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# *Helping Women Understand Their Risk in Situations of Intimate Partner Violence*

JACQUELYN C. CAMPBELL

*Johns Hopkins University School of Nursing*

*Only approximately one-half of the 456 women who were killed or almost killed by a husband, boyfriend, or ex-husband or ex-boyfriend in a recent national study of homicide of women accurately perceived their risk of being killed by their abusive partner. Women are unlikely to overestimate their risk; however, many will underestimate the severity of the situation. From the same study, it was found that relatively few of the victims of actual or attempted intimate partner femicide were seen by domestic violence advocates during the year before they were killed; they were far more likely to be seen in the health care system. Implications are drawn as to innovative ways that women who are abused can be identified and with skilled assessment of the danger in their relationship helped make more informed plans for their safety.*

**Keywords:** *domestic violence; intimate partner homicide; femicide; risk assessment; safety planning*

***In any discussion of the concept of risk*** in situations of intimate partner violence (IPV), researchers, practitioners, and victims need to be clear about the outcome they are discussing. At risk for what? The other important distinction is among whom we are trying to determine the risk factors. These are extremely important issues, not just researchers talking about obscure problems. For instance, in more than 20 years of research on IPV, there is still debate on how much risk for IPV ever occurring is attributable to sociodemographic factors, education, income, ethnicity, and marital status. Recent work suggests that class, income, and employment may be more important than race as risk factors for IPV; however, there is still much work to be done to sort out these issues (e.g., Cunradi, Caetano, Clark, & Schafer, 2000; Rennison & Planty, 2003). It also seems evident that poverty and less

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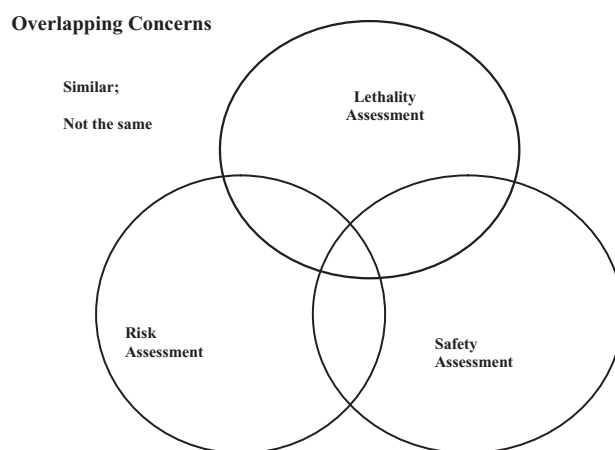
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**Figure 1: Relationship of risk factors for intimate partner violence (IPV)**

education are stronger risk factors for past year IPV victimization than for lifetime abuse, perhaps because constraints in sociodemographic factors contribute to women having fewer choices to end violence rather than influence her selection of a partner. It also matters in these explanations if we are looking at the demographic factors of the victim, the perpetrator, or any difference in such factors between the two partners.

These issues of risk for IPV occurring are important in terms of prevention of this important health and justice problem; however, there is another set of risk issues that also deserve in-depth examination. There is a great deal of current interest and debate in issues of risk for reassault and lethality after IPV first occurs. First, as with other issues of risk, it is important to distinguish what kind of risk is being discussed. It is important to differentiate among three categories of risk: factors that increase the risk of reassault or revictimization, those that increase risk of lethality, and factors that keep women who are battered safer or reduce their risk of being battered. As can be seen in Figure 1, these risk factors overlap but are not exactly the same. The purpose of the article is to review these concepts of risk, using and combining findings from the intimate partner femicide study (also known as the 12-city femicide study; Campbell, Webster, et al., 2003; Campbell, Webster, Koziol-McLain, et al., 2003) to draw inferences for the criminal justice, health, and advocacy systems in terms of talking to women who are abused about their risk.

