JOINING FORCES
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REAL WORLD RESEARCH FOR FAMILY ADVOCACY PROGRAMS

Current Discussions About Women's Violence

An Interview with Suzanne Swan, Ph.D., Assistant Professor, Department of Psychology, University of South Carolina

Conducted by James E. McCarroll, Ph.D.

Suzanne Swan, Ph.D.

Suzanne Swan, Ph.D., is an Assistant Professor in the Department of Psychology and the Women's Studies Program at the University of South Carolina. Before coming to the University of South Carolina she was the Director of Family Violence Programs at the Yale School of Medicine's Department of Psychiatry. She received her Ph.D. from the University of Illinois in 1997. Dr. Swan's recent work has focused on research with women who use violence in intimate relationships with a particular emphasis on the contextual factors underlying women's violence. She teaches courses on the Psychology of Women, Social Psychology, and Relationship Violence.

In This Issue

The theme of this issue is *risk assessment of domestic violence and the challenges of risk assessment validation.* Our featured interview is with Suzanne Swan, PhD. Dr. Swan, a noted scholar in social and women's psychology, discusses her research on women's violence in intimate partner relationships. A summary of her research follows this interview. We also present an article on the challenges of validating risk assessment of domestic violence, including the risk of homicide. Our regular statistics page describes some of the concepts used in the validation of risk assessment instruments. For those who are interested in fatality review, we provide some relevant websites. On behalf of our editorial staff, we wish our readers a Happy New Year, and look forward to providing you with *Joining Forces Joining Families* throughout 2006.

—James E. McCarroll, PhD, Editor-in-Chief

Table of Contents

Dr. McCarroll:. It is important for the Army to understand the nature and patterns of abuse by both men and women for developing more effective prevention and treatment. As a scholar of women's psychology, how does domestic violence fit into women's studies?

Dr. Swan: I think it has been there for a while. Lenore Walker wrote in her classic book "The Battered Woman" about how some of the women that she interviewed tried to use violence to defend themselves against their partners. Straus and Gelles, in the 1970s, asked men and women about using physical violence against their partners and found that about the same number of women and men used violence. But, people have not been comfortable talking about women's violence until recently.

Dr. McCarroll: What are the current discussions about women's use of violence?

Dr. Swan: Many feminists are now saying, "Of course women can be violent". We do not

Continued on page 2

We have all learned a patriarchal system of power and control. In a relationship in which one person has more power than the other, that position of power can give that person permission to do abusive things to the other person.

have to view women solely as victims, women can have agency in these situations.

Dr. McCarroll: When power and control are issues in a relationship, what are the implications of gender?

Dr. Swan: It is more complex than we tend to think. Domestic violence also occurs in gay and lesbian relationships. We have all learned a patriarchal system of power and control. In a relationship in which one person has more power than the other, that position of power can give that person permission to abuse the other person.

Dr. McCarroll: How do you differentiate between gender and sex?

Dr. Swan: Sex is a pretty specific term where you are really talking about biological differences. Gender is everything psychological including all the cultural overlay that we add to sex. I think it is an important distinction. People tend to exaggerate gender differences, i.e., "Boys do better on average in math than girls." Really the distributions overlap much more than they differ. The term gender is trying to get away from people's assumptions about differences that are based on sex and thought to be biologically determined. It is controversial. Some people argue that gender differences really are a result of brain structure and biology and genetics.

Dr. McCarroll: What does a clinician or health-care professional need to know about relationship violence?

Dr. Swan: I think I would tell them that they are not going to find too many cases of female unilateral violence that would meet the criteria for intimate terrorism. (See Johnson & Leone, 2005, for a discussion of intimate terrorism.) Most of the time when they are dealing with women, both people are violent. At times, the violence by the woman is in self-defense, but that is not always the case. Sometimes the woman's violence is in response to the man's attempt to control her. She may not know what else to do. Our cultural notions of gender are that men should have more power and control in relationships. So, she is not going to be able to use power and control to equalize the distribution of power. I think some women use violence because that is all they know.

Dr. McCarroll: How do you view existing violence prevention programs for adults?

Dr. Swan: I think education is helpful for adults to learn what is appropriate in relationships. Some people have grown up in homes where there was violence and do not know other ways of handling things. They might not define it as a problem or know what to do about it. At a minimum, let people know what resources are out there and give them a confidential way to access those resources.

Dr. McCarroll: What are the relationship implications of your research on typologies?

