Department of the Navy
Family Advocacy Program:
Service Need and Service Response

Phase I Report: Reconnaissance

February 1983

Gary L. Bowen, Ph.D.

Sabra F. Woolley, Ph.D.

Timothy A. McGaughey, Ph.D.

CONDUCTED BY:
SRA Corporation
901 S. Highland Street
Arlington, Virginia 22204

SPONSORED BY:
Department of the Navy
Office of Naval Research
Arlington, Virginia 22217

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This report reviews the scope and nature of abuse and neglect and examines past responses to the problem by summarizing available military and civilian literature. Sponsored by the Office of Naval Research, it is the first of three reports designed to guide the Department of the Navy in responding to problems of abuse and neglect among Navy and Marine Corps

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personnel and families.

Divided into five chapters, the report (1) summarizes existing military and civilian literature on abuse and neglect; (2) provides estimates from existing data of the incidence of abuse, neglect, sexual assault and rape in military and civilian populations; (3) describes key factors associated with abuse and neglect; (4) identifies successful program elements and key issues in responding to abuse and neglect; (5) reviews the development of family assistance programs addressing these problems in the Army, Air Force, Navy and Marine Corps; and (6) describes the organization and operation of the Navy Family Advocacy Program.

To date, little research exists on incidence and associated factors of abuse and neglect in the military. Available military research is scattered, unsystematic, and often difficult to obtain. These limitations force military policymakers and program practitioners to rely heavily on civilian studies which may have limited application.

The linkages between military retention and performance and family and personal well-being have been well established in the research. Researchers and human service professionals must continue to explore the complexities of abuse and neglect so that intervention and prevention strategies can be built on facts rather than assumptions. The second and third reports of this research will contribute baseline incidence data for the Navy and Marine Corps and profiles of at-risk military families.

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EXECUTIVE SUMMARY

Freedom from fear of personal harm among family members is a right all citizens should enjoy. However, reports of increasing sexual assault, spouse abuse, and child maltreatment among civilian and military families violate this principle. The credibility of these reports and their significance to the Navy and Marine Corps, particularly the Navy Family Advocacy Program, are the subjects of this report.

The Research

The Department of the Navy through the Office of Naval Research requested an indepth review of the extent and nature of personal abuse and neglect in the Navy and Marine Corps, and an assessment of how the Navy Family Advocacy Program, designed to address these problems, is performing worldwide. SRA Corporation of Arlington, Virginia was contracted in 1982:

- To learn the numerical extent and nature of abuse and neglect incidence, conditions, and effects in the military;
- To develop baseline data and profiles of at-risk military families, based on literature research and site visit case studies at 12 Navy and Marine bases in five states, Japan, Italy, and Sardinia;
- To compare military and civilian populations for incidence, prevalence, and at-risk profiles;
- To access the operation of the Navy's Family Advocacy Program at the command level; and
- To develop recommendations for future military policies, programs, and budget planning.

The project will be completed in the fall of 1983 with two more reports. This report compiles the most up-to-date information on family advocacy provisions in all the military services; examines the evolution of military family advocacy programs; describes the Family Advocacy Program in the Department of the Navy; and provides a detailed summary of the available literature on incidence, conditions and effects of abuse and neglect in the military.

Literature sought for this comprehensive review focused on military and civilian studies of and responses to personal abuse and neglect issues. This included sources on sample case incidence reports and public intervention policies and service programs. Also investigated were definitions of abuse and neglect categories; theories of causation, prevention, and treatment; legislated definitions, reporting mechanisms, judicial intervention, and treatment guidelines; and evaluations of staff training and treatment programs. Special attention was given to military

policy and procedural directives and program operations, especially those in the Navy and Marine Corps. All references to studies and other sources of information have been thoroughly cited in each chapter of the report.

Incidence

What has been learned from the literature is that very little has been documented on the scope of personal abuse and neglect in civilian or military populations. Because of limitations in military literature, data from the civilian population became the primary information source. Findings from the military are provided where available, and extrapolations are attempted from the civilian to the military population.

Despite the tendency toward underreporting of abuse and neglect incidents, the transformation of personal abuse and neglect from a private issue to a public concern began in the 1960s. Following a 1970 survey of officially reported child abuse cases, Congress passed the Child Abuse Prevention and Treatment Act of 1974 and established the National Center on Child Abuse and Neglect. By 1973, all 50 states had enacted state mandatory reporting laws concerning child abuse and neglect.

Child Maltreatment. Child maltreatment became the focus of early research studies, demonstration projects, conferences, and legislative initiatives. Service programs have since been implemented in civilian and military communities to protect children and to work with abusers. Despite this widespread interest and concern, the real incidence of child maltreatment remains unknown.

The magnitude of child abuse and neglect in the nation has been difficult to measure because many incidents still go unreported. Estimates of child abuse and neglect in the military have been based on limited data from general studies and often have been compared with civilian estimates.

Early estimates of incidence in the military ranged from a problem that is minimal, similar to civilian populations, abundant, to four times greater than civilian populations. While these early studies were of questionable validity, base-level medical personnel in all the military services were prompted to establish formal child abuse programs in the 1970s.

Research on the problems of child maltreatment among military families is scattered and unsystematic. Information primarily is clinically descriptive and based on small, unrepresentative samples of reported cases in the military. Reporting problems have been uncovered and they include unreported cases due to complicated paperwork, and cases being reported at medical or other service treatment centers and not entered into official reporting systems.

From studies conducted during the 1970s, annual child abuse incidence ranged from 30,000 to 1.5 million for the total population with 1,500 to

2,000 in the military population. The National Center on Child Abuse and Neglect has estimated 1 million incidents occur annually, resulting in 2,000 deaths. Based on recent civilian reporting techniques and extrapolating from the 652,000 reported cases in 1980 for the total population, incidence for the military approximates 15,500.

Other indicators show that children younger than six have the highest risk of physical abuse and comprise 80 percent of all physically abused children, whereas older children are more frequently the subjects of sexual abuse and neglect. Although neglect is the most common type of child maltreatment, research has focused on physical abuse. Interest in researching sexual abuse has been comparatively recent. Investigators continue to struggle with developing precise and acceptable definitions of child maltreatment.

Spouse Abuse. There also are important gaps in the research on spouse abuse and neglect. No specific data exists on incidence in the military and estimates from civilian samples are crude projections. Although there are mandatory reporting requirements for child abuse and neglect in all the states, there are no regulations for reporting spouse abuse and marital rape as detected by physicians and other service professionals.

Reliable data is lacking for the general population as well, although one 1980 study estimated that one in every 22 women are abused by their husbands. Earlier estimates put the total number as high as 28 million. There is little empirical data available to compare civilian with military rates because the civilian studies offer no simple cause and effect explanation.

The Navy added a spouse abuse component to the existing Child Advocacy Program in the late 1970s. This was a logical addition because both phenomena are forms of domestic violence and may occur in the same family. But response to these problems remain separate because prevention and treatment strategies for child and spouse abuse are quite different.

There are state mandated and funded mechanisms, such as protective services, that can back up Navy resources for child abuse; analogous services for battered adults do not exist. No existing data can be found to evaluate the true effectiveness of intervention methods, including those being used in the Navy and Marine Corps.

Rape. Practically all the research on rape has been done in the past ten years. It has uncovered demographic, attitudinal, and psychological aspects, but not direct causes. Rape is not a well understood phenomenon and has received very little study in the military. Aspects that might contribute to the occurrence of rape or inhibit sexual assault have not been well researched.

The research generally has come from studying victims in rape crisis centers or police files and convicted offenders. In both cases, these groups probably are not representative of the larger group of victims and

rapists because many victims choose not to report the assault to family, friends, police, or medical professionals for fear of reprisal, stigmatization, or trauma in giving detailed testimony.

Over half the victims of rape are age 20 years or younger and unmarried, although 15 percent of reported cases involve women over 30 years. Minority women are more likely to be sexually assaulted: black and hispanic women are overrepresented in relation to their total populations. Most convicted offenders average four to five years older than their victims. Racial minorities also are overrepresented in the offender population.

Most of the attention to rape and sexual assault has come from citizen activist groups and women's organizations to focus public awareness on the victimization experience and the inadequately responding criminal justice and human service systems. The military community has begun to review rape and sexual problems and responses. Gains in the civilian study sector can help improve military programs for victims, families, and offenders. Some suggestions for integrating successful program models have been presented in Chapter III of this report.

Gaps in the research occur in identifying characteristics of offenders, psychological and emotional effects to the victim and the community, and appropriate treatment methods. For issues that have been studied, the applicability to Navy and Marine communities can only be inferred.

Causation

A number of studies have examined demographic, individual, relational, and situational factors as cause indicators of personal abuse and neglect. These have included age, sex, race, religion, education, occupation, urban/rural background, intelligence, self-esteem, mental health, marital status, parental influence, stress, social membership and communication.

It is likely that various factors interact in complex ways and reinforce each other to create a situation conducive to forms of personal abuse and neglect, but efforts to understand this interplay are just beginning. Developing these factors into an operational model of detection, prevention, and intervention is still the challenge.

However, instances of family violence are found to be more common among younger families with limited income and men with high school education. More than half the military personnel are younger than 30, as compared with 25 percent of the civilian population, and the majority are married with small children. These factors alone tend to make the military a high risk group for family violence and personal abuse.

Given the defensive nature of the military mission and the rigid chain of command, military personnel may be more prone to violent and aggressive

behavior than the civilian population. This speculation has some empirical support but the findings are not conclusive. Further investigation is needed to understand fully the nature and extent of violent and aggressive behavior in the military and how its magnitude and characteristics differ from civilian populations.

Military Responsiveness

As published reports emerged between 1960 and 1970, calling for responsive countermeasures to child abuse, similar appeals appeared in military communities. A decade later, local initiatives also were directed toward spouse abuse, and the military developed a similar response.

By 1975, all 14 Naval Regional Medical Centers had developed child maltreatment policies and procedures, along with 19 of the 21 smaller Navy hospitals. By 1976, each of the military services had issued a regulation establishing a formal child advocacy program.

When concern over further domestic violence intensified in the mid-1970s, Child Advocacy Programs at Navy installations were expanded to prevent and treat spouse abuse. In July 1979, the Bureau of Medicine and Surgery issued BUMED Instruction 6320.57, creating the Navy Family Advocacy Program.

This program provided policies for handling child maltreatment, spouse abuse, sexual assault, and rape among Navy and Marine Corps personnel and families. Program guidance was offered in areas of case identification, assessment, followup, prevention, and interagency cooperation.

In 1979, the Navy Family Support Program also was established and the Marine Corps added a Family Service Program a year later. These two programs created additional resources in the form of Family Service Centers. Currently, there are 22 funded Family Service Centers in the Navy, with 40 more planned by fiscal year 1984. The Marine Corps has 17 operational centers.

At this time, the Navy Family Advocacy Program is operating largely in an ad hoc capacity. The program, however, is being reorganized so that Navy and Marine Corps Family Centers will assume more identity and responsibility for operations. The Navy medical community will continue to play a critical role in responding to victims and abusers.

All four military services expanded their family advocacy efforts and began to coordinate activities in 1981 after the Department of Defense issued an all-service policy directive mandating official establishment of a Family Advocacy Program. Policies for prevention, evaluation, and treatment of child abuse and neglect and spouse abuse are being issued and modified, and training is being developed for personnel working closely with family advocacy issues.

Organizational and policy developments alone will not solve the complex problems of personal abuse and neglect. A shortage of funds could jeopardize plans for improving the program responses in each military service. The significance of firmly establishing these plans lies in the recognition of the problems of abuse and neglect and the changing composition of military manpower.

The Military Community

The military careerist with a family increasingly makes up the roster of all the Armed Forces. Attendant with this change are the opportunities and problems surrounding marital status. Contemporary trends in marriage, divorce, single parenthood, and dual careers are reflected in all American families. But military families experiencing new definitions of parental and spouse responsibilities also must handle the stresses unique to the military way of life--the periodic cycles of separation and reunion; major changes in residence every two to three years; social isolation from family and friends in remote locations; constant readiness for military missions; high concentrations of foreign-born wife marriages; and prevalence of alcohol and drug abuse.

Conditions of peacetime, changing economies, and other factors have attracted more families to the military. The Armed Forces no longer represent a single, male group: members with families comprise over 55 percent of the total force. The change in military personnel has brought the benefits of a more stable defense manpower base and a continuing source of personnel. Children reared in military families are more than twice as likely to build their own military careers.

The linkages between military retention and performance and family and personal well-being are well established in the research. Conditions surrounding personal security decidedly strengthen this linkage. The traumatic personal violation of child abuse or rape has been found to have longstanding effects--on the victim, the abuser, and the community. The learned helplessness of sexually assaulted persons certainly undermines a core principle of military defense readiness.

There is evidence that abusers previously were victims and, left untreated, will become involved in further acts of violence and enter the judicial system. It is this cycle of self-destructive behavior that must be broken. If it is not, the consequences will be overburdened medical, legal, judicial, social and personnel systems. The impairment to the military member, whether victim or abuser, can mean further physical and psychological damage and continued abnormal family functioning. For the Navy and Marine Corps, these results will be translated into lower morale, distorted judgment, weaker performance, reduced defense readiness, and a turnover in manpower.

The underlying dynamics of personal abuse and neglect still are insufficiently understood. There is little statistical proof of the

severity of these problems in either civilian or military communities. Without this data base, it remains difficult to know whether present family support services are as effective as they could or should be since data does not exist for performing adequate evaluations.

The development of research and more responsive services have been hampered by narrow perceptions of the problems, uncoordinated data collection procedures, inadequate funding, and fragmented service delivery. Program planning and budget allocations are being made without benefit of this basic information. The second and third phases of this study will help narrow this information gap and with additional information, the forward-thinking human resource professionals in the Navy and Marine Corps can choose ways that decidedly strengthen the supportive military family and healthy, productive personnel.

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FOREWORD

The establishment of a Family Advocacy Program in the Department of the Navy in 1979 arose from growing concern over reports of increased personal abuse in military families and the belief that strategies and resources for addressing these problems were not sufficient. Under the auspices of the Bureau of Medicine, all BuMed facilities in the United States and overseas were instructed to establish Family Advocacy Programs. These programs have been providing policy and program guidance for the delivery of prevention, intervention, and treatment services to Navy and Marine Corps personnel and families experiencing abuse, neglect, sexual assault, and rape.

Although the program reflects the willingness of BuMed personnel to respond to the serious issues of abuse and neglect, program response has been handicapped by a lack of reliable information on the nature and extent of military family problems. Data on the real incidence and prevalence of child maltreatment, spouse abuse, sexual assault and rape remain unknown and demographic profiles of victims and abusers are unavailable. This data is needed to measure the impact of existing military programs and civilian programs available to the military. It is also needed to accurately identify successful intervention and treatment approaches that can become models for other installations.

Only a systematic analysis of program needs will allow the Department of the Navy and the individual Family Advocacy Programs to develop policy and service options that are most beneficial to military personnel and families and cost-effective to the military. The development of these administrative and operational guidelines will be especially useful to the 62 Navy Family Service Centers receiving additional responsibility for program operations by fiscal year 1984, and the 17 Marine Corps centers.

The Office of Naval Research has requested an assessment of the Navy Family Advocacy Program and the collection of data which will distinctly establish program service needs and more appropriate program responses. SRA Corporation of Arlington, Virginia has been contracted to conduct this research in three phases. Phase I provides a reconnaissance of the nature and extent of abuse and neglect in military families and the assistance currently available in military and civilian communities. Phase II expands on the initial data collected, describes the problem and program conditions observed in the field, and assesses the overall Navy Family Advocacy Program. Phase III will provide a comparative analysis of Phase I and Phase II data, research conclusions, and program recommendations.

This document reports the findings of Phase I reconnaissance activities and:

- Summarizes existing military and civilian literature on abuse and neglect, and identifies significant knowledge gaps in the literature.

- Provides estimates from the existing data of the incidence of abuse, neglect, sexual assault, and rape in military and civilian populations.
- Describes key factors that are associated with abuse and neglect.
- Identifies successful program elements and key issues in responding to abuse and neglect.
- Reviews the development of military family advocacy programs.
- Describes the organization and operation of the Navy's Family Advocacy Program.
- Provides an important theoretical and empirical foundation for Phase II assessment activities and Phase III recommendations.

The second phase of the study involves site visits to 12 Navy and Marine Corps bases. Three major objectives are planned for the research:

- Refine the demographic and social profiles of Navy and Marine Corps personnel and/or families who have been reported to be involved in abuse, neglect, sexual assault, and rape that were developed in Phase I.
- Construct profiles of "at risk" Navy and Marine Corps personnel and/or families who appear to be prone to committing or being victims of abuse, neglect, sexual assault, and rape.
- Assess the actual operation of the Navy's Family Advocacy Program at the command level.

The Phase II report is scheduled for completion in June, 1983.

The third phase of the study focuses on three major objectives:

- Integrate and compare the knowledge bases from Phases I and II.
- Identify the gaps between service needs and program responses.
- Identify program implications and recommendations from the research data.

The project is scheduled for completion in the fall of 1983.

