



Joining Families

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REAL WORLD RESEARCH FOR FAMILY ADVOCACY PROGRAMS



Abuse of Active Duty Military Women

An Interview with Dr. Jacquelyn Campbell

Conducted by John H. Newby, MSW, PhD

Jacquelyn C. Campbell, PhD, RN, FAAN, is the Associate Dean for Faculty Affairs/Professor, at the Johns Hopkins University.

Dr. Campbell's research on family violence and violence against women has included risk factor assessment for intimate partner homicide, abuse during pregnancy, marital rape, physical and mental health effects of intimate partner

violence, prevention of dating violence, and interventions to prevent and address domestic violence. She has been the principal investigator on numerous federal grants and served on the congressionally appointed U. S. Department of Defense Task Force on Domestic Violence. Her research results have been used for health policy recommendations to state, national, and international organizations. Dr. Campbell, a member of the National Institute of Medicine, is the recipient of the 2006 Pathfinder Award for Nursing Research from the Friends of the National Institute of Nursing Research. Dr. Campbell has authored and co-authored more than 50 articles and book chapters, as well as written and edited seven books on battered women and family violence.

In This Issue

This issue of *Joining Forces Joining Families* focuses on risk assessment for lethality in domestic abuse. Our featured interview is with Jacquelyn Campbell, PhD, RN, FAAN, Professor and Associate Dean for Faculty Affairs at the Johns Hopkins University. We present a brief review of Dr. Campbell's recent work including her research on the Danger Assessment (DA), a screening procedure for the risk of homicide of women. Our statistics article provides more detailed information on some of the concepts that are presented on the DA website. LTC Mary Dooley-Bernard, the Army's Family Advocacy Program Manager, provides some highlights of the results of the Army's first two annual fatality review boards. Finally, Websites of Interest provides resources on the assessment of the lethality of domestic abuse.



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Dr. Newby: Dr. Campbell, how did you become involved in the study of intimate partner violence (IPV) in the military?

Dr. Campbell: My first studies of domestic violence were of homicide against women. I found that the majority of women who were killed in this country were killed by a husband, boyfriend, ex-husband, or ex-boyfriend. I was collaborating with someone who was active duty Army when a request for proposals came out regarding the health of active duty military women. I was interested in how much abuse these women were experiencing. Up until then, research focused on active duty male service members abusing their civilian spouses. There was almost nothing in the literature about the abuse of active duty military women. Data for that study were collected from January 1998 through October 2000.

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In our survey of military women, in about 60% of the abused women, there was an overlap of at least two different types of abuse.

Dr. Newby: Would you give us a brief summary of that research?

Dr. Campbell: We found that the prevalence of physical and sexual interpersonal violence (IPV) among the military women sampled was 21.6% during their military service. It was not well known at the time that military women experienced abuse. During military service, perpetrators of abuse were: other active duty military members (43.2%), civilians (18.5%) and retirees (38.4%). Emotional abuse is not included in the 21.6% rate of abused women. In our survey of military women, in about 60% of the abused women, there was an overlap of at least two different types of abuse, physical and emotional, physical and sexual, or emotional and sexual. About 22% of the women experienced all three kinds of abuse. We also found that during military service IPV was more prevalent among enlisted women (30.6%) than officers (14.5%) and those with lower levels of education (high school=25.0%, post-graduate=15.0%). It is interesting to note, however, the percentage of IPV reported by officers, since a common belief is that such violence only occurs among the enlisted ranks.

Dr. Newby: What do you think about the reliability of your findings considering the limitations of your study?

Dr. Campbell: I would love to conduct the study again now that there is a DoD confidentiality policy. Our biggest limitation was a requirement by the institutional review board that we had to have a statement in the consent form that the research records could be reviewed by the participant's commanding officer. As a consequence our response rate was very low (13.2%).

Dr. Newby: Did they feel that it would be held against them or just did not want the information to be known.

Dr. Campbell: They were afraid of being considered less competent if they had a record of abuse even though they had been victimized. They also believed that having a personal record of being abused would hurt their chances for promotion.

Dr. Newby: Are there any specific risk factors for military women that could lead to violence?

