a causal role in increasing risk for and severity of IPV in the context of cohabiting and marital unions, the need for augmenting public health attention to DV in Chile and other Latin-American countries will be seen more clearly.

Effects of DV and SV on female youths' educational outcomes

Numerous studies have examined associations between childhood sexual abuse and subsequent educational outcomes (Oddone, Paolucci and Genuis 2001; Rees and Sabia 2011). Far less research has examined potential effects of DV and SV during adolescence and young adulthood on educational outcomes. A notable exception is a longitudinal analysis of data from a national sample of U.S. adolescents, which found that past-year victimization (including SV and other forms of interpersonal violence) was associated with lower grades, fewer years of schooling completed, and lower socio-economic attainment in early adulthood (Macmillan and Hagan 2004). As the authors acknowledge, the estimated associations may have been driven in part by unobserved

factors. Efforts to move from correlational to causal analyses in this area, using statistical techniques such as propensity-score matching models, have begun (Rees and Sabia 2011).

The studies cited above are based on U.S. data. Relatively little is known about contexts of SV and DV in youth in Latin America (Morrison, Ellsberg, and Bott 2004). Further research to examine prevalence of these problems in adolescent girls and young adult women, and their causal links to subsequent health and educational outcomes, is warranted in Chile and other Latin-American countries. In turn, such outcomes have implications for the future economic well-being of young women and the families they go on to form, and, at the macro level, for economic growth and development.

Next Steps

From both public health and economic perspectives, our findings from the SSWB data analyses strongly indicate that SV and DV in adolescents and young adults warrant further attention in Chile. To our knowledge, there are presently no established programs in colleges in the country to prevent or respond to these forms of violence. A recent national "Healthy Universities" initiative, developed with support from the Chilean Ministry of Health, lists a set of topic areas that should be addressed by each institution of higher learning in order to promote student health, as well recommendations per topic area on prevention/response efforts that could be developed and implemented (Lange and Vio 2006). The development of healthy interpersonal relationships is included among the topic areas, and the guidebook recommends that content on conflict-resolution skills be incorporated into curriculum. However, the discussion is limited to remarks about violence in general, with no specific mention of DV or SV. Other topic areas discussed include healthy sexuality, non-use of illicit drugs and non-abuse of alcohol; corresponding recommendations are listed (e.g., programs to prevent and respond to STIs, unwanted pregnancy and substance abuse). But by failing to mention DV and SV, which are closely intertwined with the above problems, the recommendations of the initiative are missing key elements.

Future studies should use a social ecological framework to examine prevalence of and risk/protective factors for DV and SV perpetration and victimization, in young

women and men in Chile – as well as in other Latin-American countries where data collection and prevention/response efforts have been similarly limited. If a critical mass of studies indicate that there is a high prevalence of DV and SV in varying contexts, this will confirm a need for development and evaluation of theory-based prevention programs in such contexts – including colleges, secondary schools and community-based contexts. In the meantime, the synthesis of research and recommendations provided in this paper may serve as guidance to advocates and service providers - a step towards bridging the gap between research and practice (Wandersman 2003).

This work will of course require resources, competing for such resources with other programs aiming to promote health and economic development. Additional efforts to document the individual and societal costs associated with DV and SV in youth should thus receive emphasis in the agenda for future investigations. As noted earlier, research to date in this area with data from industrialized countries has documented sequelae of DV and SV victimization for physical, mental and sexual health, as well as costs of SV in terms of unwanted pregnancy and increased odds of future revictimization. The present paper notes other areas that have received less attention: links between DV and increased risk and severity of subsequent IPV, and influences of DV and SV on educational outcomes. Other investigations, mostly with adult women, have attempted to quantify in dollars various costs associated with IPV and SV (Martin et al. 2011; Morrison et al. 2004, 2007; Post et al. 2002); expanding this sort of analysis to DV and SV in youth would be desirable. In this research, however, costs will be systematically understated, as the most salient ones (e.g., emotional suffering) defy dollar quantification and underfunding of services in less developed countries will produce underestimates of direct costs.

In Development as Freedom, Amartya Sen (1999) notes that the expansion of individual freedoms is both a central goal of, and requirement for, economic development. Key among such freedoms is freedom from violence (Nussbaum 2003; Panda and Agarwal 2005). The forms of aggression that are the focus of the present paper – DV and SV in adolescents and young adults – clearly warrant further attention in this context.

ENDNOTES

[1] See White et al. (2000) for caveats regarding the measures of sexual and physical aggression used in this study.

[2] See Lehrer et al. (2007, 2012) for additional information on survey administration.

[3] In the SSWB analyses, low SES was operationalized with a variable for "low parental education," indicating a high school education or less or incomplete advanced technical schooling. Future research should use measures such as income below the poverty line which better capture low SES.

[4] Rape myth acceptance among men has been found to be associated with an increased likelihood of perpetration of SV (Chiroro et al. 2004). See Vézina and Hébert (2007) for a discussion of ways in which traditional gender ideologies affect SV and DV victimization risk in women.

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