Gary L. Bowen, Ph.D.
Senior Associate
Human Resources Research and
Development Center
SRA Corporation

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Key SRA Project Staff and Consultants

SRA Project Staff

Corporate Officer-in-Charge
Gerald M. Croan, M.C.P.
Group Director
Dennis K. Orthner, Ph.D.
Project Director
Gary L. Bowen, Ph.D.
Assistant Project Directors
Sabra F. Woolley, Ph.D.
Timothy A. McGaughey, Ph.D.
Manuscript Editing and Preparation
Genevieve A. Brune, M.U.P.
Deborah K. Willoughby, M.A.
Research Assistance
Sharon M. Perkins, B.S.

Consultants

Richard J. Gelles, Ph.D.
Linda S. King, M.S.W.
George F. Lord, M.A.
Murray A. Straus, Ph.D.

INTRODUCTION

BASIS FOR THE REPORT

The military community has become increasingly aware in recent years of the interdependence between family functioning and military effectiveness. Families can assist the military mission by supporting members, by encouraging them through difficult times, and by helping them relax and find comfort within a ready support group. But abuse and neglect in the military family threaten family stability and can impair both directly and indirectly the ability of military personnel to perform their duties. The development of Family Advocacy Programs in the military is predicated on the negative impacts of abuse and neglect on the military family and the need to set policy and procedures for the identification, evaluation, intervention, treatment, and prevention of abuse, neglect, sexual assault, and rape.

Military Family Life

The military community has become increasingly aware in recent years of the interdependence between military effectiveness and family functioning. This recognition has been the product of demographic realities and mission necessities. Once the bastion of single men, the military is increasingly an institution of families. Military members with families now comprise more than half (55%) of the total forces: 52% of the Army; 54% of the Navy; 65% of the Air Force; and 36% of the Marine Corps. (Carr, Orthner, and Brown, 1980; Goldman, 1976; Hunter, 1977; Orthner and Nelson, 1980). Among members with four or more years of service, the percentage is even higher. Approximately 80% of these men and women are married.

Many of these families no longer fit into the traditional mold of military husband, dependent homemaker-wife, and children. Contemporary trends in marriage, divorce, single parenthood, dual-career patterns, and voluntary childlessness are all reflected in military families today (Carr et al., 1980; Orthner & Nelson, 1980; Williams, 1976). These families also experience many of the same pressures as other American families: inadequate family finances, contrasting values, changing role definitions for husbands and wives, new definitions of parental responsibilities, and lack of viable family support systems.

There is clear evidence that military performance, operational readiness, and personnel retention are closely linked to family considerations (Orthner, 1980; Orthner and Bowen, 1982; Szoc, 1982). The extent to which people are satisified with their family life is reflected in their job performance and ultimately tied to the decision to stay in the military.

Given the predominance of families in the military today and the importance of the family to the military mission, it is vital that military leaders and service providers remain sensitive and responsive to the needs of military families. Only then can sound policies and programs be designed that meet the needs of military families and that support military mission requirements.

Military Family Stress

Families in the military, like all families, must cope with the stress that occurs whenever individuals must coordinate their lives. But military families have the additional stress created by the military lifestyle. The nature of the military itself, which requires "readiness" and "preparedness" for missions that could be crucial to national security, creates stress for individuals and their families. Family separations are common, particularly in the Navy. Sudden transfers halfway around the world would strain any family, much less a family already experiencing problems.

A number of other factors also differentiate the military from the larger society. These factors, which may contribute to the stress experienced by service members and their families, include:

- The periodic cycles of separation and reunion of families because of sea duty or special assignments. It is estimated, for instance, that the average Navy careerist spends at least 7 of his 20 years away from home (Dingle Associates, Inc., 1980);
- Major changes in residence as often as every two or three years;
- Social and cultural isolation of families on bases in remote areas or overseas;
- The possibility of injury, captivity, or death in war or in potentially dangerous environments;
- The subservience of family needs to military objectives and requirements;
- The lack of family control over when or where to relocate;
- Long-term separation from extended families and friends;
- Financial pressures caused by low pay, especially in the grades E-4 and below.

- The high concentration of foreign-born wife marriages in the military. According to recent surveys, these couples experience lower marital commitment and higher marital stress than other military couples (Kim, 1981; Orthner and Bowen, 1982); and

- The prevalence of alcoholism and drug abuse.

Many of the stresses inherent in military life take on even greater significance in light of the changes in military family patterns. Because greater numbers of service members now are family members, the importance of family-related problems is increasing. The growing instability of military families, coupled with normal military stresses, places an increasing burden on some family members. Although no single, stress-inducing variable is unique to the military--other than those directly related to combat situations--a combination of these variables may be more likely to occur within the military system than within the civilian community.

Stress and Family Violence

It is commonly assumed that there is a link between stress and the incidence of violent and aggressive behavior within the military family. Although as yet there are no data that provide a precise indication of the incidence of intra-family violence either in America or in the military, the information available suggests that abuse, neglect, sexual assault, and rape is prevalent and cuts across all age, income, and educational boundaries (Lanier, 1978; Mace, 1982; Straus, Gelles, Steinmetz, 1980). Moreover, profiles of husbands and wives who physically assault one another are very similar to profiles of abusive and neglectful parents and those of sexually assaultive individuals. These individuals tend to have high levels of stress in their lives, and to come from families in which there was a malfunction similar to the one they are exhibiting. They tend also to feel isolated and extremely dependent on family members--who become their victims--for affection and support, and tend either to resist expressing, or to be incapable of expressing, their feelings or needs (Geller, 1978; Shwed and Straus, 1979).

Demographic Factors Linked to Family Violence

Demographic characteristics in the general population that have been identified with high levels of physical abuse, neglect, and assault are also found in the military community. Straus et al. (1980) conclude that instances of family violence and abuse are more common among younger families, among those living at or below the poverty line, and among men with a high school education than among those with either more or less education. More than half (55%) of active duty men are age 30 or younger, compared to 25.1% of males in the civilian population (Bureau of the

Census, 1980). In addition, the majority of these personnel are married and have small children. According to Straus, this factor alone makes the military a "high risk" group for family violence and neglect. In a recent study by Orthner and Bowen (1982), military families with small children were found to experience lower marital companionship, poorer sexual relations, and higher family stress than childless couples or couples with older children. In addition, the income of many military families, especially those in grades E4 and below, presents a situation of financial hardship. Finally, more than half of the service members have completed only high school (Turner and West, 1981).

Because of the parallels between the demographic makeup of the military population and those of violent families in the general population, there is ample justification for defining the military population as a "high risk" group for problems of family violence and abuse and, therefore, for focusing attention and resources on this population. The need for such attention is especially clear when the demographics are considered within the context of the stress endemic to the military lifestyle and when the nature of the military mission itself is taken into consideration.

Given the defensive nature of the military mission and the norms supporting superior-subordinate interactions, military personnel are often assumed to be more prone to violence and aggressive behavior than the general civilian population. This speculation is not without empirical support. In 1979, for instance, child abuse and neglect cases involving military families in Hawaii constituted 27% of all reported cases, although military personnel comprised only 16% of the population. Moreover, a 1979 study by Shwed and Straus found that the more the military command is associated with violence, the greater the violence in the home. These data are consistent with the recurring theme in the sociology of work that the nature of one's work has a compelling influence on one's behavior and attitudes (Kohn, 1977). These findings, however, are not conclusive. Although comparisons are drawn here, further investigation is needed to understand fully the nature and extent of violent and aggressive behavior in the Armed Forces and how its magnitude and characteristics differ between military services and the civilian population.

SCOPE OF THE REPORT

Data Strengths and Weaknesses

The military services have actively responded to problems of child maltreatment, spouse abuse, sexual assault, and rape in military communities. However, their policy, program, and intervention techniques often have been hampered by insufficient and unreliable data. This report examines the availability and reliability of current data sources for military decisionmaking purposes.

After a four month intensive review of the literature on the nature and extent of abuse and neglect in civilian and military communities, and the civilian and military responses to these issues, specific information on military communities was found to be shallow in depth, frequently contradictory, and difficult to obtain.

Because of the limited availability of military studies, information from the civilian literature provided the primary basis for discussing the issues of child maltreatment, spouse abuse, sexual assault and rape in military communities. Where available, military community data are reported, however, most of the military incidence statistics are extrapolated from civilian populations and civilian based studies. Because of this, the calculation of military prevalence rates and the construction of "at-risk profiles" are premature at this point of the research.

The information on the history and involvement of the military programs, including the Department of Navy Family Advocacy Program, was obtained through reviews of available literature and military regulations. As an extension of earlier attempts to consolidate and review this information, the report traces, rather than evaluates, the development of the family advocacy movement in the military services.

In summary, information about the nature and extent of abuse and neglect in the military is indeterminate and must continue to rely heavily on extrapolations from civilian data. To date, more questions than answers have been presented, but this should not be interpreted negatively: it merely indicates the need for additional inquiry. By providing a comprehensive review of the existing civilian and military literature on abuse and neglect and responses to these problems, this report provides the foundation to form relevant hypotheses and initiate fresh inquiry.

Overview

Department of the Navy Family Advocacy Program: Service Need and Service Response .eviews the scope and nature of abuse and neglect and examines past responses to the problem by summarizing the military and civilian literature. The report serves two purposes. First, it provides an important theoretical and empirical foundation for Phase II and Phase III activities. Second, it serves as a comprehensive source book to Navy and Marine Corps policymakers, program designers, and practitioners who are responsible for family advocacy planning and intervention and whose decisions depend upon the best available information.

The first three chapters of the report review the problems of child maltreatment, spouse abuse, and sexual assault and rape, respectively. Each of these chapters has six major subdivisions:

- Background
- Incidence

- Consequences
- Associated Factors
- Explanations
- Prevention and Intervention.

The aim is to provide an overview of the current state of knowledge on each of these problems. Although these chapters rely heavily on civilian literature, military literature is reviewed where available, and extrapolations are drawn from the civilian to the military population. Special attention is directed to the Navy and Marine Corps populations.

Chapter IV traces the history of family advocacy in the military. The chapter includes a review of the DoD Directive establishing the Family Advocacy Program, as well as the current status of the military services in response to the Directive.

The Navy Family Advocacy Program is reviewed in Chapter V. An overview is provided of its scope, organization, and operation. This chapter also describes the Navy Family Support Program, the Marine Corps Family Service Program, and their roles in the Navy Family Advocacy Program. The report concludes with an overview of Phase I results and presents implications of the report for policymakers and practitioners in the area of family advocacy. Also, strengths and weaknesses of available research are identified and preliminary hypotheses are presented for the remaining phases of the project.

Together these chapters provide an important theoretical and empirical overview of abuse and neglect in the military today and past responses to these problems. They represent another step for the Navy and Marine Corps in responding more effectively to the problems of abuse, neglect, sexual assault, and rape.

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Chapter I

Child Maltreatment

Chapter I
CHILD MALTREATMENT

A. BACKGROUND

During the past two decades, pediatricians psychiatrists, social workers, lawyers, and the general public have become increasingly concerned about the incidence of child maltreatment in this country and overseas. The military has shared this concern. In both the civilian and the military communities, numerous conferences, workshops and seminars have been held on selected aspects of child maltreatment. In addition, numerous studies have been conducted on the trends and dynamics of child maltreatment; demonstration projects have been designed to treat and prevent the incidence of child maltreatment. Articles and books abound on the subject. Yet, in spite of the widespread interest and concern, the underlying dynamics of child maltreatment are still insufficiently understood, and its real incidence is still unknown.

A number of significant gaps in the literature remain. Although neglect is the most common type of child maltreatment, research has tended to focus on physical abuse. Interest in sexual abuse is comparatively recent, and to date little is known about this subgroup of abused children. Despite the extent of adolescent maltreatment, little information is available on the nature of this problem and the characteristics of the victims and their families. Investigators also have had difficulties developing precise and generally acceptable definitions of child abuse and neglect.

Although the issue of child maltreatment in the military was recognized early in the study of child maltreatment, research on the problem of child maltreatment among military families is scattered and unsystematic. There has been little specific research either on the incidence of child maltreatment in the military or on factors associated with the maltreatment of children of military personnel. Information that does exist on child maltreatment in the military is primarily clinically descriptive in nature and is based on small and unrepresentative samples of reported cases.

In reviewing the available literature on child maltreatment, the major primary focus has been to:

- Establish reliable and standard definitions of child abuse, child neglect, and sexual abuse;
- Assess the extent and patterns of child maltreatment--including physical abuse, neglect, and sexual abuse;
- Identify the factors that are associated with the various manifestations of child maltreatment;
- Develop theoretical models of the cause of child maltreatment;

- Assess the physical, emotional, and developmental consequences of child maltreatment; and

- Assess the effectiveness of various forms of intervention.

These issues are the focus of this chapter. The intent is to establish a baseline of current knowledge about the incidence, dynamics, treatment, and prevention of child maltreatment in the military community. Because of existing limitations in military literature, data from the civilian population provides the basis for this discussion. Findings from the military are provided where available, and extrapolations are attempted from the civilian to the military population.

The Historical Context

Public and professional concern about the problem of child maltreatment has gone through tremendous transition during the past 30 years. Traditionally, child maltreatment was thought to be a rare occurrence that affected only a small number of children. Perpetrators of abusive and neglectful acts were viewed as mentally ill. In the late 19th and 20th centuries, child abuse prevention and treatment programs were confined primarily to local charity groups. Public child protection programs were also marked by an insistence on local control (Nelson, 1980).

A change in public attitudes and policy occurred in the late 1950s and early 1960s. In 1957, the U.S. Children's Bureau issued a report entitled "Proposals. . . for Legislation on Public Child Welfare and Youth Services," which suggested that each state department of child welfare investigate abuse and neglect, offer social services, or bring these problems to the attention of law enforcement agencies (Nelson, 1978). Five years later, pediatrician C. Henry Kempe and his colleagues published their seminal article, "The Battered Child Syndrome," in the Journal of the American Medical Association (1962). This publication identified child abuse as a medical problem by labeling the problem a "syndrome." Because the target audience of the publication were medical personnel, medical, public, and professional attention to the problem of abuse and neglect skyrocketed after the publication of the Kempe article (Nelson, 1978).

Kempe's publication was followed by David Gil's (1970) national survey of officially reported cases of child abuse and neglect and an attitude survey regarding the problem. Shortly after the publication of Gil's study, the federal government began a series of initatives that resulted in the passage of the Child Abuse Prevention and Treatment Act of 1974 and the establishment of the National Center on Child Abuse and Neglect. Federal model child abuse reporting laws were instrumental in motivating all 50 states to enact state mandatory reporting laws for child abuse and neglect by 1973.

In the military services, hospital-based child maltreatment programs emerged as early as the 1960s. It was not until the early 1970s, however,

that the concern over child maltreatment intensified in the military community. By 1976, each service had issued a regulation establishing a formal child advocacy program.

In a recent publication, Kempe (1978) identified five development stages that a society goes through in addressing the problem of child maltreatment. Stage I is the denial of the problem; Stage II involves paying attention to the more sensational and lurid aspects of physical abuse; Stage III comes when physical abuse is better handled and attention is paid to the issue of failure to thrive; Stage IV comes with the recognition of emotional abuse and neglect; and Stage V involves attending to the problem of sexual abuse. We have arrived at Stage V only in the past five years.

Definitions

One of the most hotly debated aspects of studying child maltreatment has been the many and varied definitions of maltreatment. There are numerous definitions of maltreatment, abuse, neglect, and sexual abuse. As a consequence, it is is often difficult to compare the results of one piece of research with another because the investigators do not use common definitions of the problem.

Child abuse has been narrowly defined by Gil (1970) to mean an occurrence where a caretaker injures a child, not by accident, but in anger or deliberately. The "battered child syndrome" discussed by Kempe et al., referred to a clinical condition, typically broken bones or physical trauma, usually diagnosed by x-rays. The Child Abuse Prevention and Treatment Act of 1974 (Public Law 93-237) defines abuse as:

> The physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby. . . .(p.2)

Other definitions of abuse and neglect include such things as failure to thrive (Bullard et al., 1967; Morris et al., 1964) child theft, abandonment, or emotional mistreatment.

One approach to defining child maltreatment is found in BUMED Instruction 6320.57, dated July 11, 1979, creating the Navy Family Advocacy Program:

- A child is an unmarried person, whether natural child, adopted child, stepchild, or ward, who either:

  -Has not passed his/her eighteenth birthday,
  -Has not become legally emancipated, or
  -Is incapable of self-support because of a mental or physical incapacity that currently exists and for whom treatment is authorized in a medical facility of the uniformed services.

- Victim or abused or neglected designates an individual whose physical or mental health or welfare is harmed or threatened with harm by the acts or omissions of another individual or individuals.

- Child Abuse/Neglect includes abuse/neglect in which the abuser or neglector is responsible for the child's welfare. This includes parents, guardians, or other individuals or agencies charged with the welfare of the child.

- Abusers or Neglectors are the persons directly or indirectly responsible for the neglect or abuse of an individual.