Dr. Campbell: One risk factor was being separated or divorced. However, the cross-sectional aspect of the study did not tell us if the separation or divorce came before or after the IPV. We know from civilian studies that separation from an abusive partner may cause an escalation of abuse. Active duty military women and their commanders should be made aware of this danger. As I mentioned before, we saw an increased risk for women in the enlisted ranks, although there was still considerable abuse among officers. We also saw an increased risk for women who had three or more children. When there is a lot of stress in the household abusive situations can be exacerbated.

Dr. Newby: Are the risk factors different from what you would find in the civilian community?

Dr. Campbell: Oftentimes, in the civilian community we find lower income related to recent abuse. If women do not have sufficient resources it is harder for them to escape from an abusive relationship. The low income factor may not be as important in a military context because of the economic floor below which we hope most military families do not fall. We do not see the degree of poverty that we see sometimes in the civilian world.

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Review of Recent Research: Jacquelyn C. Campbell, PhD, RN, FAAN

James E. McCarroll, PhD, David M. Benedek, MD, and Robert J. Ursano, MD

If a woman's perception of risk is very high, her assessment is more important than any other factor. However, if it is low then a lethality assessment, such as with the DA, becomes more important since it gives her additional information that she might not have previously considered.

Dr. Campbell has pursued a wide variety of research interests with a focus on understanding domestic violence. She has an extensive bibliography including such topics as domestic violence during pregnancy (Campbell, Garcia-Moreno, & Sharps, 2004), health consequences of intimate partner violence (Campbell, 2002), lethality and other risks of domestic violence against women (Campbell, 2004), and abuse of military women (O'Campo, Kub, Woods, et al., 2006).

Decades of research have demonstrated that women who have been abused report a higher prevalence of health problems including mental health symptoms than non-abused women. Campbell's review of this topic (2002) described the health consequences of physical or sexual assault as increasing the incidence of injury, chronic pain, gastrointestinal and gynecological diseases, depression and posttraumatic stress disorder (PTSD). She also noted that intimate partner violence has been found worldwide in 3-13% of pregnancies with detrimental outcomes to mothers and infants. She recommended increasing assessment and intervention in health care settings for intimate partner violence against women.

Much of Dr. Campbell's research has been on the prediction of the risk of homicide of women. She helped develop the Danger Assessment (DA) screening instrument. Her recent research on the murder of women is based on a 12-city study of women who were killed or almost killed by an intimate partner (Campbell, Webster, Koziol-McLain, et al., 2003; Campbell, 2004). Based on her research, Campbell (2004) gives suggestions for safety planning and risk assessment for the criminal justice and health care systems, and for advocates. She notes three types of risk that are commonly assessed, but urges caution because they are often confused. These risks are: reassault, lethality, and safety. Abused women themselves are good predictors of reassault, but usually the prediction can be improved by the use of an instrument (Heckert

& Gondolf, 2002). Importantly, she notes that if a woman's perception of risk is very high, her assessment is more important than any other factor. However, if it is low then a lethality assessment, such as with the DA, becomes more

important since it gives her additional information that she might not have previously considered. In another commentary on risk assessment of severe interpersonal violence against women, Campbell notes that strategies for assessment are not either-or enterprises. In other words, the assessment instrument alone should

not be the sole basis of decision-making at the present time. She recommends a combination of the judgment of an experienced professional, a well-validated instrument, and the input of the abused woman as the best approach to lethality assessment (Campbell, 2005).

While PTSD and depression have been studied as outcomes of abuse, their co-morbidity has received less attention. Campbell and colleagues (O'Campo, Kub, Woods, et al., 2006) studied the prevalence of PTSD and depression in abused and non-abused civilian and military women in a sample of 2,005 civilian and 616 military women. They found the prevalence of mental health symptoms was higher among abused than non-abused women. Thirty-four percent of abused civilian women and 25% of abused military women had symptoms of PTSD, depression, or both compared to 18% of non-abused civilian women and 15% of non-abused military women. Co-morbidity of PTSD and depression was more common in civilian abused women than in abused women in the military. The authors noted that military women are less likely than civilian women to have psychopathology because entrants for military service are screened for mental illness and those with mental health problems are likely to be discharged.