This article uses an abbreviated version of the Centers for Disease Control and Prevention (CDC) definition for *IPV* summarized as follows: physical and/or sexual violence (use of physical force) or threat of such violence; or psychological/emotional abuse and/or coercive tactics when there has been prior physical and/or sexual violence; between persons who are spouses or nonmarital partners (dating, boyfriend-girlfriend) or former spouses or nonmarital partners (Saltzman, Fanslow, McMahon, & Shelley, 1999).

### LITERATURE REVIEW

The most serious form of *IPV* is, of course, murder. *Femicide* (Campbell & Runyon, 1998; Russell, 1992, 2001) is actually the most accurate term for the murder of women, which is one of the leading causes of premature death for women in the United States (Hoyert, Kochanek, & Murphy, 1999) and the leading cause of death for African American women aged 15 to 34 years (Grisso, Schwartz, et al., 1999). Whereas only 3% to 6% of male homicide victims are killed by an intimate partner (Kellerman & Heron, 1999; Puzone, 2000), 30% to 55% of femicide victims are killed by an intimate partner (Greenfeld et al., 1998; Puzone, 2000; Rennison & Welchans, 2000). During the past 25 years, there has been notable development of programs and legislation that has resulted in a decrease of *IPV* by most measures (Centers for Disease Control and Prevention [CDC], 2003), including a decrease in intimate partner homicide. However, closer inspection of these trends reveals that although there has been a steady decrease in the rate of murders by intimate partners where the victim is a man, there has been far less improvement in the intimate partner femicide rate (Greenfeld et al., 1998; Paulozzi, Saltzman, Thompson, & Holmgreen, 2001; Puzone, 2000; Rennison & Welchans, 2000).

Studies have found that 65% to 80% of victims of intimate partner femicide were previously abused by the partners who killed them (Pataki, 2004; Sharps, Koziol-McLain, Campbell, McFarlane, Sachs, & Xu, 2001). The previously mentioned 12-city femicide study demonstrated that the majority of women who were killed were seen in the criminal justice, health, social services, or shelter systems during the year before they were killed, suggesting that there was an opportunity to conduct safety planning with them (Sharps, Koziol-McClain, et al., 2001). Yet, as has often been pointed out, safety planning is best conducted as an active partnership between a woman who is abused and an advocate or other service provider trained in domestic violence (DV). The question then becomes how best to help women who are abused most accurately determine their own risk?

Recent studies of reassault suggest that women who are battered are the best predictors of their own risk of reassault (Goodman, Dutton, & Bennett, 2000; Weisz, Tolman, & Saunders, 2000), or at least in conjunction with a risk assessment instrument (Heckert & Gondolf, 2002). Even so, existing research such as the 12-city femicide study (Campbell, Koziol-McLain, et al., 2003; Campbell, Webster, et al., 2003) and other studies of intimate partner homicide (Browne, Williams, & Dutton, 1998; Campbell, 1995) suggest that the risk factors for femicide and DV reassault, although overlapping, are not exactly the same. It may well be that women who are abused who perceive their partner to be extremely dangerous are indeed correct about that perception; however, at least some of those who do not perceive him to be highly dangerous are underestimating their risk. The finding from the intimate partner femicide study that approximately 50% of the women who were killed or almost killed by their intimate partner did not accurately assess him (or her) as capable of killing her continues to be persuasive in demonstrating the need for other means of helping women who are battered more accurately perceive their risk.

The Danger Assessment (DA) is a clinical and research instrument that was designed to assist women who are battered in assessing their danger of being murdered by their intimate partner. The original DA measured the total number of "yes" responses by the woman who was battered on the 15-item risk factors associated with intimate partner homicide and is scored by counting the "yes" responses; a higher number indicates that more of the risk factors for homicide are present in the relationship. There is substantial concurrent construct validity support for the DA and now two independent predictive validity studies that, at least, partially support the instrument's ability to predict reassault (Goodman et al., 2000; Heckert & Gondolf, 2002). The 12-city study also provided support for the risk factors on the DA being important risk factors for intimate partner femicide (Campbell, Koziol-McLain, et al., 2003).