- Abuse refers to direct physical injury, trauma, and/or emotional harm inflicted by other than accident. This may be evidenced by, but not limited to, such conditions as contusions, bleeding, malnutrition, sexual abuse, bone fractures, subdural hematoma, soft tissue swelling, or unexplained death, and circumstances indicate that such condition or death may not be the product of an accidental occurrence.

- Neglect involves acts of omission or commission comprising inadequate and/or improper care that result or could reasonably result in injury, trauma, or emotional harm. This includes, but is not limited to, abandonment, exploiting individuals, or failure to attend to welfare.

- Harm includes, but is not limited to:

  -Physical, emotional, or mental injury, including physical injury resulting from otherwise lawful corporal punishment (i.e., customarily accepted parental discipline) which may become unlawful when it disfigures, impairs, or otherwise traumatizes an individual.

  -Sexual offense, whether assaultive or nonassaultive, accomplished or attempted (as defined in applicable statutes).

  -Failure to supply a child with adequate food, clothing, shelter, education (as defined by applicable statutes), or health care, though financially able to do so or offered financial or other reasonable means to do so. (Adequate health care includes any medical or nonmedical remedial health care permitted or authorized under applicable statutes.)

  -Abandonment of a child, as defined by applicable statutes.

  -Failure to provide a child with adequate care, supervision, or guardianship.

B. INCIDENCE

Child Maltreatment in the Military

For the past decade, the incidence of child maltreatment in the military has been a topic of much debate, but there has been little conclusive data. Although each of the services has established a reporting system for recording child maltreatment incidents, problems exist:

- Many cases go unreported because forms are complicated and time-consuming.
- Cases seen at a medical facility of another service branch may not be entered into the appropriate reporting system.
- State reporting laws may restrict a Child Protection Agency from reporting to the military unless permission is granted by the family.
- Medical personnel or commanding officers may fear entering the information into the reporting system if they think it will damage the perpetrator's service career.
- Many cases are handled by personnel who fail to work through proper administration channels.

These problems seriously challenge the validity and reliability of available estimates of child maltreatment in the service branches (Bobrowsky, 1982; Kovalesky-McLaine 1982). In addition, they make comparisons between the military and civilian sectors questionable, at best.

Despite these problems, incidence figures that are available in the military services suggest the potential seriousness of child maltreatment in the military. In 1977, for instance, 1,500 cases of child maltreatment were reported in the military and 1,900 cases were projected in 1978 (GAO, 1979). More recently, Senator Daniel Inouye caused alarm in the military services when he charged that military families in Hawaii constituted almost one-third of the state's reported abuse, but comprised only 16 percent of Hawaii's population.

Based on theory, rudimentary evidence, and comparisons of factors associated with maltreatment in the military population, it has been suggested that child maltreatment in the military may be as high or higher than the incidence in the general population (Miller, 1976; Roth, 1980; Shwed & Straus, 1979). However, there is some preliminary evidence to suggest that child maltreatment is lower in the military than in the civilian sector (Acord, 1977). Support services in the military such as guaranteed income, medical care, and community services may lessen the potential for child maltreatment (Broadhurst et al., 1980). Given the problems with the military reporting system and the lack of comparable

data, however, there is little basis for either claim. The military services must continue to rely on extrapolations from civilian figures.

Child Maltreatment in the Civilian Community

Increased interest in the problem of child maltreatment was accompanied by concern that an accurate assessment of the extent and incidence of child abuse and neglect be made. The Child Abuse Prevention and Treatment Act of 1973 specifically called for a national incidence study of this problem. Incidence estimates involve an extensive range of techniques and final estimates.

Prior to 1975, various techniques had been used in attempts to achieve an accurate estimate of child maltreatment in the United States. In 1967, David Gil conducted a nationwide inventory of reported cases of child abuse (1970). He found 6,000 confirmed cases. This is considered an extremely low estimate because it is based on reported cases only, and the survey was conducted before all 50 states had legally required reporting of abused children. Gil's report also gave the results of an opinion survey, which asked a representative sample of 1,520 individuals if they had knowledge of families where incidents of child abuse had occurred. Forty-five individuals, or 3% of the sample, reported knowledge of 48 different incidents of abuse. Extrapolating this number to a national population of 110 million adults, Gil (1970) estimated that between 2.53 and 4.07 million children were abused the previous year, or that there were between 13.3 and 21.4 incidents per 1,000 persons in the population. Gil's data were reanalyzed by Richard Light to correct for instances where the same abuse incidents were reported by more than one person. Light's refined estimate of child abuse was 500,000 abused children in the United States during 1967, the survey year (Light, 1974).

Numerous other investigators have tried estimating how many children are physically abused by their parents. Nagi (1975) surveyed community agencies who have contact with abused children. He estimated that 167,000 cases of abuse are reported annually, while an additional 91,000 cases go unreported. Nagi estimated that there are 950,000 reportable cases of abuse and neglect each year--two-thirds of which are reported, and one-third of which are not. Vincent DeFrancis of the American Humane Association, testifying before the United States Senate in 1973, estimated that there are 30,000 to 40,000 truly abused children in the United States each year. Vincent Fontana placed the figure as high as 1.5 million (1973).

A national incidence study contracted by the National Center on Child Abuse and Neglect attempted to measure the national incidence of child maltreatment. The survey measured how many cases of child abuse and neglect were known to Child Protective Service Agencies; how many cases were known to other investigatory agencies; and how many cases were known to professionals in schools, hospitals, and other social service agencies.

Chart I-1 presents the results of the national incidence survey (Burgdorf, 1980). A total of 652,000 children were known by the agencies surveyed in the study to be maltreated. Stated in terms of incidence rates, it was estimated that 10.5 children are abused and/or neglected annually for each 1,000 children in the United States younger than 18.

Chart I-1

National incidence estimates by major form of maltreatment and by severity of maltreatment-related injury or impairment: Estimated number of recognized in-scope children per 1,000 per year.

Form of maltreatment and severity of injury/impairment	No. in-scope children	Incidence rate[2] (per 1,000)
Form of maltreatment[1]		
Total, all maltreated children	652,000	10.5
Total, all abused children	351,100	5.7
Physical assault	207,600	3.4
Sexual exploitation	44,700	0.7
Emotional abuse	138,400	2.2
Total, all neglected children	329,000	5.3
Physical neglect	108,000	1.7
Educational neglect	181,500	2.9
Emotional neglect	59,400	1.0
Severity of child's injury/impairment		
Fatal	1,000	0.02
Serious	136,900	2.2
Moderate	410,300	6.6
Probable	101,700	1.6

[1]Totals may be lower than sum of categories, since a child may have experienced more than one in-scope category of maltreatment.

[2]Numerator = estimated number of recognized in-scope children; denominator = 61,900, the estimated total number (in thousands) of children under 18 in the United States in December, 1979.

From Burgdorf, 1980.

Fifty-four percent of the children had experienced one or more types of physical abuse. Sexual exploitation was the least common form of abuse, affecting 0.7 children per 1,000 children under 18 years of age in the United States. Half of the victims of maltreatment had experienced one or more kinds of neglect, with educational neglect being the most common.

If these figures are extrapolated to the military population, this means that approximately 15,498 children are abused and/or neglected annually, 1,084 by sexual exploitation. This estimated total is considerably higher than the 1,500 cases of maltreatment reported in 1977. In the Navy and Marine Corps alone, the total annual number of incidents would exceed 4,281.[1]

Another source of data on the incidence of child maltreatment comes from the National Study of Child Neglect and Abuse Reporting, conducted each year by the American Humane Association (AHA). This annual study measures the number of families, alleged perpetrators, and children involved in official reports of child maltreatment; determines the source of the reports and their geographic distribution; describes the characteristics of families involved in official reports; and identifies and describes trends in the reporting data within states (American Humane Association, 1980). Data on child neglect and abuse are provided to the AHA by the individual states.

The total number of abuse and neglect reports received in 1980 was 788,844. This constitutes a 91% increase in abuse and neglect reporting since 1976. The AHA tabulations found that sexual abuse is the maltreatment category evidencing the most rapid growth.

Of the 788,844 reported instances of maltreatment, 61% involved children who have experienced neglect; 20% involved minor injuries; 13% involved emotional maltreatment; 7% involved sexual maltreatment; and 4% of the children experienced a major physical injury. Note that each child could have experienced more than one type of maltreatment.

Although the AHA study is a national assessment of reporting trends, these data and the analyses of the data do not shed complete light on the issues of reporting or the incidence of child maltreatment. First, definitions and reporting practices vary from one state to the next. Second, state participation in the AHA study is variable: some states provide case data on official forms, others provide case data on tapes, others provide only summaries of reporting, while a small number submit their data too late to be included in the annual report. Both the National Incidence Study and the AHA study limit their estimates to reported and recognized cases of child abuse and neglect.

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[1]Extrapolations to the military community are based on the following formula: $\frac{\text{Number of Military Children}}{1000} \times 10.5$.

Figures for the total number of children in the military and in the Navy and Marine Corps are based on September 1981 population profiles supplied by the Armed Forces Information Service (AFIS).

A source of data not based on official reports and including only one aspect of child maltreatment--physical abuse--is the survey carried out by Straus and his colleages in 1976. Straus and his colleagues (1980) conducted a survey on the subject of family violence using a nationally representative sample of 2,146 individuals. One part of the interview asked subjects to report on their own "conflict tactics techniques" with their children. Among the list of conflict tactics were eight items pertaining to physical violence. These items ranged from pushing and shoving to the use of a gun or knife. From these answers, the researchers (1) generated an incidence rate for all types of violence towards children; (2) generated a 3.8% rate of severe (or abusive violence) based on those items that the investigators believed held a high probability of injury; and (3) projected these results for the national population of children 3 to 17 years of age who lived with both parents, thus, estimating 1.4 million incidents of abusive violence each year (see Straus et al., 1980; Gelles, 1978).

There were a number of limitations to the survey by Straus and associates. First, the survey measured violence towards children between the ages of 3 and 17, omitting children under 3 years of age, who are considered to be a high-risk population for abuse. Second, the survey included only "intact families," and excluded single parent families, also believed to have higher than average rates of abuse and neglect. Third, the survey measured only self-reports of violence towards children. No attempt was made to measure the consequences of the violence. The investigators had no knowledge of how many of the children were injured. Fourth, the measure of child abuse was actually confined to a small number of violent acts. Burning, scalding, sexual abuse, etc., were not measured in the study. Finally, the study did not explore the extent of acts of child neglect.

Nevertheless, the study did yield normative data regarding violence towards children, and a projection of child abuse which was considerably higher than previous estimates of reported physical abuse of children. This is especially noteworthy because the class of acts considered violent and/or abusive was restricted.

In summary, estimates of child maltreatment range from tens of thousands of children to millions. Clearly, increased public awareness of physical abuse, neglect, and sexual abuse has led to an increase in reporting instances of child maltreatment. Although sexual abuse constitutes a small percentage of the total number of maltreatment cases, there is reason to believe that the number of officially reported cases of sexual abuse constitutes only a fraction of the real number. A recent survey of college students, for example, found that 28% of the girls surveyed reported sexual experiences with relatives or near relatives. Twenty-three percent of the boys surveyed indicated they had sexual experiences with relatives or near relatives (Finkelhor, 1979).

C. CONSEQUENCES

The child maltreatment literature contains many assumptions about the consequences of child maltreatment for the victim, his or her family, and society. Some researchers argue that the consequences of abuse extend beyond the immediate risk of injury or death experienced by the victim. Not only is maltreatment assumed to harm the victim, but untreated families also are thought to produce children who grow up to be juvenile delinquents, murderers, and batterers of the next generation of children (Schmitt & Kempe, 1975).

The child maltreatment literature consistently discusses the belief that parents of abused children are often themselves victims of abuse and neglect in childhood (Steele & Pollock, 1974). As adults, abused children are thought to have higher rates of drug and alcohol abuse, criminal behavior, and psychiatric disturbance (Smith, Hanson, & Nobel, 1973). Psychiatric workers observing the behavior of abused children in clinical and laboratory settings also report problems with the developmental sequelae of maltreated children (Galdston, 1975; Martin et al., 1974).

Additional data supports the assumptions drawn from case studies. A case study of 4,465 children and their siblings who were reported to be victims of maltreatment in eight counties in New York state, found that children who were maltreated had high rates of later involvement in the juvenile justice system (Alfaro, 1977; Carr, 1977). Recent research on adolescent-to-parent violence also demonstrates that early exposure to, and experience with, violence is strongly related to the chances of a teenager using abusive violence towards a parent (Cornell and Gelles, 1982).

Child maltreatment also has consequences for the human service delivery systems in both the civilian and military communities. Cases of child maltreatment strain our medical, human service, legal, and judicial resources.

In the military, child maltreatment can seriously impair the job performance and operational readiness of the member, whether he or she is involved directly or indirectly. The link between family well-being and support and job productivity and retention in the military is well established (Orthner, 1980; Orthner & Bowen, 1982; Szoc, 1982).

Child maltreatment also affects the military in a more direct way. Intergenerational links are central to the recruitment and retention of military personnel. Compared to children with civilian parents, children reared in the military are more than twice as likely to enlist in the military services. In addition, military children who join the enlisted ranks are more than twice as likely as their civilian contempories to be careerists (Faris, 1981). Children who are abused and later join the military are likely to perpetuate the occurrence of child maltreatment in the military community and display dysfunctional coping styles. Consequently, an investment in the welfare of military children is not only humanitarian, it is also an investment into the future of the military services.

D. ASSOCIATED FACTORS

Data Sources on Child Maltreatment

Information on factors associated with child maltreatment come primarily from three different types of data, each having specific benefits and weaknesses. Frequently the different types of data yield different conclusions, so to gain the most complete picture on child abuse, the findings of particular studies need to be evaluated in terms of the relative strength of the data source. To aid in this process, a brief review of the relative strengths and weaknesses of the major types of data sources is presented below.

One source of information about child maltreatment is clinical studies, that is, information collected by clinicians such as psychiatrists, psychologists, or counselors during the course of therapy. The clinical setting lends itself well to the collection of extensive, in-depth information about particular cases of maltreatment. Clinical data usually include information about a few cases that are not randomly selected. Consequently, clinical studies are unable to provide much information about the representativeness of related factors or about the frequency of factors associated with abuse.

Another source of information about child abuse is official reports. In this country, the American Humane Association (AHA) is a clearinghouse for all officially reported incidents of child maltreatment. It publishes annual aggregate statistics regarding the number and characteristics of reported cases. AHA data as well as other sources of official reports, such as the National Incidence Study (Westat, Inc., 1981), provide information about a large number of cases and describe a wide range of varying cases.

In the military, each of the service branches has established central registry files for recording cases of child maltreatment. In CONUS, most cases of child maltreatment also are reported to State Child Protection Services.

Although these data provide information on a large number of cases, they are still biased because they only describe cases of officially reported or detected maltreatment. There is a tendency, for example, for lower income and lower status individuals to be overrepresented in these reports. Thus, although the information provided by official reports on child maltreatment describes a large group of abusive cases, they cannot be generalized to describe all cases; they only describe cases where people were apprehended.

Probably the best source of information for making statements about general patterns of maltreatment is survey data collected from representative samples of a given population. Unfortunately, there have been very few surveys conducted; none have been conducted in the military services. One such study, however, was the national study of family violence conducted by Straus and Associates (1980). This study and other

general population studies, such as Finkelhor's studies of sexual abuse (1979, 1982), provide information about a wide range of cases, and allow for estimations of frequencies of various factors. However, because of the expense, this method is not useful for collecting in-depth details about particular cases.

Current research suggests that child maltreatment varies significantly across a number of demographic, individual, relational, and situational factors:

- Age and sex of victim
- Age and sex of perpetrator
- Socioeconomic situation
- Race
- Education
- Intelligence
- Mental health
- Parenting role
- Alcohol use
- Marital status and quality
- Stress in the family
- Social isolation
- Occupational situation

It is likely that these factors interact in complex ways and reinforce each other in creating a situation conducive to the various forms of child maltreatment.

Demographic Factors

Age and Sex of Victims

Children younger than six are at the highest risk of physical abuse (Ferguson, et al., 1972; Gil, 1970; Johnson, 1974; Lanier, 1978). In a recent Army study of 225 abuse cases for example, 32% of the abused children were less than one year old and 80% were age six and younger (Lanier, 1978). One reason for this finding may be that younger children are physically more fragile and, given the same level of force, are more susceptible to injury. But surveys on the use of force without injury also

show that younger children are more often the recipients of violence (Straus et al., 1980).

Why is more violence directed at younger children?

- They may require more attention than older children and therefore may be more likely to incur a parent's ire.
- They are less susceptible to control through reason and suggestion, and parents may be more tempted to use force.
- They are less powerful and agile themselves; they cannot run away or fight back.
- They cannot appeal as easily to another parent or authority for protection.

Although younger children are more frequently abused, teenagers are also targets of physical abuse. The AHA (1978), for example, indicates that approximately 30% of all reported abuse cases involve teenagers as victims. However, this undoubtedly underestimates adolescent abuse because several states do not count the maltreatment of 15 to 17 year-olds as child abuse. Clinical data also suggest that many adolescents are labeled "incorrigible" or "delinquent" rather than as abuse victims because they respond to their parents' violence with rebellion (Lourie, 1977). Although research on adolescent abuse is limited, especially in the military community, findings suggest that it occurs more often than previously thought.