In a separate study of the same sample, Gielen et al. (2006) reported the beliefs of active duty military women about routine screening for domestic violence by health

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care providers and the mandatory reporting of domestic violence to commanders. At the time this research was conducted, reporting of domestic violence to commanders was mandatory. The majority of respondents supported mandatory reporting, but also recognized that there were negative as well as positive consequences in terms of safety, privacy, autonomy, and conflicts between personal and professional (career) priorities. However, abused women were much less likely to agree with mandatory reporting. The authors concluded that much more work needs to be done on gaining an understanding of the complexities of women's perceptions of domestic violence reporting policies in the military.

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Building Bridges to Research: Screening for Dangerousness

James E. McCarroll, PhD, David M. Benedek, MD, and Robert J. Ursano, MD

Screening is a complex undertaking. Those persons contemplating using screening instruments should understand the concepts of screening as well as the implications of false positives and false negatives.

Dr. Jacquelyn Campbell and other investigators in 1985 and 1988 (Campbell, Webster, Koziol-McLain, et al., 2003) developed the Danger Assessment (DA) instrument to assist abused women in estimating their risk of homicide. A second purpose of the DA is to assist persons who work with domestic violence victims, such as police, advocates, and health care professionals, in measuring and warning women of their danger level. We have previously presented a discussion of the concepts involved in risk assessment using screening instruments in *JFJF* Vol. 9, No. 1. Two articles discuss the prediction of incidents of domestic violence: "Predicting the Risk of Re-assault" and "Statistical Concepts in Risk Assessment." The first discusses general issues in risk assessment, including the use of instruments, while the second defines important statistical concepts used in prediction based on instruments that use a cutoff score. Our interview in this issue with Dr. Campbell allows us to re-visit the statistical

issues involved in screening and to give specific examples of the concepts presented on the DA website page at <http://www.dangerassessment.com> (also see Websites of interest in this issue of *Joining Forces/Joining Families*). We make no evaluation of the DA, but use it as an example of some of the statistical properties of screening instruments for purposes of illustration.

The DA is conducted in two parts. First, the severity and frequency of assault is measured by presenting the woman with a calendar of the past year. She is asked to mark the approximate days when physically abusive incidents occurred and to rank the severity of the incident on a 1 to 5 scale where 1 is the least severe. The second part of the DA is a 20-item yes/no response format of risk factors associated with intimate partner homicide. Examples include "Has the physical violence increased in frequency over the past year?" and "Does he ever try to choke you?" The DA is scored by counting the "Yes" responses.

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Update on the Army Domestic Violence and Child Maltreatment Fatality Review Process

LTC Mary Dooley-Bernard, MSW and Mr. Rich Stagliano, MSW

The primary objective of fatality review is to improve the military community's response to domestic violence and child abuse by using the lessons learned and identified trends to assist in developing policy recommendations for earlier and more effective interventions.

“Crime Scene: Two soldiers die in apparent murder-suicide. Several stunned members of the Division converged on the scene where two of the Division’s soldiers lay shot to death in what police believe was a murder-suicide. The incident involved a husband and wife who had a history of domestic violence. The couple had two children: a son, 4; and a daughter, 20 months old.” (July 23, 2004, Killeen Daily Herald)

Child and spouse maltreatment deaths are very serious issues for the military services. The National Defense Authorization Act for Fiscal Year (FY) 2000 required the establishment of the Department of Defense (DOD) Task Force on Domestic Violence. In its third year report, the Task Force recommended that the Department develop guidance for fatality reviews. Fatality reviews are a mechanism for ongoing examination of domestic violence and child maltreatment policies and case practices that may inadvertently contribute to or fail to identify factors contributing to fatalities. Identification of these factors enables the services to make changes in policies and practices. The primary objective of fatality review is to improve the military community’s response to domestic violence and child abuse by using the lessons learned and identified trends to assist in developing policy recommendations for earlier and more effective interventions.

The Headquarters, Department of the Army Fatality Review Board conducted its first two fatality reviews in fiscal 2005 and 2006. The Board reviewed domestic violence and child maltreatment fatalities (including related suicides) that occurred in the two years prior to review. The Board utilized a multi-disciplinary team whose members represented organiza-

tions responsible for the reporting, prevention, intervention, treatment, and prosecution of incidents of domestic violence and child abuse.