Dr. Swan: The typologies are relational, but I think gender is always there. When you look at coercive control, you still find that it is much more common for women to *receive* it than to be coercive toward their partners. When they are coercive, they seem to be less effective than men. When we interviewed women about how they might try to control their partner's behavior, they would say something like, "Yeah, I told him he couldn't go out, but he would do it anyway. He would just laugh in my face and leave." I think many women, especially those in abusive relationships, would feel much more constrained if their partner tells them, "You

Continued on p. 8

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Women's Violence: Research of Suzanne Swan and David Snow

Although surveys find that the number of women and men who report using physical aggression against their partners is equivalent, women are more likely to report being injured.

James E. McCarroll, Ph.D.

Women's violence in intimate relationships is not well understood. Swan and Snow (2002) note several factors that add urgency to the need for a greater understanding of women's violence. First, in more than 100 studies of intimate partner violence, women report as much physical aggression as men. This finding is not the whole story. Although surveys find that the number of women and men who report using physical aggression against their partners is equivalent, women are more likely to report being injured. Women are also more likely to be subjected to sexual assault from intimate partners. Finally, mandatory arrest policies in some states have resulted in increasing dual arrests in which the criminal justice system treats both members of the couple as perpetrators. When dual arrests occur without a careful analysis of the history of violence in the relationship, some women who were violent in self-defense are criminalized. Swan and Snow argue that women's violence needs to be examined in the context in which it occurs, which often includes violence against them.

Dr. Swan and her colleagues have published a series of articles on women's violence (Swan & Snow, 2002; Swan & Snow, 2003; Swan, Gambone, Fields, Sullivan, & Snow, 2005; Swan & Snow, in press). Their model proposes that women's violence occurs in the context of their victimization by their male partners, their experiences of childhood trauma, and as a consequence of depression, anxiety, posttraumatic stress symptoms, and substance use. The studies by Swan and Snow were derived from a sample of 108 women who had used some form of physical violence against a male intimate partner within the last 6 months. The women provided descriptions of their own violence and that of their partners.

The sample revealed that ninety-nine percent had committed at least moderate physical violence, 57% had committed severe violence, 54% had injured their partner, 28% had used sexual coercion, and 86% used some form of coercive control. Women committed equivalent levels of emotional abuse as men. However, almost all of the women were also victims of violence. Only 6 of the 108 experienced no physical victimization or injury from their partners. Although a high percentage of women committed violence, their male partners committed significantly more of the severe types of violence: sexual coercion, coercive control, and injury (Swan & Snow, 2002).

Swan and Snow (2002) developed a typology of the different types of abusive relationships in which women were violent. Their typology consisted of the following types of relationships: *women as victims* (34%), *women as aggressors* (12%), and *mixed relationships* (50%). There were two types of mixed relationships. The first mixed type was called *mixed-male coercive* (32%). In this type, the female used more severe violence than the male partner, but the male partner was more controlling (coercive). In the *mixed-female coercive* type (18%), the male was more severely violent, but the female partner was more controlling. Four percent of the participants could not be classified.

Overall levels of violence were highest in the victim and aggressor types. In both the victim and aggressor types, there was a large disparity between partners' frequency of abuse. This suggests that the most dangerous and violent relationships are those in which there is a very different distribution of power favoring one partner. Little is known about male victims: what is his level of fear, how much does he modify his behavior to avoid angering his partner, what is the extent to which he feels controlled by her, and what is his sense of disempowerment and helplessness? Swan and Snow believe that, in the majority of relationships, women do not instill fear in men or succeed in controlling their behavior.

Swan and Snow (2003) examined behavioral and psychological differences among women in the four typologies. The women in *the women as victims* group fared the worst. They had the highest levels of harmful drinking and suppressed anger, and little anger control, as well as high levels of depression, anxiety, and posttraumatic stress symptoms. Their primary motive for violence was self-defense and they had the highest frequency of injuries. Women in the *aggressor group* were doing almost as poorly as the women in the victim group. Their levels of depression, anxiety, and posttraumatic stress symptoms did not differ from

Their model proposes that women's violence occurs in the context of their victimization by their male partners, their experiences of childhood trauma, and as a consequence of depression, anxiety, posttraumatic stress symptoms, and substance

the victims. Aggressors had much higher levels of childhood trauma, which predicted female aggression.

Women in the *mixed-female coercive* group had the most positive findings on almost all measures. They were the least depressed, had the lowest level of posttraumatic stress symptoms, and were the least anxious of all groups. They were the least angry and were able to control their anger more than other groups. They also experienced and inflicted the least amount of injury.

In the *mixed-male coercive group*, male and female partners were approximately equal in their use of violence, but the men were much more coercively controlling. Their outcomes were better than the women in the *women as victims* or the *women as aggressors* groups, but they did not fare as well as the women in the *mixed-female coercive* group.