There is also a relationship between the age and sex of the child and the incidence of physical abuse. According to the National Incidence Study of Child Abuse and Neglect (Westat, Inc., 1981), younger boys are more likely to be victims of abuse than older boys, but the opposite is true for girls. Older girls are more likely to be victims of abuse than younger girls.

Compared to younger children, a higher percentage of older adolescents are victims of neglect (Westat, Inc., 1981). Although children younger than three are most likely to be victims of physical neglect, in general, the older the child, the more likely he/she is to be a victim of neglect, especially educational neglect. Sex differences also are reported in the incidence of neglect. Starting around the ages six to eight, boys are more frequently neglected than girls.

Sexual abuse also varies by the age and sex of victims. As most people are aware, girls are more often sexually abused than boys. But the predominance of sexual abuse in girls is probably exaggerated because the sexual abuse of boys is less likely to be reported (Finkelhor 1982). However, in recent years, the percentage of reports involving sexual abuse of boys has grown. Surveys of the general population suggest that as many as one boy may be victimized for every two girls.

The peak ages of vulnerability for sexual abuse are between 8 and 12 years (Finkelhor, 1979). Thus, most children are victimized well before puberty. The number of cases of extremely young children has also been increasing in recent years. In fact, some agencies now report that as many as a third of their cases involve children younger than six. In one study of Navy file statistics, Doucette (1981) reported that most victims of sexual abuse were five or younger.

Age and Sex of Perpetrators

Females are more likely to be perpetrators of physical abuse than males (Straus et. al., 1980). This finding, however, is undoubtedly confounded by the fact that females spend more time with children than males, particularly with younger children. Females also inflict the most severe types of abuse (Gil, 1970; Steele and Pollock, 1974).

Researchers agree most abusers are young adults. Gil (1970) found 37% of the abusing fathers and 56% of the mothers in his study were under age 30. Lauer (1974) found median age of abusive mothers to be 22.5 years and abusive fathers 25.2 years, as compared to a matched sample of nonabusing parents, where the mothers were 26.5 years and the fathers were 29 years. Finally, the AHA (1978) reports that as the age of a parent increases, the chance of the perpetrator being male also increases.

In contrast to physical abuse, most perpetrators of sexual abuse are males. This is true in cases of abuse of both boys and girls. Although sexual abuse by females is less likely to be reported, even in surveys of nonclinical populations, abuse by males makes up 85 to 95% of the recorded cases (Finkelhor, 1979, 1982).

The persons who sexually abuse children usually are family members and friends: fathers, stepfathers, older brothers, uncles, and mothers' boyfriends. The most frequent age category for sexual abusers is 30 to 40, somewhat older than the peak ages for physical abusers. However, a fair amount of sexual abuse is committed by adolescents (baby sitters and older brothers).

Socioeconomic Status

One of the most significant factors related to physical abuse of children is socioeconomic status. Some researchers have gone so far as to suggest that doing away with poverty in this country would be the best way to reduce the incidence of child abuse (Pelton, 1978). The relationship between economic status and child abuse has been a much debated topic.

The earliest official data collected on child abuse show a strong relationship between low income and reported abuse. In the National Incidence Study (Westat, Inc., 1981), the percentage of families with incomes less than $7,000 was found to be three times higher for families in which abuse was reported than for families in the general public. In addition, the AHA (1981) found that 48% of all households reported for child maltreatment were on some form of public assistance.

In the 1970s, it was popular to argue that child abuse was unrelated to social class. Many social policy critics voiced concern that child abuse would be considered solely a problem of poor families. They also were concerned about stigmatizing the poor. It was suggested that the poor families were over-represented in reported cases simply because child abuse was more likely to be detected in poor families than in families with higher income.

In the military, social standing tends to be defined by military rank. Rank offers status, financial benefits, and respect. There is a direct link between the military rank of the member and the socioeconomic status of the family.

Although military communities have no unemployment, this is no guarantee against financial hardship. Financial stress is a problem among many junior enlisted families. With the link between socioeconomic standing and child abuse documented in civilian communities, it is not surprising to find similiar links between military rank and incidence of abuse. Although abuse occurs across the rank hierarchy, studies indicate that the higher the rank, the lower the rate of abuse (Lanier, 1978; Shwed and Straus, 1979). It should be noted, however, that rank varies with other factors associated with abuse besides income such as age. In addition, Lanier (1978) suggests that the link between rank and abuse may be more a factor of low job satisfaction and self image than of income alone.

The most recent research shows that child abuse occurs in all social classes to some extent, but the incidence appears to be higher among the economically disadvantaged. In one study, families earning less than $6,000 yearly were found to be twice as violent as families earning more than $20,000 (Straus, et al., 1980). It is suggested that membership in a middle and upper class family provides resources for mediating many stress-producing and potentially violent situations. Higher income families often have more alternatives for getting help with family problems.

In looking at the relationship between economic factors and neglect, it appears that socioeconomic factors are more predictive of child neglect than any other type of child maltreatment (AHA, 1978; Westat, Inc., 1981). Compared to physical and sexual abuse, neglect is more related to environmental factors, such as insufficient income, than to interpersonal difficulties in the marriage or parent-child conflicts.

Unlike physical abuse and neglect, most cases of sexual abuse appear in middle income families (Westat, Inc., 1981). In part, this reflects the fact that sexually abused children are less likely to come from single-parent households headed by females than physically abused or neglected children. But even in two-parent families, sexual abuse is more equally distributed among social classes than physical abuse.

Race

Compared to the percentage of blacks in the general population, blacks are overrepresented in reports of child maltreatment, including physical

and sexual abuse, and neglect. According to figures from AHA (1981), 19% of reported maltreatment involved black families, although these families comprised only 11% of the total population. Only 69% of the reported cases of maltreatment involved white families, whereas 87% of the general population is white. Because blacks comprise nearly 20% of military personnel, these findings would appear to have special significance. The percentage of black members in the Navy and the Marine Corps is 10.8 and 20.3, respectively (AFIS, 1982).

Despite the overrepresentation of blacks among military personnel, demographic profiles suggest that blacks in the military have higher educational levels and high vocational aptitudes than blacks in the civilian community. As a consequence, extrapolations from the civilian to the military community about the link between race and the occurrence of child maltreatment are tenuous, at best.

The National Incidence Study (Westat, Inc., 1981) found small differences in rates of maltreatment for different ethnic groups. Whites had an incidence estimate of 10.5 children per 1,000, and the rate for blacks was 11.6. For other groups, the rate was somewhat less--7.0 per 1,000 children. Due to sample limitations, the reliability of this later rate is questionable.

In analyzing these findings, it should be remembered that official reports may reflect the vagaries of the reporting system. In fact, the National Probability Study by Straus and Associates (1980) found similar rates of child abuse among blacks and whites. Higher rates of abuse were reported for Native Americans, Orientals, and other racial minorities. There is no evidence that sexual abuse is any more common among blacks and other minority groups than among whites.

Education

The relationship between parent education and physical child abuse appears to be curvilinear. Men and women who are the most abusive toward children usually are high school graduates. Parents who are least likely to abuse their children have either dropped out of high school or completed several years of college (Straus, et al., 1980). In the military, over half of all members have completed high school only (AFIS, 1982).

Religious Affiliation

Whether or not parents have a religious affiliation appears unrelated to the physical abuse of children. However, members of the Jewish faith have the lowest rate of physical child abuse (Straus et al., 1980). No comparable data are available on the link between either religious affiliation and neglect or religious affiliation and sexual abuse.

Urban/Rural Differences

Studies report that a child living in a rural area is more likely to be mistreated than one living in the city or the suburbs. The National

Incidence Study (Westat, Inc., 1981) produced the following incidence rates per 1,000 children: 11.4 for rural counties, 10.9 for urban counties, and 8.8 for suburban counties. Shwed and Straus (1979) found that physical abuse was more common in the military among families stationed in rural areas and overseas, compared to more populated locations. Sexual abuse also may be more common in rural areas (Finkelhor, 1980).

Individual Factors

Intelligence

Although some studies have found physically abusing parents to score lower on intelligence tests (Smith et al., 1973; Wright, 1971), most report no differences between abusing and nonabusing parents (Kempe et al., 1962; Steele and Pollock, 1974). Similarly, studies suggest no relationship between the intellectual functioning of the parent and the occurrence of sexual abuse (Martin & Walters, 1982).

On the other hand, research shows a strong relationship between neglect and parental intellectual inadequacies (Martin & Walters, 1982). The factor helps account for the low motivation for change of many families who have neglected their children.

Mental Health

Although most experts agree that the prevalence of psychosis among physically abusive parents is not great (Kempe, 1973; Steele and Pollock, 1974), others find that abusive parents do suffer more frequently from depression, immaturity, and impulsiveness (Kempe, 1973; Lanier, 1978; Steele and Pollock, 1974). Abusive parents also tend to have more rigid and inadequate defenses than nonabusing parents (Elmer, 1967; Steele & Pollock, 1974).

Although no single personality profile can be drawn of abusive parents, some personality deficiencies are common to them. For example, abusing parents generally have unmet dependency needs and impaired impulse control (Smith & Hanson, 1975; Steele & Pollock, 1974). Despite these general tendencies of abusing parents, child abuse may be best understood as a pattern of behavior rather than a psychiatric phenomenon (Steele & Pollock, 1974).

Individual background experiences of abusers also play a role in creating a child abuser. The literature suggests that persons who were victims of violence in childhood or adulthood are more likely to be abusers, as are persons who have a history of violent and antisocial behavior (Wasserman, 1967; Elmer, 1967; and Green, 1976). Being the victim of violence may result in displacement of frustrations to the child; it is also likely that such an environment legitimizes the use of violence.

Like the findings for physical assaultive parents, studies suggest that few sexual abusers are actually suffering from psychosis. However,

studies of sexual abusers do distinguish between two types of abusers. The smaller group includes men who have a longstanding and often exclusive sexual interest in children. These men usually are referred to as pedophiles. The larger group of men are those who sexually abuse a child in the face of certain stresses or opportunities, even though this is not their predominant sexual orientation. These men are referred to as situational or regressed abusers (Groth, 1979).

Most parents or stepparents who sexually abuse children are situational or regressed abusers. The abuse often occurs in the wake of personal frustration such as a career disappointment, or during the times when they lack emotional or sexual support, such as during marital separation and divorce. In these cases, girls usually are the victims rather than boys.

Pedophilic abusers are frequently unmarried and often have a history of fantasy and involvement with children. They are more frequently sexually attracted to boys (Burgess et al., 1981).

Parenting Role

Compared to non-abusive parents, parents who physically abuse their children tend to have different approaches to the role of parenting. They frequently expect their young children to behave in ways that are only possible for older children or adults. They often lack empathy and have difficulty interpreting cues given by children. In general, many physically abusing parents prematurely expect and demand a great deal from their children (Steele & Pollock, 1974).

Some observations also have been made about the special parenting characteristics of sexually abusive fathers. In some cases, these men had little involvement with the child during its early years either because the men were away or did not join the family as a stepparent until later in the child's life. In addition, these men often cultivate a "special" relationship with the child. The child receives presents, favors, and privileges far beyond those of other children. Many times these fathers and stepfathers will create a rivalry between the abused child and the mother (Meiselman, 1978).

Alcohol

Numerous studies have linked alcohol use and drug addiction to the physical and sexual assault of children (Young, 1964; Johnson and Morse, 1968; Gil, 1970; Martin & Walters, 1982; Wertham, 1972; and Fontana, 1973). Several researchers, however, have noted the problems in attempting to establish a causal relationship between alcohol use and child abuse (Gelles, 1974; Straus et al., 1980). They suggest that those factors that may cause parents to abuse their children may also cause them to drink. Drunkenness also may be used to justify abusing children.

Comparisons of alcoholic and drug uses between military and civilian populations produce similar rates and patterns (Burt & Biegel, 1980).

Relational Factors

Mothers and Fathers

Most experts agree that parents are the primary perpetrators of most forms of child maltreatment (Gil, 1970; Johnson, 1974; Maden, 1975). For example, the American Humane Association (AHA) (1979) reports 86.4% of all cases involve natural parents and 9.6% involve either stepparents or foster parents.

AHA also indicates that mothers more often are perpetrators of physical abuse and neglect than fathers (1978). Mothers also have been found to engage in more severe abuse than fathers (Gil, 1970; Steele & Pollock, 1974; Straus et al., 1980).

Compared to cases of physical abuse and neglect, sexual abusers are less likely to be parents (Finkelhor & Hotaling, in-press). More sexual abuse than physical abuse occurs at the hands of other relatives such as brothers and uncles, and persons outside the family such as neighbors, teachers, and strangers.

Still, sexual abuse by parents is not uncommon. In a third to a half of all reported cases of sexual abuse, a parent is the perpetrator. Fathers are more likely to be sexual abusers than mothers. Stepfathers and paramours of the mother are responsible for a number of sexual abuse incidents.

Marital Status and Quality

The presence of marital discord in physically abusive and neglectful families is common (AHA, 1978; Smith and Hanson, 1975). This is especially true, however, in cases of abuse. According to AHA (1978), family discord was present in 42% of abuse cases. On the other hand, family discord was reported in only one-third of neglect cases. Numerous studies also have recorded significant number of separated, divorced, and single parent households in cases of abuse and neglect (AHA, 1978; Garbarino, 1976).

When controlled for social class differences, however, research suggests that the marital situation of physically abusive families may not vary greatly from non-abusing families (Corey et al., 1975; Steele and Pollock, 1974). In addition, even if broken homes are linked to child abuse, children are not necessarily better off in two-parent households. Sometimes it is only through marital separation that children escape from abuse.

Compared to physically abused and neglected children, sexually abused children are more often from a two-parent family (Westat, Inc., 1981). However, marital discord has been frequently associated with sexual abuse. In father and stepfather incest, it is common for sexual and emotional relations between husband and wife to be highly strained (Herman, 1982; Meiselman, 1978).

Situational Factors

Stress

The link between stress and family problems and instabilities is becoming increasingly apparent. Stresses repeatedly encountered are not only cumulative, but also may result in dysfunctional coping patterns, such as child maltreatment. Official reports of maltreatment suggest the presence of high stress in abusive families. According to the AHA (1978), 18.1% of the families reported for abuse had continuous child care responsibilities, 12.8% had recently relocated, 10% had new babies in the household, and 3.8% had a physically handicapped person living in the home. Out of all families reported for neglect, 27.5% had continuous child care responsibilities, 19.4% had recently relocated, 12.4% had new babies in the household, and 5.8% had a physically handicapped family member. Individually, these factors may not seem very stressful; combined, the effects can be devastating, especially to a family lacking adequate coping skills.

Because of their link to stress, economic factors have also been linked to child maltreatment. As previously mentioned, for instance, low income has been shown to be related both to physical abuse and neglect of children, especially neglect. The employment status of the household head also is important. Unemployment, underemployment, and discontinuous employment are strongly associated with physical child abuse (Gil, 1970; Holter and Friedman, 1968; Johnson and Morse, 1968; Steele and Pollock, 1974; Straus et al., 1980). For example, Gil (1970) found that 48% of the abusive fathers in his sample had been unemployed during the year prior to the abuse. Straus and Associates (1980) found that fathers working part time were twice as likely to engage in severe violence than fathers working full time.

Factors related to the economic situation of families are frequently found in abusive and neglectful families. These factors include substandard or inadequate housing (AHA, 1978; Gil, 1970; Holter and Friedman, 1968; Johnson and Morse, 1968) and large family size (Straus, et al., 1980; Gil, 1970). Families with four or more children tend to be more abusive and neglectful than families with fewer children. A reanalysis of this data, controlled for income, ethnicity, and father's education, still found family size directly related to child abuse (Light, 1973).

Other stress producing factors frequently present in families who maltreat include pregnancy, illness, injury, and often death of a friend or relative. Several studies also have established a relationship between prematurity and child abuse (Lenoski, 1974; Lynch, 1976). Lenoski found that abused children were twice as likely to be prematurely born. Prematurity and other factors, which may interfere with the bonding process between parent and child, place a child at high risk for abuse and neglect (Lynch, 1976).

Another source of stress commonly associated with child abuse and neglect results from adolescent and premarital pregnancies (Wasserman,

1967). Unwed and very young mothers show disproportionately higher rates of child abuse and neglect. This is usually a result of several factors including a lack of parenting skills, poverty, and the isolation that accompanies some mothers and their children.

Stress and isolation are endemic to the military lifestyle. The military mission requires constant readiness and high mobility. Families experience frequent separations and sometimes economic hardship. Working with other stress factors, situations conducive to child maltreatment can result.

Social Isolation

Physically abusive parents tend to be socially isolated from formal and informal social networks (Elmer, 1967; Garbarino & Gilliam, 1980). Comparing abusive and nonabusive mothers, Smith (1975), for instance, found abusive mothers to have fewer contacts with their parents, relatives, neighbors, or friends and few of them engaged in social or recreational outlets.