## METHOD

The descriptive data presented in this article are from a national 12-city (Baltimore; Houston, Texas; Kansas City, Kansas; Kansas City, Missouri; Los Angeles; New York; Portland, Oregon; Seattle, Washington; St. Petersburg/Tampa area, Florida; Wichita, Kansas) study of risk factors for homicide in violent intimate relationships (Campbell, Webster, et al., 2003). These cities were selected based on size and geographic representativeness of the United States.

At each site, coinvestigators worked with the local police department, the district attorney's office, and the medical examiner's office to identify closed police records of women who had been victims of homicide or an attempted homicide by an intimate partner between 1994 through 1998. Police records or medical examiner cases were considered a femicide if the female had been murdered by an intimate partner (spouse, ex-spouse, boyfriend, ex-boyfriend, partner, or ex-partner). Attempted femicide was considered if the police or medical examiners records indicated serious injury by firearm, blunt/cutting/piercing object or strangulation or clear police-validated intent to kill by an intimate partner. Police and medical examiners reports were reviewed using a Police Abstraction Form, a computerized database form for purposes of the current study. The coinvestigators used this form to extract details from the police records related to the demographic background of the victim, survivor, and perpetrator; details of the femicide event or attempted femicide event; types of injuries; health care system utilization; prior arrests of the victim, survivor, and perpetrator; alcohol and/or drug use by victim, survivor, or perpetrator; details of the relationship including domestic abuse; and witnesses, including children. The reliability of the abstraction was established by two investigators abstracting together until agreement was reached on meanings of questions. Bimonthly conference calls were held to discuss coding issues with directions electronically mailed, and/or the database form updated to reflect interpretation decisions. Coinvestigators and other staff were trained to use the form by the principal investigator or a coinvestigator.

Proxy family members or friends of the homicide victims who knew the details of the deceased women's intimate relationship were identified from the police or medical examiners' records description of the case for follow-up interviews about the characteristics of the relationship and the violence in the relationship. The informants were most often mothers (26.6%), sisters (17.3%), close female friends (8.4%), adult female child of victim (8.9%), and other family members (39%). All potential proxies received a letter describing the study and inviting their participation by contacting the telephone number in the letter or returning the stamped, addressed postcard to the coinvestigators. Proxies not responding to the letters received follow-up phone calls. Phone interviews to potential proxy informants were conducted to determine eligibility to complete the full telephone interviews and to obtain consent. Potential informants were asked questions related to the nature of their relationship to the victim, length of the relationship, and their knowledge of the details of the intimate relationship between the victim and the perpetrator including knowledge of abuse (or absence thereof) during the relationship. Proxy informants who indicated positive responses to the pre-

liminary screening questions and gave informed consent to the study were considered appropriate informants. Approximately 10% of identified proxies refused to participate, at which point they were asked to identify another knowledgeable proxy. A similar sample recruitment process was used for women who survived an attempt on their life. These women completed a telephone interview about their intimate relationships and the violence in the intimate relationships. Eligibility criteria for proxy informants and survivors also included ability to speak and understand English.

Sample recruitment began after agency approvals and institutional review approvals for human participants were obtained. A structured short-answer interview questionnaire was used to complete the preliminary screening telephone interview that determined proxy eligibility and for the follow-up interviews of proxies and survivors. The interview questionnaire grouped questions into the following 11 categories: demographics about victim; demographics about perpetrator and relationship with perpetrator; other partners; femicide or attempted femicide incident; history of abuse before fatal or near-fatal incident; perpetrator stalking and harassing behaviors, use of shelters, police, and other resources; weapon ownership; attempted separations; victim and perpetrator alcohol and/or drug use; and family or victim income, as well as other risk factors for intimate partner homicide from the Danger Assessment (Campbell, 1995; Campbell, Koziol-McLain, et al., 2003). The stalking questions came from the National Violence Against Women Survey (Tjaden & Thoennes, 2000) and the harassment queries from the Sheridan Harassment in Abusive Relationships: A Self-Report Scale (HARASS) instrument (Campbell, Torres, McKenna, Sheridan, & Landenburger, 2004). Additional questions were asked about health care utilization by victims, perpetrators, and children witnesses to the femicide or attempted femicide. Proxy interviews were necessary because these details are not routinely a part of the police or medical examiners' records. Factual elements such as prior arrest, employment status, previous calls to police, or use of protection orders were verified with data abstracted from police files.