The Board developed a model that reviewed data on victim demographics, injuries, autopsy findings, homicide or suicide methods, weapons, police information, assailant demographics, and household/family information. The Board reviewed 43 fatalities (31 children and 12 adults). Sixty-eight percent of the

child deaths were children under the age of four years. Fifty-two percent of the adults involved in the child abuse fatalities had active substance abuse or other behavioral health issues. Nine child abuse fatalities occurred while the soldier was deployed.

The Army fatality statistics are consistent with the

latest national report from US Department of Health and Human Services (HHS) in 2004 (2006) which indicate that more than three-quarters (78.7%) of children who were killed as a result of abuse were younger than 4 years of age. HHS also reports that 10.2% were 4–7 years of age; 5.4% were 8–11 years of age; and 5.7% were 12–17 years of age.

The Board recommended changes in Army policies to facilitate early and effective intervention in family maltreatment cases and many of the recommendations geared toward children have been implemented. The US Army Medical Command revised their social work home assessment policy to permit home visits, initiated screening and intervention procedures for post-partum depression of eligible beneficiaries, and provided updated instructions on safe sleeping to all new parents. They will also provide instructions on safe sleeping, bath safety, and avoidance of shaking babies to all new parents prior to the mother’s discharge, and to

As a result of the fatality review boards, the Army has revised the social work home assessment policy to permit home visits, initiated screening and intervention procedures for post-partum depression of eligible beneficiaries, provided updated instructions on safe sleeping, bath safety, and avoidance of shaking babies to all new parents.

ensure that educational materials are available for parents who deliver in civilian hospitals.

The Army will also develop a fatality review training package for installation fatality review committees so that local reviews can be conducted before the cases are forwarded to Army headquarters. The package will include roles and responsibilities of the committee members, operational procedures, analysis of significant findings, and descriptions of lessons learned. The Army continues to revise operational procedures for increased cooperation with military and civilian law enforcement agencies and data reporting requirements for future fatality reviews.

In conclusion, the fatality review process within the military services is an opportunity to learn about the causes and circumstances of domestic violence and child fatalities in order to prevent future deaths. Every fatality is a profound loss to parents, families and the community. We hope that this new process will encourage everyone to become more involved in preventing the untimely deaths of our service members, their spouses, and children.

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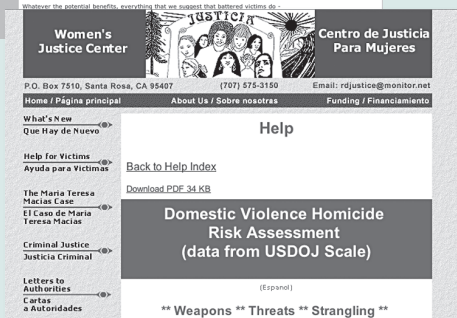
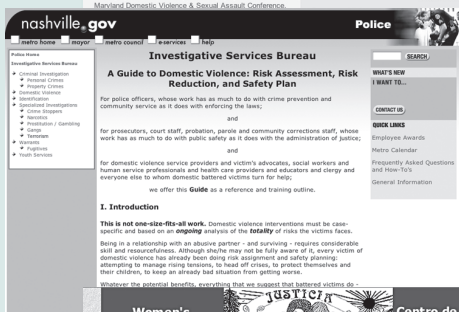
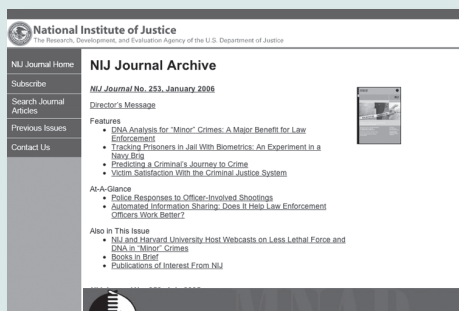
Websites of Interest

There are many websites on risk assessment in the context of domestic violence and homicide. The National Institute of Justice offers an on-line publication (the *NIJ Journal*) that has articles of interest to the spouse and child maltreatment communities. For example, Issue 250 was devoted to intimate partner homicide. There are articles by Dr. Campbell and colleagues on how practitioners can help a woman lower her risk of death; drinking, drug use, and homicide; cross-cultural issues in domestic violence; and others. See <http://www.ojp.usdoj.gov/nij/journals/archive.html>.