This link between social isolation and child maltreatment is significant for several reasons. First, parents lack a social support system during times of stress. Second, they are less likely to be influenced by community expectations or to modify their behavior in response to these expectations (Steinmetz, 1978).

These results have special significance for the military community. In a recent study of military family life, Orthner and Bowen (1982) found a high proportion of Air Force families to be highly self-reliant. More than half of family members interviewed had no close friends, neighbors, or work associates. Although this self-reliance can be viewed as a healthy response to the frequent moves and transitions experienced in the military, it can leave families very vulnerable to stress and open to dysfunctional coping patterns such as child maltreatment.

Occupational Situation

Literature in the sociology of work asserts that a person's occupation has a compelling influence on his behavior and values (Kohn, 1977; Steimetz, 1972). Recent research, for example, demonstrates a link between the nature of the parents' occupations and child-rearing techniques. In occupations requiring a high degree of conformity, as compared with self direction, parents rely more heavily on the use of physical punishment in child-rearing (Kohn, 1977).

Extending these concepts to the military where organizational goals are associated with defense and superordinate-subordinate interactions, the potential exists for higher than usual rates of child abuse. Although the link between parents' occupations and child abuse has not been examined in the civilian population, studies have been conducted in the Army and the Air Force (Lanier, 1978; Shwed & Straus, 1979).

Analyzing confirmed cases of child maltreatment, both studies found that the more the military member's work assignment was associated with violence, the higher the rate of child abuse recorded. This finding was true for the Army with its missions of hand-to-hand combat as well as for the Air Force, with missions associated with less direct types of military violence. The direct association of violent work assignments and child maltreatment may be even greater for members of the Marine Corps.

E. EXPLANATIONS

The tragic picture of a defenseless child subjected to abuse and neglect tends to arouse the strongest emotions of clinicians and others who treat and study the problem of child maltreatment. There frequently seems to be no rational explanation for harming a defenseless child. It is not surprising, therefore, that a psychiatric model explaining child abuse was the first applied to the problem, and has endured for years, even in the absence of strong empirical data to support such a model. In recent years, other explanations have also been advanced that are relevant to understanding child maltreatment, including the social situational, ecological, and social learning theories.

The Psychiatric Model

The psychiatric model focuses on the abuser or neglecter's personality characteristics as the chief determinants of maltreatment. A psychiatric model links mental illness, personality defects, psychopathology, alcohol and drug use, or intraindividual abnormalities to acts of child maltreatment. Research, however, indicates that less than 10% of child maltreatment is attributable to personality traits, mental illness, or psychopathology (Steele, 1978).

A Social-Situational Explanation

That personality problems and psycholopathology do not fully explain acts of child maltreatment does not mean that personal problems are not related to abuse and neglect. These personal problems, however, tend to arise from social antecedents (Gelles 1973). Some of the social factors related to child maltreatment include marital conflict, unemployment, social isolation, and unwanted pregnancy.

A social situational explanation of child maltreatment proposes that abuse and neglect arise out of two main factors. The first is structural stress. The association between low family income and child maltreatment, for instance, indicates that a central factor in child maltreatment are inadequate financial resources. The second factor is the cultural norm concerning force and violence towards children. In contemporary American families, violence towards children is normative (Straus et al., 1980). Thus, the cultural approval of force and violence as a child rearing technique, together with high stress and lack of social, psychological, and

economic resources, leads many parents to physically abuse their children. Similarly, norms concerning sexuality and children, together with blocked opportunities for appropriate sexual outlets, can lead to the sexual misuse of children. Neglect also arises out of the cultural values placed on children, combined with inadequate resources for protecting and providing for children in certain households.

An Ecological Explanation

Garbarino (1977) has proposed an ecological model to explain the complex nature of child maltreatment. The ecological approach examines maltreatment in terms of the relationship between three interacting systems. On the first level is the individual, his or her abilities, and developmental progress. The second level focuses on social interaction. Both husband-wife relations and parent-child interactions are examined at this level. The third level focuses on the environment. At this level, the primary concern is with the kinds of social supports and institutions available to the family and the individual.

To somewhat oversimplfy the ecological model, maltreatment risk is greatest when the functioning of children and parents is limited and constrained by developmental problems. Children with learning disabilities, social or emotional handicaps are at an increased risk of maltreatment. Parents who are under considerable stress or have personality problems are at an increased risk of maltreating their offspring. These conditions are exacerbated when social interaction between spouses or parents and children heightens the stress or makes the personal problems worse. Finally, if there are few institutions and agencies in the community to support the troubled family, then the risk of abuse is further increased. Garbarino (1977) has found that rates of child maltreatment are highest in communities with the fewest human and social service resources. Rates are highest in families where marital conflict and stress are the highest, and among families who are socially isolated. Lastly, specific personal and social characteristics of children and parents increase the likelihood of maltreatment. In short, maltreatment is believed to arise out of a mismatch between parent, child, family, and neighborhood.

Social Learning Theory

A commonly stated explanation for child maltreatment is that parents learn to abuse and neglect their children. The family is the place where people learn the roles of mother and father, and learn how to deal with children and cope with stress and frustration. The family is also the place where people are most likely to first experience violence, neglect, and sexual misuse. Abuse, neglect, and sexual abuse are found to be transmitted from generation to generation. Obviously, not all maltreatment victims grow up to be maltreaters themselves. But, a history of maltreatment dramatically increases the risk that an individual will mistreat his or her own children. Individuals not only are exposed to the techniques of maltreatment, but they also learn the social and moral

justifications for the behavior. Thus, it is not uncommon to hear a parent who has physically abused his or her own child explain that they were punishing the child for the child's own good. Sexual abusers frequently try to disavow the deviance of their act either by claiming that the child was not harmed by the sexual encounter, that the child enticed them into the sexual encounter, or that the offender did not know what he was doing because he had too much to drink. Irrespective of the truth of these claims, the claims themselves are learned, and then used to justify or disavow the actual maltreatment.

F. PREVENTION AND INTERVENTION

Since the 1970s, extensive legislation and services have been implemented to protect children and to work with perpetrators of abusive and neglectful acts against children. In addition, each of the military services has developed policies and programs to prevent and treat child maltreatment. Sexual assault against children also has emerged as a focus for the human service and criminal justice system.

Literature in the field shows a predominance of information on the incidence and dynamics of child maltreatment. Comparatively less information is available on successful program models and components. Descriptions of operating programs tend to be fragmented and difficult to locate.

Although the importance of community intervention in the problem of child maltreatment is recognized, there are no simple solutions. Child maltreatment is a complex problem. Its causes are numerous, and vary among individuals and groups of individuals. Accordingly, no single response will substantially reduce the incidence of child maltreatment. Any community program, therefore, should combine a number of different strategies and be integrated with other program components.

Although effective program models and intervention strategies in the field of child maltreatment vary on a number of dimensions, they share certain underlying assumptions and program elements. These common assumptions and program elements are the focus of this section and are subdivided into the following categories:

- Program Planning
- Goals and Philosophy
- Organizational Structure
- Staffing Patterns and Support
- Direct Services
- Prevention and Community Education

- Support Agencies and Resources, and
- Program Evaluation.

Although the discussion reflects the prescriptive and theoretical nature of the materials assessed, program elements are documented whenever possible by examples from the field. Current issues, gaps, and barriers in service delivery are discussed, as are suggested areas for change.

Program Planning

The definition of child abuse, neglect, and sexual assault is critical to the development of any system for intervention. It establishes the philosophical framework for all subsequent decisions. It also is basic to developing and implementing programs and to establishing a rationale for intervention into family life.

The needs of the abused child and his or her family cannot be filled by a single agency or type of service. Comprehensive programs require adequate funding, resources, and commitment. A community-wide approach is necessary. In planning new programs or coordinating existing ones, key elements include:

- A coordinated, interdisciplinary, interagency community response;
- An assessment of community resources to identify programs and services as well as gaps, duplications, and fragmentation in service delivery;
- A comprehensive treatment program;
- An effective case management system; and
- An active prevention program, including community education (NCCAN, 1980b, p.68).

Goals and Philosophy

Because child abuse, neglect, and sexual assaults against children are complex problems and tied to other social problems, underlying program assumptions vary according to perceptions of the nature and dynamics of the problem. Intervention into the privacy of the family and the rights of individual family members are central controversies.

Despite these issues, many programs and practitioners have similar perspectives and approaches to the problem:

- Child abuse and neglect are symptoms of serious family unhappiness or dysfunction. . .

- Abuse and neglect are patterns of interaction involving both the parents/guardians and the child.
- Effective intervention involves addressing the needs of the entire family unit as well as the needs of individual members in order to alleviate the stresses that resulted in the symptom.
- Strengthening family life and maintaining the integrity of the family is a primary goal.
- The prevention and treatment of child abuse and neglect requires a variety of disciplines working together in a unified approach (Ebeling & Hill, 1975; National Institute of Juvenile Justice and Delinquency, 1980).

Organizational Structure

A coordinated community response to child maltreatment requires a structured service delivery system. The structure of program components varies according to role, function, and the availability of resources. Attempts to offer comprehensive care involve:

- Development of a multi-agency coordinating or advisory body;
- A 24-hour centralized reporting and response system;
- Formal methods for agencies to work together; and
- Community education (NCCAN, 1980b).

Case management and effective intervention rely on:

- A quick response to all initial reports of abuse or neglect;
- Accurate diagnosis and service planning;
- Availability of interdisciplinary input, beginning with identification and continuing through treatment and termination;
- Follow up of all referrals to avoid losing cases;
- Review of cases to determine current needs; and
- Follow up of terminated cases.

Multidisciplinary review teams or committees are suggested and typically would include a pediatrician, a mental health professional, lawyer, teacher, protective service or social worker, and a police and/or court worker (National Institute for Juvenile Justice and Delinquency, 1980).

Staffing Patterns and Support

Given the range of agencies and disciplines involved in handling abuse and neglect cases, staffing patterns vary according to agency size, function, and funding. However, all staff need specialized training in identification, reporting procedures, treatment, and prevention. In addition, staff must be knowledgeable about, and show respect for, community norms and resources. This is especially true of civilians who work in the military community.

The critical nature of child abuse, the high level of responsibility and decisionmaking involved in handling cases, the demands of heavy caseloads, and the multiple needs of families served are special issues for staff. If qualified and experienced treatment workers are to be retained, specific policies are needed to enable workers to participate in organizational decisionmaking, to create flexibility and a variety of job tasks and roles, and to provide a sense of shared responsibility (NCCAN, 1980a).

Program strategies include:

- Rotating the intake function;
- Creating opportunities for staff to have other than client contact, such as public and professional presentations;
- Providing adequate supervision and consultation; and
- Creating forums for discussing problems and concerns.

For example, one program, the Child Abuse Study Group at Dartmouth Medical School, New Hampshire, provides training and support to community service workers through inservice seminars to increase their cognitive and affective understanding of their own behavior and the behavior of vulnerable families.

Direct Services

Most communities have at least several treatment programs for providing services to children and families, even if they are not labeled as child abuse and neglect programs. A full complement of services would include a coordinated working relationship among:

- Individual and group services for adults;
- Supportive and advocacy services, as well as therapeutic and educational ones;
- Crisis and emergency treatment and long-term treatment;
- Day services and residential care;

- Child protective services; and

- Law enforcement and criminal justice agencies.

Policies and procedures within service facilities need to be modified to facilitate service delivery. Examples of such modifications include: flexible appointment schedules; follow-up on missed appointments; outreach and home visits; involvement with the family environment; and 24-hour staff availability (NCCAN, 1979d).

Case planning is a systematic response that begins with the initial identification of abuse and involves:

- Providing any emergency measures necessary to protect the child and/or to provide medical services;

- Reporting to the appropriate agency;

- Conducting an investigation to confirm the abuse and to identify the needs of the family, including referral; and

- Providing continuous monitoring throughout the treatment process (NCCAN, 1979b).

Parent needs for service include:

- Individual, couple, family, and group therapy;

- Financial, legal, and medical assistance;

- A 24-hour crisis line;

- Lay therapy and self-help groups, such as Parents Anonymous;

- Education on child rearing and family life;

- Family planning and sex education; and

- Supportive services, such as community health nurses, homemaker services, parent aides, child care, and employment or training programs (NCCAN, 1979d).

Needs of children include:

- Crisis nurseries or therapeutic play schools;

- Day care programs or preschool;

- Play therapy, counseling, or group therapy;

- Protected environment or foster care; and

- Support services, such as Big Brother, Big Sister, foster grandparents, church or community activities, and social enrichment programs (NCCAN, 1979d).

In the event that the child is removed from the home, intensive services to the family need to be provided to help ensure that the child can be returned to a safe and stable environment.

Additional program elements in service delivery include Identification, Reporting, Intake and Assessment, Treatment, Coordination, and Follow Up.

Identification

Definitions of child abuse, neglect, and sexual assault are found in procedures, informal practices of agencies, legal statutes, and in generally held community standards. From a medical and treatment perspective, special protocols, examination procedures, and methods for interviewing are important diagnostic tools.

Reporting

All states and the District of Columbia have passed reporting laws, but they differ with respect to:

- Types of instances that must be reported;
- Persons who must report;
- Time limits for reporting;
- Manner of reporting; and
- Degree of immunity conferred on those who report.

Reporting is usually handled by the child welfare or law enforcement system. In conjunction with reporting, state laws frequently require the establishment and operation of a statewide central register for child abuse and neglect cases. Jurisdictional issues within military communities are often resolved by assigning case responsibility to the state agency, with military service providers maintaining a supportive and cooperative relationship (Broadhurst et al., 1979).

Intake and Assessment

Intake is part of the initial response to suspicion, identification, or reporting of abuse or neglect. The nature and severity of the situation and potential danger to the child are assessed. Social, psychiatric, and medical information is evaluated to determine the special problems in a family, contributing factors, and the needs and strengths of each family member and of the family as a unit (NCCAN, 1979b).

Investigation is a process of interviewing, observing, and gathering information to determine the validity of a report. It is based on a general concern for the functioning of the entire family. Four purposes of investigation are:

- To determine if abuse and neglect is occurring and if there are any emergency needs for medical assistance;
- To determine whether the child is "at risk" in the home;
- To determine whether the risk is sufficiently serious to warrant immediate intervention to guarantee the child's safety; and
- To determine the need for treatment or family support services.

If it is necessary to interview the child, this is done after considering the alternatives. Some programs have developed special techniques for use with children who have been victims of sexual assault. The Harborview Sexual Assault Center in Washington State, for example, has developed a protocol for sensitive questioning of sexually assaulted children and techniques for working with a child witness in criminal justice proceedings.

Treatment

Mental health and medical practitioners have the expertise to assist Child Protective Services or the justice system, as well as to provide direct services to the abused child and the family. Treatment focuses on addressing the needs of the individual and the family in order to prevent further abuse. Client mistrust and resistance are often high, thus, special outreach methods can be effective in developing a therapeutic relationship. It is usually necessary to involve more than one service to treat families.

An accurate and detailed social history is key to successful treatment of the abused child and the family. Parents who maltreat, for instance, can be classified as either chronic, episodic, or acute maltreaters. Each require different intervention strategies.

One of the obstacles to treatment of maltreaters in the military is the high degree of mobility of the family. In the case of incest, however, the Navy has issued an article responding to this problem. Under the Navy article (Naval Military Personnel Manual, article 342018, April 1982), any enlisted member convicted of incest or self referred may be recommended for treatment in the Navy Family Advocacy Program for a maximum of one year. During this time, the member is eligible for reassignment only with the concurrence of NMPC-66.

Another model treatment intervention includes Parents Anonymous. This program is a national self-help organization that supports members with weekly group meetings and personal and telephone contacts among members during periods of crisis. Parents Anonymous has been working very effectively at Fort McClellan in Alabama, for example.

Coordination

A multidisciplinary approach to child maltreatment has the greatest potential for success. Effective coordination of the different systems involved in abuse cases depends on the development and implementation of a working agreement and mutual acceptance of responsibilities between agencies. The establishment of a child protection coordinating committee helps ensure coordination of service delivery (NCCAN, 1979a).

The Children's Advocate Program in Massachusetts demonstrates the use of such a committee. It was established in response to the need for coordinated services and to overcome interagency communication problems. The agency delegates meet monthly to work on subcommittees to develop additional resources, to provide public education, to educate court personnel, and to study case management issues.

Follow Up

In child maltreatment cases, the term "follow up" usually refers to early detection or suspicion of maltreatment and subsequent case management, investigation, and treatment. The term also refers to providing services after case termination and encouraging families to return for assistance in the future if needed.

Prevention and Community Education

In recent years, the concept of prevention has been increasingly applied to the problem of child maltreatment. There are three levels of prevention: primary, secondary, and tertiary.

- Primary prevention includes delivering support services to families that strengthen their immunity to stresses potentially leading to abuse and neglect. It also involves diminishing the social conditions that lead to child maltreatment.

- Secondary prevention involves the early diagnosis and treatment of child maltreatment. Its aim is to minimize the impact and duration of the problem.