As the interviewer listened, the responses were recorded into structured response categories. Responses not fitting into the structured response categories were recorded as other categories or as margin notes. Interviewers hand-recorded responses and tape-recorded the interview simultaneously. After each interview, the interviewers used the tape-recorded interview to fill in any gaps or other information not accurately completed during the phone interview. All interview data was sent to the Baltimore site where data was reviewed for completeness and then entered into the computer database for analysis. Telephone interviews of proxy informants and women survivors consenting to participate were conducted by doctorally prepared researchers

or doctoral students experienced in conducting sensitive communications with victims of domestic abuse. Interviews took approximately 1 to 1½ hours to complete.

### Sample

The total sample of women victims of attempted and actual femicide ( $N = 445$ ) had an average age of 34 while the average age of the abused controls was younger (30.2) but not significantly so, compared to the average age of a random sample of women in the same cities of 34.2. The partners who were homicidal were slightly older than the women they killed or almost killed (36.1) while the abusive men were slightly younger than their partners (31.3) and about the same age as the male partners who were nonabusive (37). Almost one-half of the women who were killed or almost killed (47%) were African American, 28% White, 21.5% Latina, and 3.2% Other (primarily Asian American and Native American). A greater proportion of the women who were abused were White (48.4%) with fewer (21.4%) of that group African American but approximately the same proportion of Latina women (22%) and 8.2% identifying themselves as belonging to other ethnic groups. The proportions of perpetrators of abuse and homicide or attempted homicides in each ethnic group was very similar to those of their female partners. The women who were abused had higher educational levels (83% high school education or more) than their male partners (74%), and the women who were killed or almost killed (69%) and their male partners had the lowest educational levels (54% high school education or less). Employment followed the same pattern with 24% of the women who were abused unemployed, 34% of their partners unemployed, 37% of the victims of homicide or attempted homicide unemployed, and 55% of the perpetrators of homicide unemployed. Although all of these demographic differences between groups were significant in the bivariate analysis, the only significant demographic predictor of intimate partner femicide was perpetrator unemployment in the multivariate analysis (Campbell, Webster, et al., 2003).

### FINDINGS RELATIVE TO THE CRIMINAL JUSTICE SYSTEM

Traditionally, we have thought that the most dangerous batterers are generally violent. Prior arrest for violent crime is one of the most trusted and fre-

quently mentioned risk factors for DV reassault. Although we found that almost twice as many of the perpetrators of femicide or attempted femicide were arrested for violent crime prior to the murder than the partners of women who were abused in the same cities (21.8% vs. 11.5%  $p < .05$ ), this factor became nonsignificant in the multivariate analysis. In other words, other risk factors were more important than perpetrator prior arrest for violent crime in the final analysis. A similar finding resulted for use of protective orders with 24.5% of the victims of femicide having an order of protection in comparison to 4.7% of the women who were abused. This risk factor also became nonsignificant in the multivariate analysis (Campbell, Webster, et al., 2003).

One of the most surprising findings in the 12-city femicide study was that prior arrest for domestic violence was a protective factor (odds ratio [OR] = .3) in the multivariate risk assessment for intimate partner femicide and attempted femicide. In contrast, Gondolf (1997), Heckert and Gondolf (2002) and Williams and Houghton (in press) have found prior DV arrest as a risk factor for subsequent reassault. When we examined this finding in more detail, we found that although 25.6% of the 220 perpetrators of intimate partner femicide and 29% of the 183 perpetrators of attempted femicide had been arrested for DV in comparison to 13.9% of the control sample of women who were battered (25 missing data), in the multivariate analysis in both samples, prior arrest becomes protective. To explain the shift from increased risk in the bivariate analysis to protection in the multivariate analysis, we examined for interaction effects between arrest and other demographic risk factors but found none. We also looked at relationships between arrest and other variables and found that it was among the women most at risk, according to DA scores, that prior arrest was strongly protective whereas for women at lower risk, it increased risk of murder or attempted murder. In other words, arrest seemed to function to keep highly dangerous abusive men from killing their victims, perhaps by surveillance or by setting in motion a criminal justice system response.