■ Other websites featuring risk assessment for homicide are available. For example, the Maryland Network Against Domestic Violence <http://www.mnadv.org/> also has information on lethality and fatality resources. These include a lethality screen and a protocol for first responders. This site also describes the organization's lethality assessment that encourages victims in high danger to seek domestic violence program services.

■ At <http://police.nashville.org/bureaus/investigative/domestic/stalking.htm> the Nashville police department provides a guide to domestic violence services including risk assessment, risk reduction and safety planning.

■ The Women's Justice Center http://www.justicewomen.com/tips_dv_assessment.html Santa Rosa, California, emphasizes the top five risk factors that indicate that a domestic violence victim's risk of homicide is increased. These data come from the US Department of Justice Scale (See *NIJ Journal*, Issue No. 250, November 2003).



The prevalence of mental health symptoms was higher among abused than non-abused women in both samples and also higher among the civilian sample compared to the military sample. Military women, more than civilian women, were pretty resilient relative to mental health consequences. However, if they had been abused, they still experienced significantly elevated mental health symptoms.

Dr. Campbell Interview, from page 2

Dr. Newby: What were some of the physical health and mental health consequences of IPV that you found in your study?

Dr. Campbell: We saw almost exactly the same pattern of physical health consequences for active duty women as we did among civilian women. Symptoms clustered around stress-related problems such as gastrointestinal symptoms and more overall physical symptoms. We also saw more chronic pain among women who were abused. The other cluster of symptoms that we saw included gynecological problems probably related to forced sex. There were also neurological problems such as headaches and other symptoms that were not so clearly defined.

Dr. Newby: Were there any distinct mental health consequences?

Dr. Campbell: We saw a different pattern of mental health consequences for the active duty women than we saw for the civilian women. The prevalence of mental health symptoms was higher among abused than non-abused women in both samples and also higher among the civilian sample compared to the military sample. Additionally, 34% of the abused civilian women versus 25% of the abused military women had symptoms that met criteria for a major depressive disorder, posttraumatic stress disorder (PTSD), or the co-occurrence of PTSD and depression. That compares with 18% and 15% of non-abused women in civilian and military groups, respectively. Military women, more than civilian women, were pretty resilient relative to mental health consequences.

Dr. Newby: What were the results of your research that addressed active duty females' perceptions of the positive and negative consequences of mandatory reporting and routine screening for IPV?

Dr. Campbell: About 57% of women thought that routine screening or the routine assessment for domestic violence in health care settings was a good idea, and 48% thought that there should be mandatory reporting. Non-abused women were more in favor of mandatory reporting than abused women. Both military and civilian women thought that they ought to be able to control the reporting process. The military women wanted to determine whether the abuse would be reported to

the commander or military police. A powerful dimension of that research was its evidence-based link to the formulation of a confidentiality policy in DoD. During my time as a member of the congressionally appointed Defense Task Force on Domestic Violence, I used the data from our study to help persuade the committee to make a recommendation to give victims more say in whether or not domestic violence is reported. Starting in January 2006, there is now for the first time a restrictive reporting policy that applies to health care providers as well as domestic violence advocates. The reporting of domestic violence is restricted to those the victim specifically designates unless there is a likelihood of imminent harm to someone, child abuse, a subpoena for a directly relevant case, or a relevant disability hearing. Otherwise, neither the commanding officer nor the military police nor anyone else is notified of domestic violence if the victim so chooses. This is an example of an important policy change based, in part, on our research.

Dr. Newby: Were there other barriers to the self-reporting of IPV by active duty women.

Dr. Campbell: Yes, if a woman was on active duty and her husband was civilian, she wanted her partner to become non-violent without the risk of him getting a criminal record. If she was married to an immigrant, she was fearful that the reporting of IPV could possibly hurt her partner's chances of obtaining citizenship. Children may also serve as a barrier to self-reporting. Accordingly, women often feel that the reporting of IPV will negatively affect the perception of them as parents by various authorities.

Dr. Newby: Are these barriers different from those experienced by civilian women?

Dr. Campbell: The major difference for active duty military women was the role of the commander. If her partner is also active duty military, she may be afraid that he is going to be thrown out of the military. She may not want his career to be ended. She just wants the violence to end. It takes a woman a while to realize that these two goals may be incompatible.