Across all groups, childhood abuse and greater frequency of victimization from partners increased the likelihood of female aggression against their partners, as well as posttraumatic stress symptoms, and depression. Also, women with posttraumatic stress symptoms were more likely to express anger outwardly, which predicted an increased likelihood that they would use aggression against their partner (Swan & Snow, 2005).

Swan and Snow (2003) believe that their findings may be explained by the women's sense of control over their lives, their autonomy, and their sense of agency within their relationships. The women in the *mixed-female coercive* group seemed to have the most even balance of power and control with their partners. The women in the *victim* and the *aggressor* groups seemed to be the most worrisome. Even though the women in the *women as aggressors* group may appear to have the greater power in terms of their level of aggression, their poor outcomes (high rates of injuries, depression, and posttraumatic stress symptoms) may indicate little autonomy or control in their lives. Swan and Snow (2003) suggest their aggression was used to try to create a sense of control.

Swan and Snow (2005) believe that it is important for violence cessation programs to have women assess their safety in their homes and, when necessary, to develop safety plans. They also recommend that programs for domestically violent women assess posttraumatic stress symptoms since these symptoms predict anger directed outward as well as aggression. They suggest that women will have difficulty reducing their violent behavior until they are no longer being victimized and have received treatment for posttraumatic stress symptoms and other trauma-related disorders.

The study of women's violence is important to the Army. The Army Central Registry recognizes both men and women as victims and perpetrators of domestic violence. Whether abuse is unilateral or bilateral, the causes and consequences of men's and women's violence are likely to be different. A better understanding of the causes and dynamics of both male and female violence will help the Army Family Advocacy Program (FAP) make better decisions about case substantiation and treatment of both victims and perpetrators.

Today's military life with its high level of operational tempo and frequent, long, and hazardous deployments adds additional dimensions to the stress of relationships for both male and female soldiers and their family members. These dimensions add to the context in which men's and women's violence occurs and should be considered in assessing case substantiation, treatment, and follow-up of FAP clients.

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Predicting the Risk of Re-assault: Challenges in Developing Assessment Procedures

Based on A Monograph by Roehl et al.

The issues and challenges in designing and validating risk assessment procedures are complex. Research and practice in this area are in an early stage.

James E. McCarroll, Ph.D.

A recent monograph by Roehl et al. (2005) reported the results of a prospective study of victims of intimate partner violence. The purpose of the study was to explore several evaluation procedures for assessing the risk of repeated assault or lethality. The development of procedures to assess risk of re-assault is important to victims, medical personnel, police, probation officers, judges and others who come in contact with domestic violence perpetrators and victims. This monograph, which can be found at http://www.ncjrs.org/pdffiles1/nij/grants/209731.pdf, raises an important question: How can we assess a victim's risk of future abuse?

The issues and challenges in designing and validating risk assessment procedures are complex. Research and practice in this area are in an early stage. Only through careful research and the application of sound scientific methods will this research and practice advance. Misapplication of risk assessment procedures can lead to lack of faith in research, lack of support by practitioners, police, and courts, and result in a disservice to both victims and perpetrators. Specific scientific procedures should drive and guide instrument development. There are a number of questions to be asked around specific issues of the process to determine the feasibility of developing a risk assessment procedure.

Issue: The feasibility of performing or obtaining the estimate.

Question: Can you get the data? Will the victim cooperate?

Issue: Determining the reliability and validity of the instrument and predictive value under varying circumstances.

Question: How sure do you want to be of your results? Is "pretty good" good enough?

Issue: Results of the assessment.

Question: Is it of immediate value or just nice to have? Is there a plan for intervention based on the outcome of your assessment? What will you do with the information?

Issue: Time course in which the information will be useful.

Question: What conditions do you believe are subject to rapid change and which are likely to be relatively stable? Things change.

Issue: Item selection leading to an instrument.

Question: What are "the right questions" and how do you decide if they are the best questions?

Assuming that you believe you can develop a risk assessment procedure, what will you include? Such a procedure may include an interview of the victim, review of statements of witnesses, examination of physical evidence, and self-report questionnaires. The following issues should be considered in determining whether to use a risk assessment procedure and, if so, how to use it.