Even with this finding, it is important to take into full account that the majority of the killers had never been arrested for DV. Of the women who were abused, 38% had called the police during the year before she was killed, demonstrating that even in these highly dangerous situations, there were far more calls to the police than actual arrests (25.6%). Although the criminal justice was the system that had the most interaction with these cases of DV before the women were killed, even that system had not seen the majority of the victims.

### FINDINGS IMPORTANT TO THE HEALTH CARE SYSTEM

Some of the most important findings with implications for the prevention of intimate partner femicide were the use of the health care system by the victims before they were killed or almost killed. Although 44 (14.1%) of the women who were killed had been in the health care system with injuries from DV, more of the women were in the health care system for general health problems or for mental health problems including substance abuse. A total of 47% of the victims had been seen in the health care system for something during the year before they were killed. Although far more of the perpetrators of femicide ( $n = 191$  or 61.4%) had substance abuse problems than victims ( $n = 67$  or 21.5%), a larger proportion of the women (26.8%) with substance abuse problems had actually been to drug or alcohol treatment than men (7.8%). Nonetheless, there is clearly a large segment of women who are battered and their perpetrators with substance abuse problems that are not getting treatment. This is an important avenue for prevention strategies. Although intervention for substance abuse will not cure the IPV problems, these interventions are needed in addition to interventions for DV because the two issues definitely exacerbate each other. For the few victims and perpetrators who were in substance abuse treatment, these programs were an opportunity to be sure that the IPV in the couples' lives was being addressed and an opportunity for the potential lethality of the relationship to be assessed.

Some of these cases were also involved with the justice system through child abuse. Because of human participants' concerns about mandated reporting, we did not ask about ongoing child abuse, but rather if the perpetrators of abuse and homicide had ever been officially reported for child abuse. Again, official rates of child abuse were low, with 9% of the perpetrators of actual and attempted femicide known to the local child protection system. Even so, this was almost 3 times as much reported child abuse as among the abusive men (3%). We also asked if the perpetrators had ever threatened to harm the children and found a higher proportion among the victims of homicide and attempted homicide than among the controls who were abused. We believe that this item probably more closely approximates actual child abuse. These then were another group of families who should have been under surveillance by the justice system but apparently were not.

### **FINDINGS IMPORTANT TO THE ADVOCACY, SHELTER SYSTEM**

The vast majority of the women who were killed or the victim of attempted femicide in the 12-city femicide study did not access a shelter or DV advocacy system in the year before they were killed. Several of the family members spoke of urging their daughter or sister to "call the shelter"; however, only 4% of the victims of actual and attempted femicide actually took such action (close to the same percentage as among the controls who were abused). We interpret this finding as an indication of the efficacy of shelter and DV advocacy programs; that women who actually took advantage of these services were almost never the victim of murder or attempted murder. However, we also note the lack of accessing of these services among women who were severely abused. Implications for advocacy programs would include becoming more proactive in advertising their services to women who were abused through other systems such as the health care system. Because 47% of the women were seen in a health care system during the year before they were killed, it becomes imperative that the advocacy network advertise their services in those systems. Posters, brochures, and collaborative agreements with health care agencies to form shelter programs to provide on-call DV advocates by phone or in person as well as on-site DV advocates have been successfully implemented in a number of settings (Hadley, Short, Lesin, & Zook, 1995). The Pennsylvania Coalition Against Domestic Violence (PCADV) has led the nation in providing training, funding, and organizational support for a statewide network of health-care-setting DV advocacy programs. Another innovative strategy is to provide computer terminals in health care settings with the local shelter program Web site easily accessible. In that way, patients can access information about these services while waiting for appointments or after seeing the provider. It is important that advocacy programs and health care agencies reach out to each other rather than waiting for an invitation.