- Tertiary prevention includes treatment efforts designed to rehabilitate the family and to prevent the reoccurrence of child maltreatment.

The major distinction between these three levels of prevention is the time of intervention. Only primary prevention takes place before maltreatment actually occurs. Secondary and tertiary prevention are analogous to treatment; the main objective is to deal with an existing problem (Gilbert, 1982).

Primary prevention activities in the area of child maltreatment have included:

- Programs to increase parent-infant bonding and interaction;
- Services to families with special needs;
- Child care services;
- Family life education; and
- Family planning and sex education.

But developing primary preventive programs and services is not enough. These programs must also be able to identify "at risk" groups, and once identified, involve these individuals and families in prevention programs. Demonstrating the potential value of prevention programs to possible recipients and motivating these individuals and families to participate is a challenging task.

Prevention programs need community support and often involve public awareness campaigns. A high level of public and professional awareness of the scope and severity of child abuse and neglect is essential. Community education is a responsibility of all agencies involved with child abuse. Agency staff can make educational presentations to community and civic groups.

Support Agencies and Resources

Protective Services

Child protective services is mandated to protect children and has two major functions: investigation and casework. It is a key agency in determining case disposition. Child abuse programs closely affiliated with, or housed within, child protective services have been found to be more effective in handling child abuse cases (National Institute of Juvenile Justice and Delinquency, 1980).

Some underlying principles of child protective services include:

- Viewing child abuse and neglect as primarily a social rather than a legal problem;
- Keeping children with their natural families when their safety can be assured; and
- Involving families in the casework process (Holder & Mohr, 1981).

Medical Care

Hospital emergency rooms receive many cases of maltreatment, either through the police, schools, or parents themselves. Because child abuse

problems by their nature encompass many disciplines, some hospitals have developed special diagnostic units using a multidisciplinary team approach.

Priority is given to the child's immediate physical injuries but a complete medical examination is necessary to determine if there are other medical problems. Detailed documentation of the injuries needs to be made; colored photographs are useful. Follow-up treatment should be instituted (NCCAN, 1979e).

Law Enforcement

Law enforcement officers are legally mandated to intervene in community problems and often are involved in the initial investigation and reporting of child maltreatment. The responsibilities of the law enforcement officer in child abuse and neglect reporting include:

- Reporting suspected cases of abuse and neglect;
- Investigating suspicious cases either because a report has been received or because a case surfaces through investigation of other violations of the law; and
- Providing emergency services to protect the child.

Officers must be aware of any special jurisdictional arrangements, such as those regarding Indian reservations or military installations (NCCAN, 1979c).

Criminal Justice System

In most communities, only a small proportion of child abuse cases result in arrest and prosecution. Court referrals usually involve family courts rather than criminal courts. Family courts:

- Mandate services for the family;
- Protect the child from further injury;
- Provide a fair and impartial review of social service agency decisions; and
- Protect the constitutional rights of parents and children.

The court has the authority to order:

- The child to be placed in his or her home under supervision of court probation or child protective services;
- Parents to obtain counseling;
- Child placement outside of the home; and

- Termination of parental rights (in some jurisdictions)(NCCAN, 1979b).

The Child Sexual Abuse Treatment Program for example was initiated by the Juvenile Probation Department in California and works closely with the justice system. This program receives victim offender, and family referrals from the police and probation department. Victims and fathers are initially counseled individually. Joint therapy for mothers and daughters, husbands and wives, parents and daughters, entire families, and fathers and daughters are provided sequentially, with the goal of reuniting the family.

Schools

Schools are an important resource in detecting and reporting abuse, especially for the older child. Some state statutes require teachers to report suspected abuse or maltreatment. Liaison between the school or teacher and the caseworker facilitates both treatment and reporting. Schools are also able to provide curriculum about child abuse and child sexual assault as part of health education. For example, The Sex Offense Committee of Montgomery County, Maryland, has outlined a comprehensive educational curriculum for children in kindergarten through twelfth grade to give them an understanding of their own bodies and child abuse and sexual assault.

Program Evaluation

Formal and informal methods of evaluation appear lacking in most programs. There are a number of specific reasons for evaluating a program:

- To find out how effectively a program is in meeting the needs of the client population;
- To obtain information that will help in restructuring a program or managing it more effectively;
- To test a model for others to follow;
- To direct program planning efforts;
- To find out how the program is working from the client's point of view; and
- To improve public relations or establish credibility (Clifton & Dahms, 1980).

Program evaluation can provide the information necessary to decide whether to continue a program, to improve its practices and procedures, or to institute similar programs elsewhere. Unfortunately, program evaluation is one of the most overlooked aspects of social service programming.

Issues in Service Delivery

Although a number of theoretical and prescriptive materials have been written about child maltreatment intervention, program descriptions are difficult to obtain because of the lack of centralized information. This limits the sharing of expertise and the replication of successful program development and intervention techniques.

Child abuse and neglect are widely viewed as unacceptable behaviors, yet the field is filled with conflict over legal and ethical issues involved in intervention, acceptable methods for intervention, and the impact of treatment. Although interdisciplinary cooperation and a coordinated community response is regarded as the theoretical ideal, in reality, coordination is often fragmented by mistrust between service providers and agencies.

Concern focuses on protecting the rights of both parents and children, reporting laws that threaten the sanctity of the professional-client relationship, and general apprehension over criminal justice intervention. Lack of resolution of these issues is reflected in underreporting, negative attitudes toward state intervention, tension between the social service and the law enforcement/criminal justice system, and poor coordination in service delivery.

Even with underreporting, protective and treatment services are overburdened. Scarce funding, resources, and fragmented services, differences in professional judgment, and professional and organizational rivalries increase the need for coordination, while simultaneously undermining it.

Within the child welfare and protection system, problems stem from the dual role of the agency as both helper and investigator. Inadequate training of workers and lack of program resources also pose service delivery problems. This often results in heavy caseloads, too much reliance on law enforcement, and too great a dependence on foster care.

Although it is viewed as a short-term intervention, foster care often turns into long-term placement or begins a series of residential placements for children. Foster care placement is frequently inappropriate and based more on available resources than on needs.

Even though neglect cases constitute the bulk of child protective service cases, neglect is the child maltreatment problem that receives the least attention. Abuse receives more attention because of its dramatic nature. As a result, research and treatment have focused more on abuse.

The significance of the family and working with the family as a unit tends to be overlooked. Service programs often choose to treat the symptom rather than the cause of child maltreatment. In general, the field suffers from lack of knowledge of the most effective treatment approaches.

Services provided to military families require addressing their special needs. Military communities operate within certain constraints.

Generally, military installations view themselves as distinct and separate from the civilian community, but the management of child maltreatment cases requires liaison with civilian resources because of the legal issues and service needs of abusive families. Military and civilian cooperation often require overcoming negative stereotyping by each group, as well as settling jurisdictional issues.

One of the potential obstacles to intervening in child maltreatment in the military is that disposition of the case is often left to the discretion of the commanding officer, especially in areas of exclusive juridication and overseas. Although the commanding officer may respond effectively, using the full range of alternatives, he or she also may choose to ignore the problem or to respond punitively, ignoring recommended alternatives (Kovalesky-McLaine, 1981). Fear of recrimination or punitive action hampers primary and secondary prevention of maltreatment.

Families overseas often experience increased stress due to living in a foreign culture. Military personnel overseas may be in jurisdictions that limit legal options in dealing with child abuse and neglect. It often is more difficult to provide services overseas because of long distances and shortages of military hospitals, medical personnel, and practitioners.

In addition, families involved in maltreatment overseas often are returned to the continental United States with minimal notice. This may add stress to an already stressful situation and may do little to alleviate the problem. It is also possible that the family may fail to follow through with intervention plans or be lost within the system.

G. CHAPTER SUMMARY

American society has often been described as child centered. This idealized image, however, is contradicted by the prevalence of child maltreatment in the United States. Child maltreatment not only poses a serious threat to the growth and development of its victims, but also challenges the very foundations of family integrity and social stability.

Not surprisingly, child maltreatment has attracted considerable interest in recent decades. It has been the focus of numerous research studies and demonstration projects, conferences, and legislative initiatives. In addition, services and programs have been implemented in both the civilian and military communities to protect children and to work with perpetrators of abuse and neglect.

Despite this widespread interest and concern, the real incidence of child maltreatment remains unknown. Its underlying dynamics are still insufficiently understood, especially in the military services. In addition, the development of programs and services have been hampered by inadequate funding and fragmentation of available services.

The seriousness of child maltreatment demands continued attention. Researchers and human service professionals must continue to explore the

complexities of this problem. Only then can programs and services be built on facts rather than assumptions, real needs instead of assumed needs.

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Chapter II

Spouse Abuse

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SPOUSE ABUSE

A. BACKGROUND

Both anecdotal and historical data confirm that the family has long been a scene of interpersonal violence. For most of that time, spouse abuse and neglect have suffered from selective inattention (Dexter, 1958; Straus, 1974; and Gelles, 1980). The victims have been among the missing persons in literature on social problems, families, and criminal violence. In the late 1960s and early 1970s, however, the issue of spouse abuse and neglect was transformed from a private issue to a public problem. In the late 1970s, the Navy added a spouse abuse component to the already existing child abuse reporting system.

This was a logical addition because both phenomena are forms of domestic violence and because both may occur within the same family. At the same time, adding spouse abuse complicated the Navy program. The prevention and treatment strategies for spouse abuse are quite different from those used in child abuse. In addition, there are state-mandated and funded mechanisms, such as protective services, which can back up Navy resources for child abuse; analogous services do not exist for battered adults.

Marital rape can be viewed as one aspect of a continuum of spouse abuse; it is sexual rather than physical abuse. Although this problem is not mentioned specifically in the DoD Directive and constitutes a legal offense only in a few states, it is included within the BUMED Instruction and is becoming recognized as a widespread problem in the civilian sector.

There are no state regulations concerning mandatory reporting of spouse abuse or marital rape by physicians or other professionals. Consequently, reliable data is lacking on the incidence of abuse within the general United States population. The studies that are available are discussed in the following sections. There is even less information available on the incidence of spouse maltreatment in the military population, especially in the Navy and Marine Corps. In the past few years, there has been speculation about the comparability of civilian and military rates of abuse, but little empirical data. Although this chapter suggests where civilian factors may be relevant to the military population, these judgments are extremely tentative because the civilian studies offer no simple cause-and-effect explanations. This makes comparability that much more tenuous. However, some of the more obvious similarities and differences have been addressed.

Research to Date

The prevailing attitude in the 1960s was that spouse abuse was rare, and, when it did occur, it was the product of mental illness or

psychological disorder. One of the earliest studies of marital violence focused on the psychological characteristics of abused wives (Snell et al., 1964), while another early study by Schultz (1960) examined the psychological profile of wife assaulters.

Once spouse abuse was identified as a significant social problem, research was aimed at refuting the conventional myths concerning the rarity of marital violence and the claim that its cause exists in the psychopathology of the husband and wife.

The major research to date has been designed to: (1) establish a reliable estimate of the incidence of marital violence; (2) identify the factors associated with violence between spouses; and (3) develop theoretical models of the causes of marital assault. Finally, there has been considerable interest in examining and explaining why women who are abused stay with their assaultive husbands (Gelles, 1976), or why, once they flee to a shelter, they choose to return to a violent husband.

The primary emphasis of this research is on the violence of husbands against wives. There is good reason for this emphasis. Straus et al. (1980) point out that husbands use the most dangerous and injurious forms of violence; violence by husbands does the most damage and is repeated more often than violence by wives. Evidence also suggests that violence of wives toward husbands is often self-defense or is a response to blows initiated by husbands. Lastly, a large number of attacks by husbands seem to occur when the wife is pregnant (Gelles, 1975), thus posing a danger to the unborn child. Still, violence on the part of wives does occur. Because factors associated with husband abuse are associated with other forms of family violence, the following review considers both violence by husbands and by wives.

Marital Rape and Wife Beating

Much of the work to date on marital rape has been from the perspective of wife abuse. There is good reason for this. Marital rape victims are trapped with their abusers, subject to repeated assaults, and victimized by the psychological abuse that goes along with the physical abuse. They are more likely to require the services of a battered women's shelter than a rape crisis hotline. In addition to behavioral similarities between victims of marital rape and victims of physical violence evidence suggests that the two problems frequently occur together. Finkelhor and Yllo (1982), for example, found that battered women are highly vulnerable to marital rape. When 300 battered women in ten shelters in the state of Minnesota were surveyed, 36% said they had been raped by their husbands or cohabitating partner.

Gaps in the Literature

There are number of important gaps in the knowledge about spouse abuse and neglect. First, no specific data exist on the incidence of spouse

abuse and neglect in the military. Estimates of the extent of abuse and violence in military families are at best crude projections from civilian samples, which are also inadequate. Second, little rigorous data are available that evaluate the effectiveness of interventions in instances of marital violence. Although shelters are considered a significant and cost-effective intervention, little data exist on either their short or long term effect on women leaving an abusive spouse and spending time in a women's shelter or safe house. Finally, there is insufficient information on the nature and extent of "mutual violence." Although men and women are both assaulters and victims, little is known about the sequence of events leading to marital assault and its outcomes.

Definitions

Spouse abuse researchers have experienced less difficulty in developing definitions of violence and abuse than researchers in the field of child abuse and neglect. Generally, spouse abuse researchers have concerned themselves with acts of violence between couples or marital partners. Although some definitions of marital violence extend to sexual abuse and marital rape and others view the degrading portrayal of women as abusive (London, 1978), there is general consensus that violence and abuse refer to "acts committed with the intent or perceived intent of hurting the other person" (Gelles & Straus, 1979).

One problem with a definition of violence that refers to acts intended to physically hurt another is that these acts can range from a push or a slap to a lethal assault. Some researchers attempt to distinguish between legitimate acts of force between family members and illegitimate acts of abuse (Goode, 1971). Straus et al. (1980) have nominally defined abusive marital violence as acts of violence that "have the high probability of injuring the victim--such as biting, kicking, hitting with a fist, beating, hitting with an object, or using a weapon" (p. 26).

In contrast to the civilian sector, the definition established by the Navy in BUMEDINST 6320.57 does not distinguish abuse of a child from abuse of a spouse and concentrates on diagnostic features: "Direct physical injury, trauma and/or emotional harm inflicted by other than accident ... may be evidenced by . . . contusions, bleeding, malnutrition, sexual abuse, bone fractures, subdural hematoma . . . " (Enclosure, p.1). To be a recipient of medical or other services, the victim must be a partner in a lawful marriage.

B. INCIDENCE

Because violence between husbands and wives was traditionally hidden in the home, there has been a general lack of awareness of the seriousness and the extent of the problem. Moreover, unlike child abuse and neglect, no official agencies have been mandated to record the incidence of spouse abuse. Whereas mandatory reporting laws for child abuse and neglect were

enacted in the late 1960s and early 1970s, no mandatory reporting laws exist for spouse violence. Nevertheless, a variety of data sources suggest that spouse violence is far more extensive than commonly realized.

Homicide

Homicide is one aspect of spouse violence on which data are available. Researchers generally report that intrafamily homicides account for between 20% and 40% of all homicides (Curtis, 1974). In 1979, 844 husbands were killed by their wives, while 1,009 wives were slain by their husbands (Uniform Crime Reports, 1980).

Assault

In one study, aggravated assault between husbands and wives made up 11% of all reported assaults (Pittman and Handy, 1964). In another report in Detroit husband-wife assault constituted 52% of all assaults (Boudouris, 1971).

Incidence of Marital Rape

Russell (1980) in a random sample of 930 women in San Francisco 18 years and older, reported that 12% of 644 married women in the sample reported a rape by a husband. When Finkelhor and Yllo (1982) asked a random sample of women "Has your spouse (or person you were living with as a couple) ever used physical force or threat to try to have sex with you?", 10% of the women who had been married (or living as a couple) said this had happened. Both studies produced a remarkable finding: sexual assaults by husbands were the most common kind of sexual assault. In Russell's study, more than twice as many women had been raped by a husband as had been raped by a stranger. In the Finkelhor and Yllo study, ten of the women had been sexually assaulted by a husband while "only" three had been forced by a stranger. All of the above incidence rates are probably low because of the sensitive nature of marital rape and reluctance to consider forced sex with a mate as rape.

Applicants for Divorce

Studies of couples applying for divorce also provide some data on the extent of husband-wife violence. Levinger (1966) found that 22% of the middle class and 40% of the working class applicants for divorce whom he interviewed discussed "physical violence" as a major complaint. O'Brien (1971) reports that 17% of the couples he interviewed spontaneously mentioned violent behavior in their marriages.

A National Survey of Marital Violence

Although each of the studies mentioned above offers a clue to the actual level of marital violence, the studies have numerous methodological problems, such as reliance on small or nonrepresentative samples and use of unofficial data.

A study based on a large nationally representative sample of families was conducted in 1980. In this study, Strauss adopted a standard definition of violence as "an act carried out with the intention or perceived intention of physically hurting another person." The investigators based their estimates of violence and abuse on self-reports of a nationally representative sample of 2,143 individual family members who responded to Straus' (1979) Conflict Tactics Scale measure of violence.