- **For what purpose was the assessment procedure developed? How will it be used?** Often instruments are used for purposes other than that for which they were intended. An assessment procedure is usually developed and validated for a specific purpose. Often, it is then applied in another. Risk assessment procedures are used to assist police, emergency room personnel, social workers, nurses, or others having contact with a victim to develop a safety plan, to decide if the victim needs protection, or to make other decisions. An assessment procedure that has been found useful in one setting may not be helpful at all in another. If you are considering using a risk assessment procedure, know the purpose for which it was developed and determine whether it is applicable to your needs and its possible limitations.
- **What event do you want to predict?** There are many types of domestic violence: homicide, marital rape, battering (physical abuse), emotional (psychological) abuse, neglect (medical, financial, emotional), and stalking. In addition to these are associated factors that often occur in domestic violence: use of weapons, substance abuse, abduction of children, mental illness, and abandonment. What do you want to predict?

All instruments have a level of fallibility and they should never be taken as definitive by themselves.

- **What are the psychometric data supporting the procedure?** Psychometric data refer to measures of how good is the assessment procedure. These include, at a minimum, reliability, validity and predictive value of the instrument. (See statistics article entitled "How Is Risk Measured?" for more discussion of these concepts.) Psychometric data usually start with an estimate of reliability and then validity. An assessment method must find the result reliable (e.g., able to be repeated accurately) before it makes sense to assess its validity. An assessment procedure may be validated for interviewing a client. At a later time, it may be changed to a paper and pencil instrument or computerized. Without re-validation of the paper and pencil version of the assessment, the validity is questionable.
- **Is an instrument helpful in predicting future domestic violence? How does it compare to a victim's own assessment of risk?** This is a theoretical and methodological issue with practical implications. In several studies, a woman's prediction of her own risk of future violence has been about as accurate as that of an instrument. Risk assessment instruments need to perform significantly better than expert judgment, the view of experienced victim advocates, law enforcement officers, probation officers, or other practitioners, or they are not worth the time and effort they take to administer and interpret. Data on this comparison are often difficult to obtain and interpret.
- **Does the event (domestic violence or lethality) occur frequently enough in the population to allow a reasonable prediction?** Events that are relatively rare (such as suicide and homicide) are difficult to predict statistically. An assessment procedure is likely to produce a high number of false positives for rare events.
- **What is the effect of false positives?** Most instruments are low on specificity, meaning that only moderately do they hit their target. False positives are not a trivial issue. In the case of dealing with perpetrators, a false positive means that that someone is classified as likely to re-assault, but in fact, do not. This is more of a concern for offender rights than for victim safety as it could mean depriving a person of their liberty, refusing probation, or other negative outcomes. It could also result in unduly frightening the victim who thinks their partner is at high risk for re-assaulting them. In addition, false positives lead to expending scarce resources on low risk cases and losing credibility for risk assessment procedures.

Further Cautions

All instruments have a level of fallibility and they should never be taken as definitive by themselves. The practitioner should carefully explore the victim's perception of risk and combine this information with all other aspects of the case. A combination of instruments or formal methods and expert judgment is often thought to be the best approach. Future research on the role of various risk assessment procedures is needed to increase victim safety.

Army Applicability

The Army has ample opportunity to explore risk assessment. Data can be collected on the usefulness of the methods to the victim, the police, the courts, and the offender. In addition, the military family advocacy program is required to provide victim advocacy services. The advocate may be the first person to discuss safety and risk with the victim. Regardless of the risk assessment method used, interviews at incident and follow-up can explore victim perceptions of safety and risk, precipitants of abuse incidents, and levels of severity. Information from such interviews can be used to critically evaluate the effectiveness of current risk assessment procedures.

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Building Bridges to Research: Statistical Concepts in Risk Assessment

James E. McCarroll, Ph.D., David M. Benedek, M.D., and Robert J. Ursano, M.D.

The assessment of risk is based on probabilities and, thus, while an instrument may be used to predict some form of domestic violence, it is impossible to insure 100% accuracy.

The risk assessment methods evaluated by Roehl et al. (2005) give the probability of whether the outcome (re-assault, stalking, or serious injury or death) will or will not occur within the time period specified. The additional statistics they present (sensitivity, specificity, positive predictive value, and negative predictive value) apply to screening tests that predict whether a condition is likely to exist. Risk assessment research requires an understanding of the following terms:

- ***Reliability.*** A similar outcome is obtained if the measures are taken again under the same or similar circumstances.
- ***Validity.*** This term generally refers to the fact that the measure reflects the concept that is sought. Does a scale that purports to measure depression provide a measure of whether a person is depressed or not, or how depressed they are?
- ***Sensitivity.*** The ability of a test to identify if a person has the condition. Sensitivity is calculated by taking the number of true positives (people with the outcome) and dividing by the sum of true positives plus false negatives. (True positives are people with the outcome who are correctly identified by the test. False negatives are people who actually have the outcome, but are not detected by the test.)
- ***Specificity.*** The ability of a test to identify if a person does not have the outcome. It is calculated by taking the number of true negatives (people without the outcome) and dividing by the sum of true negatives plus false positives. (True negatives are people who are correctly identified by the test as not having the outcome. False positives are people who do not actually have the outcome, but are seen by the test as positive for the condition).
- ***Positive predictive value.*** The likelihood that a person with a positive test has the outcome. It is calculated by taking the number of true positives and dividing by the sum of true positives and false positives.
- ***Negative predictive value.*** The likelihood that a person with a negative test does not have the outcome. It is calculated by taking the number of true negatives and dividing by the sum of true negatives and false negatives.

For a test result to be determined as positive or negative, there must be a set criterion point. Those above or below this criterion point are judged as positive or negative for the outcome of the test. If the criterion is set high, there will be more false negatives (people who have the outcome, but are not selected for the outcome). Alternatively, if the cut point (criterion) is set low, there will be more false positives (people who do not have the outcome, but are said by the test to be positive).

There are other statistical procedures that contribute to the determination of whether a test is useful or not such as the prevalence of the outcome in the population. (Is it a rare or a common condition?)

If one is predicting risk by perpetrators, what are the implications of having false positives and false negatives? False positives incorrectly identify people as likely to commit a violent event. False negatives fail to identify a person who is likely to commit a violent event. Sensitivity and specificity often (or usually) work in opposite directions. If sensitivity is high (people with the condition are identified), the specificity is usually somewhat lower (people who do not have the condition are not ruled out). It is important to have high sensitivity when you do not want to miss correctly predicting the outcome when it could be harmful or lethal. High sensitivity is especially hard to achieve in a population with a low prevalence of the outcome.

The research by Roehl et al. (2005) is an important step forward in domestic violence risk assessment, but also shows the tremendous difficulty in designing and conducting a validation study. The potential user should be wary of claims for instruments and methods and insist on reviewing supporting data prior to use.

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can't go out." It's going to have more of an impact on them.

In looking at the literature of motivations for using violence, the studies tend to find that women are more likely to use violence in self-defense than men

Dr. McCarroll: How would you measure those typologies clinically?

Dr. Swan: One could develop a list of criteria that a couple would have to meet to fit into a particular typology. I am really interested in a better understanding of coercive control and particularly how women do that. (While there is currently no accepted measure of coercive control, see Dutton and Goodman, 2005, for a discussion of the concept and their efforts at developing a measure.) In all societies, women have some ways of maintaining power and it is often indirect. Even women who are being terribly abused are *doing something*. They are not just victims. They are active agents trying to manage their situation. I am interested in learning more about that.

Dr. McCarroll: Could you expand upon the differences in causes for men's and women's violence?

Dr. Swan: In looking at the literature of motivations for using violence, the studies tend to find that women are more likely to use violence in self-defense than men. Men are more likely to use it to try to control their partner. But, I actually think that the motivations are really much more complex and people often have multiple motivations. Fighting back may not be only about self-defense, it may also be about retribution because the person is angry about experiencing this victimization. When we asked about motivations in some of my studies, about three out of four women said that they had used violence in self-defense and one out of three said they had used violence at least once to try to make their partner do something. Forty-five percent had used violence for purposes of retribution.

Dr. McCarroll: We look forward to your future research.

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Important Websites on Fatality Review

There are national and state websites on fatality review. At the state level these sites tend to present laws and regulations establishing fatality (or death) review boards and reports of their reviews. There are many websites that are national in scope. For example, the U.S. Department of Justice has the **National Center on Child Fatality Review (NCCFR). Go to http://www.ncjrs.gov/ and search under National Center on Child Fatality Review.** This will give you a fact sheet on the NCCFR that describes the history of child fatality review, the composition and mission of local review teams, Internet communications such as directories, listservs, links and data, video and written materials, and presentations related to the review process.

The National Clearinghouse on Child Abuse and Neglect Information [http://nccanch.acf.hhs.gov/]. Search under child abuse and neglect fatalities. This site gives information on child deaths as a result of abuse or neglect by a parent or primary caregiver, vulnerable children, and prevention efforts.

San Diego County, California, recently posted their **local report on domestic violence fatalities [http://www2.sdcounty.ca.gov/hhsa/ServiceDetails.asp?ServiceID=725].** This report provides a description of their mission, history, accomplishments, and a link to their Fatality Review Team 2004 Report. This report gives an overview of case findings including lethality risk factors.