### **IMPLICATIONS FOR SAFETY PLANNING WITH WOMEN WHO ARE BATTERED**

Although safety planning with women who are battered in official DV programs is extremely important, it also needs to be done in every system where these women might be seen. In addition to the usual places that we

think of, we also need to try to reach women outside of the health care, criminal justice, and advocacy or shelter systems. We need to think about reaching out to nontraditional sites for conducting lethality assessments and safety planning with women who are battered. Many batterer intervention programs have decided that it is extremely important to be in touch with the partners of their clients to conduct safety planning and maintain communication about the perpetrator's progress and attendance (Campbell, 2002). Those programs and researchers such as Gondolf (Heckert & Gondolf, 2002) have developed careful safety strategies in conjunction with shelters and community coalitions to maintain and even enhance victim safety with these contacts.

### SUMMARY AND CONCLUSIONS

The findings from the intimate partner femicide study give us important implications for talking to women about their risk of reassault and homicide. First, we must help women understand that their own perceptions of risk are extremely important, and if they are frightened for their lives and safety for whatever reason, they should pay attention to that fear (DeBecker, 1997; Goodman et al., 2000; Heckert & Gondolf, 2002; Weisz et al., 2000). Advocates, health care professionals, and criminal justice providers should all pay attention to that fear as a legitimate and important sign of increased risk and engage in assertive safety planning that includes strong advocacy and facilitation of risk reduction strategies (such as extended shelter residence and removal of the batterer by incarceration, high bail, or high-level probation supervision) no matter what the score on any risk assessment instrument. Because none of the existing risk assessment instruments is as yet fully validated (Roehl & Guertin, 1996) and will never be perfectly predictive (Heckert & Gondolf, 2002), the woman's perception of risk and the DV professional experience are important sources of information in addition to information from an instrument for the degree of risk. If a woman's perception is of high risk, this assessment should be considered as more important than any other; however, if her perception of risk is low, it becomes particularly important to engage in a lethality assessment with her.

One of the best ways to approach a woman in terms of lethality assessment and safety planning is to refer to her children if she has children (Hardesty & Campbell, in press). Almost all women who are abused are concerned about their children and an entry phrase such as "I'd like to talk to you about ways to keep you and your children safe" is a great way to broach the subject. Then the criminal justice practitioner, health care professional, or advocate can say that the place to start this discussion is with an assessment of how much dan-

ger she is in. Although I believe the DA is an excellent means of conducting this assessment and at least partially validated (Campbell, 2002; Campbell, Koziol-McLain, et al., 2003; Campbell, Sharps, Sachs & Yam, 2003), there are other instruments that can be used for this assessment (Dutton & Kropp, 2000; Roehl & Guertin, 1996). The process of risk assessment with a survivor of intimate partner violence gives the service provider access to the gold standard of information about the violence in the relationship but also makes the survivors a partner in that assessment so that they assess for themselves the extent of their danger. They will then be much more likely to engage in the kind of risk reduction strategies in partnership with service providers that are needed to keep women and their children safe.

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*Jacquelyn C. Campbell, Ph.D., RN, F.A.A.N., is the Anna D. Wolf Chair and Associate Dean for Faculty Affairs in the Johns Hopkins University School of Nursing with a joint appointment in the JHU Bloomberg School of Public Health. She has conducted advocacy policy work and research in domestic violence since 1980, been the primary investigator of nine major National Institutes of Health, National Institute of Justice, or Centers for Disease Control and Prevention research grants and published more than 120 articles and seven books. She is an elected member of the Institute of Medicine and a board member of the Family Violence Prevention Fund and the House of Ruth Battered Women's Shelter.*