In 16% of those surveyed, some kind of physical violence between spouses had occurred during the year of the survey, while 28% of those interviewed reported marital violence at some point in their marriage (Straus et al., 1980). In terms of acts of violence that could be considered wife-beating, the national survey revealed that 3.8% of American women were victims of abusive violence during the 12-month period prior to the interview.

The same survey found that 4.6% of the wives admitted to, or were reported by their husbands as having engaged in, violence that was included in the researcher's "Husband Abuse Index." The data on husbands however, does not adequately represent the actual extent of the phenomena of "husband abuse." First, the researchers point out that in the large number of instances, the wives' act of violence were in response to violent assaults by their husbands. Secondly, women who struck their husbands are thought to be less likely to harm their husbands than men who used the same forms of violence towards their wives.

National Crime Survey Report

Another source of data on the extent and patterns of domestic violence is the National Crime Survey. This survey estimates the amount of crime committed both against persons aged 12 and older and against households, whether the crimes were reported to the police or not. The published results of this survey, Intimate Victims: A Study of Violence Among Friends and Relatives (U.S. Department of Justice, 1980), reported on events occurring between 1973 and 1976 as derived from semiannual interviews with approximately 136,000 occupants of a representative sample of some 60,000 housing units in the United States.

These were the key findings of the National Crime Victims Survey:

- There were about 3.8 million incidents of violence among intimates in the four-year period of the survey. Nearly a third were committed by offenders related to the victims.

- An analysis of single offender incidents revealed 1,055,000 incidents between relatives. Of this number, 616,000 (58%) were between spouses or ex-spouses.

In addition to these estimates, others have placed the figure of abused spouses as high as 28 million (Langley & Levy, 1977). Nevertheless, it would appear that the Straus et al. (1980) estimate of nearly 1 in 22 women abused by their husbands is a relatively accurate picture of the extent of spouse abuse.

C. CONSEQUENCES

Impact on Individuals

The consequences of spouse abuse and neglect extend beyond the obvious injuries experienced by the victims of spouse violence. Walker has found that women who experience repeated physical assaults at the hands of their husbands have much lower self-concepts than women whose marriages are free of violence (1979). Moreover, Walker finds that battered women develop an inability to protect themselves from future assaults. Walker's "learned helplessness" theory postulates that repeated physical assaults diminish a women's belief that she is capable of controlling the events that go on around her. Walker claims that it is this "learned helplessness" that keeps women from fleeing battering husbands. Moreover, Walker also claims that women who experience "learned helplessness" may believe that killing their husbands is the only escape from victimization.

Although marital rape occurs in conjunction with violence toward wives in many situations, there are many instances of rapes by husbands who are not otherwise violent toward their wives (Finkelhor & Yllo, in press; Shields & Hanmeke, 1981). There also seem to be a unique set of responses among women who are raped but not beaten by their husbands versus women who are beaten but not raped by their husbands.

Finkelhor and Yllo (1983) report that marital rape victims experience grief, despair, anger, hatred, shame, and guilt because of the experience of marital rape. Shields and Hanneke (1983) report that marital rape has a debilitating effect on self-esteem. Marital rape victims develop negative attitudes toward men, do not want any sexual relations with their partners, and use alcohol to combat depression. In the same sample, women who experienced nonsexual violence reported different reactions including psychosomatic symptoms, seeking help for the violence, and involvement in extramarital sex. Reactions to marital rape extend primarily to negative attitudes toward self and men and to reducing the victim's desire to engage in sex with her partner. These findings are consistent with other research on marital rape (Doron, 1980; Finkelhor & Yllo, 1982; Russell 1980).

Straus and his colleagues (1980) have reported that children who grow up observing their mothers being physically assaulted are much more likely to abuse their own children and their own spouses. Thus, a consequence of

spouse abuse in one generation is that it can set off a cycle of violence that repeats itself in the next generation.

Spousal violence influences the family in other ways. Researchers have found that one form of family violence tends to be linked with other forms of family violence. A family with spouse abuse is also at risk for child abuse and even of children assaulting their parents; women who were sexually victimized as children are almost three times as likely to be sexually victimized by their husband.

The consequences of spouse abuse for society include the days lost from work by victims of spouse abuse and the medical care that victims frequently require. Research has shown that domestic disturbance calls constitute the single largest category of police calls (Parnas, 1967), and police officers are more likely to be killed answering a domestic disturbance call than doing any other type of police work--including chasing armed robbers (Parnas, 1967). There is no precise data on whether spousal violence leads to mental and psychological problems for the victims and other members of the family, but it is at least plausible that it does, thus compounding the costs for the individual, for the family, and for the social service system that is called upon to diagnose and treat these problems.

Impact on the Navy

For the Navy, the potential costs of spousal violence include the possibility that domestic problems may reduce the efficiency of the active duty spouse and thus affect morale, performance, readiness, and personnel retention. If the victim is a female active-duty member, it is reasonable to assume that her productivity would be directly affected.

D. FACTORS ASSOCIATED WITH SPOUSE ABUSE

During the past 10 years, studies of spouse abuse in the general population and studies of women seeking help for these problems have uncovered a number of demographic, individual, relational, and situational variables associated with the use of violence between husbands and wives. In all likelihood, these variables are highly interrelated. For example, individual variables such as self-esteem, communication skills, and feelings of helplessness may be linked to social class. This review will point out interactions between variables when they have been reported in the literature.

Demographic Variables

Age

Straus et al. (1980) in a study of a nationally representative sample of 2,143 families reports that violence occurs most often in younger

families. The rate of violence for husbands and wives 30 years of age or younger is more than twice that of the next age group, 31 to 50 years old. Studies of women who seek help because of abuse by their husbands also show them to be younger than average. Gayford (1975) reports a mean age of 30 for women seeking help at a women's shelter and a mean age of 33 for their batterers. Fagan et al. (in press) in a study of users of federally funded programs for battered women found that 67% of the husbands who batter were 30 or younger. Women under 30 (and over 50) were also more likely to have been raped by their husband. The younger age associated with family violence has particular relevance for the armed forces. Turner and West (1981) report that in the military, more than 55% of active duty men are 30 years old or younger, while only 25.1% of the civilian male population fall in this age group. And, because age is related to military rank, one might assume that rates of spouse abuse will be highest among those officer and enlisted populations with the highest proportion of personnel younger than 30.

Duration of Relationship

Although violence occurs throughout the marriage cycle, it may be somewhat more concentrated in newer marriages. In an examination of 150 cases of battered women, Roy (1977) finds the highest percentage of women who were battered among those who have been in relationships with their batterers from 2.5 to 5 years. Fagan et al. (in press) reports that the median length of the relationship is slightly less than 5 years. Gayford's survey of battered wives who sought help (1975) reports that in 25% of cases violence started before marriage and in the remainder it started soon after. These findings suggest that violence begins early in relationships, and that women may be more likely to seek help for violence early in the relationship.

Socioeconomic Status

Research on family violence in the seventies supported the hypothesis that spousal violence is more prevalent in low socioeconomic status families (Gelles, 1974; Levinger, 1966; Gayford, 1975; Straus et al., 1980). These findings do not mean that spousal violence is confined to lower class households; in part it reflects the fact that violence may come to the attention of the police more readily in such places. The lower the income, the less the chance that violence can be hidden by such features as the widely-spaced houses and larger lots owned by more affluent families. The contrast in living spaces between enlisted and officer housing on some military installations is an example. Spouse abuse is found in families across the spectrum of socioeconomic status (Steinmetz, 1982), but there is more at lower levels.

Blue collar/White collar. The most common social class categorization is blue collar/white collar (i.e., manual versus non-manual workers). Using this broad division as a mean of comparing working class with middle class families, research finds that blue collar status is associated with a

higher rate of family violence for both males and females (Steinmetz, 1977; Straus et al., 1980) and for the violence of males toward females (Peterson, 1980). Straus et al. (1980) report that the blue collar rate of spousal violence is twice that of the white collar rate. Gelles (1974) in a sample of families who sought help for spousal violence finds blue collar husbands to be involved in more frequent violence against their wives, which may indicate that rates of violence may vary by military rank.

Income. An inverse relation exists between income and conjugal violence: the lower the income, the higher the violence rate. Gelles (1974) found the highest incidence as well as the greatest frequency of spousal violence at the low end of total family income. Violence is most frequent in the $3,000 to $4,999 group, and least frequent in families with incomes over $15,000. Peterson's random telephone survey of women in Maryland (1980) found low family income significantly related to violence by husbands toward wives. Straus et al. (1980) finds that the rate of violence between husbands and wives living at or below the poverty line ($6,000) is almost five times greater than families whose income is over $20,000. Also, women with incomes under $10,000 were more likely to have experienced forced sex.

Although all active duty military members earn a guaranteed income during their period of military service, this security is no guarantee against financial stress. According to Turner and West (1981), many servicemen earn wages that place them near the poverty line. Financial stress for military members is especially likely in high cost of living areas of the United States and overseas.

Education. In general, researchers have found that the more formal education a husband or wife has, the less violence in the family, with the exception that the least violent men are grammar school dropouts. Again, according to Turner and West (1981), 1979 Defense Department statistics show that more than half of the service members had completed only high school, and those figures are increasing. In 1980, 73% of new recruits had only a high school education.

Employment. Being unemployed is often perceived by males as demonstrating their incompetence in fulfilling their provider roles. In studies of battered women who have sought help, Rounsaville (1978) and Gayford (1975) found male unemployment in 32% and 29% of their representative samples. Prescott and Setko (1977) studied battered women who responded to a request for information in MS. magazine and reported that husbands who were unemployed or employed part time were extremely violent compared with husbands who were employed full time. The national survey by Straus et al. (1980) revealed that households where husbands were unemployed or employed only part time had the highest rate of violence between spouses, and that unemployed men are twice as likely as full time employed men to use violence on their wives. Also, unemployed men and men employed part time are three times more likely to have violence used against them by their wives. Because unemployment is not a factor associated with active duty Navy members, this might tend to lower incidence as compared with the civilian sector.

Race. Straus et al. (1980) report that wife abuse is highest among blacks--nearly four times greater than in white families. Similarly, husband abuse is twice as common in black families as compared to white families. However, in an earlier analysis, Cazenave and Straus (1979) found that blacks are less likely than whites to have engaged in spousal violence when income is the same for both groups--except in the $6,000 to $11,999 range. Blacks and whites show no significant differences in rates of marital rape.

Urban/Rural Differences

Again, the national study of family violence by Straus et al. (1980) was able to examine urban/rural differences because of the scope of the sample. Families in large cities (population greater than one million) have higher rates of violence between husbands and wives. Wife abuse, however, is as common in rural areas as in large cities. Also, the rate of wife abuse in the suburbs is half the rate of wife abuse in cities with population lower than a million.

Individual Variables

Childhood Experiences

One of the consistent conclusions of family violence research is that individuals who have experienced violent and abusive childhoods are more likely to grow up and become child and spouse abusers than individuals who experienced little or no violence in their childhood years (Byrd, 1979; Gayford, 1975; Gelles, 1974; Owens and Straus, 1975; Steimetz, 1977; Straus, 1979). Steinmetz reports that even less severe forms of violence are passed on from generation to generation. Straus et al. (1980) not only find support for the hypothesis that "violence begets violence," they also provide data that demonstrates the greater the frequency of violence, the greater the chance the victim will grow up to be a violent partner or parent.

- Gayford (1975), in a study of battered wives, discovered that both the batterer and victim had a violence-ridden childhood.
- Roy (1977), in a sample of 150 battered women, reported violence in the families of origin of 81% of abusive husbands and 33% of abused wives.
- Fagan (1983), in studying batterers, reported a high level of violence by members of the childhood families of both the battered and batters.

Personality Characteristics

Batterers. The following are characteristics of batters most commonly cited:

- A vulnerable self-concept or low self esteem (Ball, 1977; Saunders, 1982);
- A sense of helplessness, powerlessness, or inadequacy (Ball, 1977; Weitzman and Dreen, 1982); and
- Dependency, fears of abandonment, and conflicts over being dependent (Makman, 1978; Saunders, 1982).

Abused women. The literature on personality characteristics of abused women is difficult to interpret. It is never clear whether factors cited are the cause or effect of victimization. Another difficulty is that many of the studies are based on case reports and clinical observations of only a few cases. Characteristics noted are that the victim is dependent, has low self-esteem, and has feelings of inadequacy and helplessness (Ball, 1977; Shainess, 1979; Walker, in press). Feldman (1980) describes her as being overly emotional, aggressive, concrete in her mode of thinking, with weakened ties to reality when under stress. Contoni (1981) perceived role reversal, inappropriate sexual expression, lack of trust, conflict over dependency, expectation of perfection, and either lack of or excess of self-control. While some view battered women as unassertive, shy, and reserved (Weitzman and Dreen, 1981), others view her as aggressive, masculine, frigid, and masochistic (Snell et al., 1964; Ball, 1977).

Some studies have compared the psychological characteristics of help-seeking battered women with matched samples of nonbattered women. Graff (1979) found abused and nonabused women to be generally alike. The abused women, however, were more social, dominant, sympathetic, and skeptical than nonabused women, as well as more hostile. Hartik (1979) administered the Tennessee Self-Concept Scale and the Sixteen Personality Factor Questionnaire to 30 abused and 30 non-abused married women. Abused women showed less ego strength, lower self-esteem, more problems with basic identity, and were less satisfied with themselves than nonabused women. Hofeller (1980) matched 50 abused and 50 nonabused women on educational level and administered personality measures to them. She found that abused women were lower in self-esteem, but did not differ from nonabused women in any other traits. Coleman et al. (1980) administered the Bem Sex Role Inventory to 30 abused and 30 nonabused women seeking help from a psychiatric clinic. No matching was performed. The women did not differ when categorized by gender type (androgynous, masculine, feminine, undifferentiated); but when considering the masculinity and femininity scores separately, the abused women had significantly higher mean scores on femininity.

Both Partners. There have also been psychological studies of the marital relationship. Star et al. (1979), for example, describes the inability to relate to one another, emotional restriction, low tolerance

for stress, and poor parenting skills as volatile catalysts for family violence. Other research has cited:

- Mutual conflict over spouse dependency (Scott, 1974);
- Unrealistic marriage expectations (Rounsaville, 1978);
- Inability to communicate (Steinmetz, 1977); and
- Sexual jealousy (Steinmetz, 1977).

Alcohol

Studies of the relationship between alcohol and violence typically find alcohol abuse occurring between 36 and 52% of the time in men who batter (Brekke and Saunders, 1982). Almost all other studies found alcohol to be closely linked to wife abuse (Gelles, 1974; Gayford, 1975; Roy, 1977; Prescott and Setko, 1977; Coleman and Straus, in press). In a study of 139 persons appearing in family court during 3 months of 1974, 52% reported physical assaults on the wife, 10% reported assaults on the children, and 46% reported a problem with alcohol.

It is difficult in this research to ascertain the actual sequence of events in alcohol use and violence. Do men drink, lose control, and then beat their wives? Or do men wish to vent their anger on their partners and then drink in order to provide a excuse for their violence? Gelles (1974) and data presented by Coleman and Straus (in press) suggest that men get drunk in order to have an excuse to be violent toward their wives.

Mental Health

Studies of the relationship between mental illness and family violence suggest that mental illness is a causal factor in only a small proportion of cases. For women, the data are particularly ambiguous because, as noted earlier, it is not clear whether their psychiatric symptoms are a cause or an effect of violence between husbands and wives. Sixty interviews (38 female, 22 male) with in-patients at a pyschiatric hospital revealed that almost half had a history of battering within an intimate relationship. (Past et al, 1980). Thirty females revealed that they had been battered, while a fifth of the patients reported that they had battered their partners. Hilberman and Munson (1977), in their study of 60 battered women, found that almost the entire sample had sought medical help for stress related complaints and had symptoms commonly associated with rape-trauma syndrome. Furthermore, more than half of the 60 women had evidence of prior psychological dysfunction, including depressive illness, schizophrenia, manic-depression, and severe character disorders.

Current literature suggests that symptoms of psychological impairment on the part of abused women is the result of violence, not the cause of it. Finkelhor (in press) argues that all forms of family violence occur in

the context of psychological abuse and exploitation, a process victims describe as "brainwashing." Walker (in press) sees the learned helplessness displayed by battered women as due to the socialization process and reinforced in women by the threat and/or actual use of violence by their partners.

Relational Variables

Status Differences

Status inconsistency (a husband whose educational background is greater than his occupational attainment) and status incompatibility (husband and wife with unequal status) are factors that can be used to predict marital violence (Horning, McCullough and Sugimoto, (1981). Other researchers agree:

- Steinmetz (1982) argues that a woman's high status occupation relative to her husband's is particularly likely to result in severe violence.
- Rounsaville (1978) found that 42% of the wife abuse victims in the sample were more highly educated than their husbands; 36% had a higher job level.

Power Distribution in the Family

Violence toward wives is much more common in homes where the power of decisionmaking is concentrated in the hands of the husband. The least amount of violence toward wives occurs in democratic households. Husbands in democratic homes are the least likely to be attacked (Straus et al., 1980).