Dr. Newby: Would you comment on the possible overlap of IPV and sexual assault issues among active duty military women?

Dr. Campbell: Many women are not only physically abused by their partners; they are

Dr. Campbell Interview, from page 7

also being forced to engage in sexual activities. It really is sexual assault or rape even though the assault is done by an intimate partner. In our study, 33% of the physically abused women also reported being forced into sex by the same partner. This type of sexual assault can be a very common part of intimate partner violence. There is a lot of shame that goes along with it and it is difficult for a woman to admit that she is being raped by the person who is supposed to love her. Our questioning of victims should focus on “forced sex” rather than using rape or sexual assault language.

Dr. Newby: What are your current research interests relative to IPV?

Dr. Campbell: We have been looking at the occurrence of workplace violence relative to particular health-related outcomes. I would like to replicate that in the military. I am also interested in our returning combat-exposed male veterans and whether those veterans who have PTSD are more likely to abuse their wives and children. Also, now that we have large numbers

of combat-exposed females, I would also like to know whether there will be an increased risk for these women as either perpetrators or victims of domestic violence. One other thing I would like to study is whether or not the new DoD restricted confidentiality policy encourages more active duty women to come forward and report intimate partner violence. I would like to determine if the policy is really increasing the perception of safety by active duty military women.

Dr. Newby: Do you think the policy of providing soldiers and their families with post-deployment classes, briefings, counseling and other interventions will decrease the potential for negative repercussions?

Dr. Campbell: I certainly hope so. Oftentimes it is the non-abusing families that step forward and become involved in those programs. Unfortunately, families that need the services the most often do not ask for help. We need to determine how best we can reach them. I do hope that our current post-deployment interventions to help and support military families are effective. Sometimes we find that what we think is going to be helpful is not. There is a need for much more research in this area.

Building Bridges, from page 4

Among the statistics presented on the DA website are estimates of its reliability, validity, sensitivity, specificity, cutoff scores, and the receiver operating curve (ROC) analysis. Reliability statistics for the DA are provided for internal consistency (how well each item relates independently to the rest of the items on the scale) and test-retest (the correlation between two or more administrations of the same scale). Validity statistics are given for discriminant construct group validity (how well the instrument discriminates between groups) and convergent construct validity (how well the measures that should be related are related). Convergent validity means that different measures converge on the construct that you measure. Predictive validity is the ability of an instrument to predict what it is supposed to predict.

The effects of different cutoff scores on prediction using the DA are also presented. At this point, the statistical concepts become more difficult to understand. There are many ways to describe measures of how well a screening test actually works. A cutoff score on a screening test balances at least two essential concepts in prediction: sensitivity and specificity (see JFJF Vol. 9, No. 1). In this example, sensitivity is the ability of a test to correctly identify the persons who *are* in danger. Specificity is the ability of the test to correctly identify persons who *are not* in danger. The investigator can set a cutoff score to select persons correctly screened (sensitivity) and eliminate those who should not be selected by the test (specificity). However, since tests are not perfect and do not represent reality, there will always be false positives and false negatives. If sensitivity is high (i.e., you correctly identify the people in danger, then specificity is often low. If specificity is high (i.e., you correctly identify the people who are not in danger) then sensitivity is often low. For example, for a cutoff of 4 on the DA, about 80%

of those in danger were correctly identified (sensitivity), but only about 40% of those who were not in danger were correctly identified. At a cutoff of 7, 58% of those who were in danger were correctly identified and 87% who were not in danger were correctly identified. It was noted that the sensitivity of 58% was worrisome because an additional 42% of the women in danger were not identified. The authors of the psychometric data page provide more information about an improved scoring system that involves a weighted score that correctly identifies 90.8% of the cases.

The validity of the DA has not been specifically established for any military population. As a result, some of the items that were particularly predictive in the civilian population may not have the same predictive power in the military (Campbell, Webster, Koziol-McLain, et al., 2003). For example, gun ownership was important in the 12-city study. However, in the military many soldiers collect guns and this item may not have the same predictive power as was found in a civilian population. Unemployment of the perpetrator was also predictive of homicide, but this item would not apply to an active duty military perpetrator population since all are employed.

Screening is a complex undertaking. Those persons contemplating using screening instruments should understand the concepts of screening as well as the implications of false positives and false negatives.

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