Beliefs about the distribution of power in families are an important consideration in understanding the use of violence. In families where husbands lack resources such as money, occupational status, or valued personal traits, but feel entitled to a position of dominance, violence is more likely to be used.

The issue of "belief in male dominance" was the focus of a broad analysis comparing the 50 states. Yllo and Straus (1981) found that the greater the belief in patriarchal norms, the higher the rate of wife beating. In most of the states, as the status of women improves, violence decreases. However, in 20% of states where women have the highest status, the rate of wife beating went up. Yllo and Straus interpret this as reflecting increased marital conflict growing out of the rapid change in sex roles, and resistance by husbands to changes in the balance of power between the sexes.

Violent Family Environment

Spouse abuse tends to be associated with violence in other spheres of family life:

- Straus et al. (1980) report that in families where the husband had hit his wife, the incidence of child abuse was 129% greater.

- Hilberman and Munson (1977) report that in one-third of the families of battered women in their study, physical and/or sexual abuse of children was identified.

Finkelhor's (in press) review of family violence and abuse research concludes that the presence of one form of abuse may be a good predictor of the presence of other forms of abuse in the family. Forms of behavior, such as verbal aggression or family conflict, also co-occur with violence. Straus (1974) presents evidence to show that as more husbands and wives are verbally aggressive to one another, the rate of violence between them increases.

Family Characteristics

A number of researchers have noted that some of the features of family life not only may contribute to warmth and intimacy but also may make the family system prone to violence. Some of these features include:

- Range of Activities: In practical terms, this means that families interact in a multitude of ways, and more "events" take place over which a dispute or failure to meet each other's expectations can occur.

- Intensity of Involvement: The degree of injury felt when a person is "let down" by other family members may far exceed the disappointment of being let down by an outsider.

- Infringing Activities: Conflict may arise over issues such as whether to play Bach or Linda Ronstadt, go to a movie or bowling, and how to line up for the bathroom. Simple differences in tastes must constantly be renegotiated.

- Right to Influence: Membership in a family carries with it an implicit right to influence the behavior of other members which may result in conflict.

- Family Privacy: In our society, the nuclear family may frequently be insulated from both the social controls and the social assistance provided by extended kinship systems.

- High Stress: The nuclear family continually undergoes major changes--birth, maturation, aging, retirement, moving, and illness.

These changes, combined with the huge emotional investment typical of family relationships, make the family a likely focus of serious stress.

- Intimate Knowledge: Spouses usually have an in-depth knowledge of each other's strengths and vulnerabilities, abilities and shortcomings. This can be used to support the other but also to damage and launch highly "efficient" verbal assaults.

Situational Factors

Family Stressors

A recurrent finding in domestic violence research is that spouse abuse rates are directly related to the amount of social stress experienced by families (Straus et al., 1980; Gelles, 1980). Investigators have reported associations between spouse abuse and particular stressors:

- Unemployment and part-time employment of males,
- Financial problems,
- Low job satisfaction,
- Large family size, and
- Poor housing.

Perhaps the most extensive study of family stressors and spousal violence has been conducted by Straus (1980). Using data from the national study of 2,143 families, he examined the impact of 18 family stressors on rates of husband-to-wife violence and wife-to-husband violence during the survey year. Stressors included troubles with boss, sexual difficulties, in-law troubles, job loss, and health problems. Straus found that respondents who experienced none of the 18 stressors had the lowest rate of spousal assault. The assault rate increased as the number of stressors experienced during the year increased. This applied to assaults by wives as well as by husbands.

Although numerous hypotheses have been advanced about stress factors in the military, a thorough study of what constitutes stress in terms of rank or rate has yet to be done.

Social Isolation

Gelles (1980) considers isolation to be a major risk factor in both child abuse and spouse abuse. Social isolation may be particularly important for understanding spousal violence in military families. Turner and West (1981) cite the frequent number of moves, the isolation from

friends and family, and the social dislocation that occurs when military families move overseas.

E. EXPLANATIONS

Psychiatric Model

The psychiatric model focuses on the offender's personality characteristics as the chief determinants of violence and abuse. The model includes explanations that link mental illness, alcohol and drug use, and other characteristics of individuals to acts of spouse abuse. The psychiatric model is not generally thought of as a powerful means of explaining spouse abuse: less than 10% of the instances of spouse abuse can be traced to a psychiatric factor. Even though alcohol use is often related to abuse and violence, researchers also conclude that alcohol use and misuse is usually a symptom of personal or family problems and not a cause of violent or abusive behavior.

Learning Theory

One of the consistent conclusions of research on spouse abuse is that individuals who have experienced violent and abusive childhoods are more likely to grow up and become spouse abusers than are individuals who have experienced little or no violence in their childhood years (Straus, 1979; Steinmetz, 1977; Gayford, 1975; Gelles, 1974; Byrd, 1979). Steinmetz (1977) reports that even less severe forms of violence are passed on from generation to generation.

There are a number of elements of learning theory. First, individuals can learn violence from violent models (Bandura, 1973). A second component is exposure to, and the learning of, norms and rules that approve of violence (Owens and Straus, 1975). Finally, there is the role model approach which proposes that violence is learned by viewing violence in an appropriate role model (Singer, 1971).

A learning theory explanation implies that the family is a "training ground for violence." The family provides examples for imitation and role models that can be adopted in later life as individuals draw from their childhood experiences to develop appropriate marital or parental roles. The family also provides rewards and punishments for appropriate and inappropriate behavior.

Social Stress

Another consistent finding in the spouse abuse research literature is that spouse abuse is directly related to social stress in families (Straus et al., 1980). Unemployment, part-time employment, financial problems, pregnancies, and other stressors increase the chances of violence.

A stress explanation of spouse abuse focuses on the uneven distribution of stress in families. Certain families because of their social status, not only encounter greater stressors, but have fewer resources to cope with those stressors. Frequently a culturally approved means of coping with stress and frustration is to use violence. In summary, a stress explanation explains abuse as resulting from differential distribution of stress and the differential learning experiences that provide norms and values that legitimize the use of violence, both as a means of self expression and as a means of solving problems.

Resource Theory

Another explanation of spouse abuse that is supported by available evidence is resource theory (Goode, 1971). This theory assumes that all social systems rest to some degree on force or the threat of force. The more resources--social, personal, and economic--which a person can command, the more force he can muster. However, the more resources the person actually has, the less he will actually use force in an open manner. Violence is used as a resource only when other resources are insufficient. Thus, a husband who wants to be the dominant person in the family but has little education, has a job which is low in prestige and income, and lacks interpersonal skills may choose to use violence to maintain a dominant position. In addition, family members may use violence to redress a grievance with a spouse when they have few alternative resources available. O'Brien found (1971) that husbands whose education and or income are lower than their wives are more likely to use violence towards their wives.

F. PREVENTION AND INTERVENTION

Unlike the issues of child abuse and neglect, spouse abuse prevention and intervention have no government mandated responses: there are no statutory reporting requirements or any equivalent of child protective services for battered adults.

Recognition of spouse abuse both as a widespread social problem and as a public issue was sparked by activities of community-based women's groups in this country and England. The programs generated during the past decade have focused on the victim rather than on the offender. They have centered on the development of emergency and short-term shelters for victims and their children, counseling, and other support services. Although responding to victims of ongoing violence has received funding priority, prevention services including public awareness and education programs are considered essential.

Shelters and counseling services that began as "grass roots" programs had a minimal amount of professional help and relied on private funding or local support. As demands for services quickly exceeded available resources, it became evident these community-based programs needed to

establish a relationship with the existing social service, health, mental health, criminal justice, and law enforcement institutions. Federal agencies, such as the Law Enforcement Assistance Administration, began funding model programs in the early 1970s.

The focus on victims and their children expanded to include working with perpetrators as an alternative to prosecution or incarceration. Certain populations, such as military families, were identified as having special needs for service.

Spouse abuse programs in the military still are in the formative stage. In general, they are based on the same problem interpretation underlying many established civilian programs. However, implementation requires adapting civilian programs to address the needs of military families and the military mission.

Program Components

While a range of program models exist for spouse abuse intervention and treatment, certain program elements are necessary for program effectiveness. Elements examined here include program goals, organization, staffing, client sensitivity, client identification, service coordination, program evaluation, and community education.

Goals and Philosophy

Effective programs and intervention strategies are based on a clear understanding of the dynamics of battering and the social, cultural, and interpersonal factors that contribute to the problem. Regardless of the model used for delivering services, most programs share certain common assumptions (King, 1981):

- The primary goal is to ensure the safety of the victim(s) and to stop the battering or violence.
- Violent acts between adults engaged in an intimate relationship are crimes in the same sense that violent acts between strangers are crimes.
- Spouse abuse falls under the jurisdiction of the criminal justice system and requires a response from law enforcement, human service, and community agencies.
- Battering is viewed primarily as a social problem and as learned behavior rather than as a mental illness.
- Regardless of the problems and stresses that may be present in the relationship, they can and should be solved by means other than physical force or violence.

Organizational Structure

Organizational structure and management are essential variables in effective service delivery. Most grass root programs tend to be non-hierarchical rather than bureaucratic. Despite differences in program models, stability, continuity, and perpetuation of programs depends largely on such factors as:

- The use of community groups, task forces, advisory boards, and volunteers to help establish and support programs. For example, at Ft. Campbell, Kentucky, military wives generated support and supplied furniture for a battered women's shelter.

- Formal policies and procedures and clear delegation of responsibilities and roles for all levels of programming, as at White Sands Missile Range, New Mexico, where a Commander's Guide and Standard Operating Procedure codifies the entire spouse abuse program.

- A secure funding base and/or the institutionalization of services. For example, a state tax on filing for divorce in Minnesota, Illinois, and Indiana yields revenue that helps fund doemstic violence programs.

Staffing Patterns and Support

Program staffing patterns vary by numbers, disciplines represented, gender, roles, and functions depending on service objectives, program size, setting, and funding. Professionals, former victims, para professionals, and volunteers provide services and represent various fields: social services, health, mental health, legal services, and the ministry. Staff members often have several roles within a program, work full or part time, on shifts or as a member of a team.

Shelters and advocacy groups have a strong preference for using female staff, although children's programs may use male staff for role models. There also is an emphasis on using minority women and formerly battered women as service providers.

In response to the multitude of demands placed on staff members, some strategies have been developed to provide support and help alleviate stress:

- Regular staff meetings;

- Rotation of staff duties and use of staff in multifunctional roles;

- Malpractice insurance policies for professionals;

- Education about spouse abuse, the dynamics of battering, and special techniques for intervention;

- Supervision and in-service training, including peer group support and encouragement to attend workshops on spouse abuse. (At Andrews Air Force Base, Maryland, a workshop delivered to unit commanders is available at the library on videotape.)

Sensitivity to Diverse Clientele

Victims and offenders represent all socieoeconomic, religious, and educational backgrounds. Some characteristics may necessitate special services. These include:

- Multicultural background and language barriers,
- Presence of child abuse and neglect,
- Alcohol or drug abuse,
- Developmental or physical disabilities,
- Clients living in rural or isolated locations,
- Homosexuality, and
- Military background (Health and Human Services, 1980).

The stresses experienced by military wives include separations from their husbands due to deployment, isolation, repeated family moves, cross cultural marriages, financial pressures, and the changing role of women. Spouse abuse interventions may need to address any or all of these stresses. Informal reporting from practitioners in programs in the field indicates that a significant number of Vietnam veterans experiencing difficulties in readjusting to civilian life also abuse their spouses (Center for Women Policy Studies, 1981).

Asian-born wives may have extreme difficulties in locating help in battering situations; the Commission on the Status of Women in Virginia works with the Vietnam Women's Association and the Cambodian Women's Program to recruit refugee women as volunteers for local shelters. California has a center for the Pacific-Asian Family, which helps abused women.

Direct and Referral Services

Because spouse abuse may come to the attention of a number of human service agencies or to law enforcement and criminal justice officials, clients enter the system at various points. Regardless of point of entry, the primary goal of service is to ensure the client's safety.

Victims and their children may need one, some, or all of the following types of assistance. Offenders may have similar needs.

- Immediate help;
- Protection and physical safety, away from the home if necessary;
- Basic material needs such as medical and dental care, emergency financial aid, housing, food, clothing, and child care;
- Emotional and psychological support, including individual, couple, family, child abuse, and substance abuse counseling, or peer group support;
- Resources such as legal aid, job training, employment, long-term housing, independent living skills, parent education, and family planning;
- Crisis intervention and the availability of 24-hour services, which is most often provided by police intervention, crisis-lines, or emergency shelters and focuses on the immediate trauma;
- Emergency room treatment of victims which focuses on accurate identification, diagnosis treatment/referral, and gathering of evidence, including photographs of injuries, (National Clearing House on Domestic Violence, 1980); and
- Offender services, which are sometimes sought voluntarily or mandated through the criminal justice system. Individual and group counseling focus on stopping the violent behavior and learning non-violent behavior for coping with stress. Liaison with the criminal justice system is essential (Ganley, 1981).

Identification and Assessment

Accurate identification is essential to appropriate intervention. Careful screening, use of special protocols, and training practitioners to directly inquire about abuse are necessary to overcome victim and offender denial or reluctance to acknowledge abuse and to avoid misdiagnosis based on presenting symptoms (King, 1981). At Malcomb Grove Air Force Base, for example, emergency room nurses are trained to look for injuries inconsistent with explanations and ask specifically whether there has been battering.

Basic intake functions are necessary to provide information, make referrals, and accept clients for service. The extent of intake activities varies according to the program setting. Assessment of spouse abuse in all settings focuses on evaluating the level of danger and the clients' immediate needs, including referrals (King, 1981).

Additional Services

Some shelters have special programs for children in residence. For example, the Women's Support Shelter in Virginia has child services including counseling, limited day care, a well-child clinic, and a nutrition program. In cases of child abuse, children are referred to Child Protective Services. In addition, programs often include direct advocacy methods to help the victim assess her needs and act on her own behalf to use available services. Indirect advocacy focuses on changing procedures, laws, and regulations that affect service delivery.

Coordination and Liaison

A comprehensive service delivery system requires all program components to function in an integrated manner. Both internal and external coordinating mechanisms are necessary for referral and maintenance of liaison between staff, programs, and systems involved in case management.

The police are often called to the scene of domestic disturbances. Police need special training in spouse abuse crisis intervention to enhance victim safety, prevent injuries to police officers, and assist victims in getting needed services (Loving, 1980).

If charges are brought against the offender, court-mandated or diversion treatment is a possible alternative to prosecution or incarceration.

Both civil and criminal remedies including protection orders, filing charges against the offender, and legal separation and divorce are available. Special policies and services are being developed in some communities to overcome underenforcement of criminal law in cases of non-stranger violence (Lerman, 1981). At Ft. Campbell, Kentucky, military police are dispatched to the scene and the batterer's commander is notified of the incident.

Follow Up and Program Evaluation

Follow up of victims and offenders should occur as intervention and prevention services are rendered. However, because of client reluctance to maintain contact and heavy staff demands, follow up activities usually play a secondary role in most programs. To lay the groundwork for follow up, information on the range of services available can be presented to victims and abusers in the initial contact session. This information can be very helpful should the client choose to delay using services.

When services are provided to victims and offenders and service termination is appropriate, follow up assistance can encourage them to return for future help, if needed. Some service centers, such as the

Family Crisis Center in Maine, arrange for former residents of the shelter to make home visits to victims who have used services.

Program accountability depends on monitoring program functioning and impact. Program evaluation and gathering statistics is usually essential in obtaining funding. There generally is a lack of formal and systemmatic program evaluation in spouse abuse programs, although some shelters and victim services seek informal input from staff as well as clients.

Community Education

Prevention includes such disparate activities as identifying the problem of spouse abuse and eliminathng the social and cultural attitudes and values that contribute to the problem. It focuses on institutional change and the establishment of additional resources. Activities include:

- Dissemination of information on available services,
- Media coverage,
- Speaking to professional, social, and civil groups,
- Contacting schools and parent groups and designing family life curricula.

In one state, Nebraska, a bill was passed in the legislature that calls for a domestic violence curriculum for grades K-12, a community awareness program state-wide, and training programs.

A Civilian Model Program

Citizens Assisting and Sheltering the Abused (CASA) which illustrates many of the components already discussed, was cited by the Women's Bureau of the U.S. Department of Labor as "one successful method of project development" (U.S. Department of Labor, 1981).

The program includes:

- Emergency and temporary shelter for victims and their children through arrangement with hotels and motels;
- Provision of clothing and food when necessary;
- Job training;
- Counseling for both spouses--although persuading the abusing spouse to come "is rarely successful" (p. 12);
- Assertiveness training;

- Support network;
- 24-hour hot line;
- Work experience programs;
- Public information programs;
- Development of accurate statistics;
- Cooperation with law enforcement agencies;
- Support of legislation designed to aid battered persons;
- Fund raising; and
- Monitoring and evaluation.

This particular program serves a county of 112,000; its caseload varies between 90 to 100 clients per month; the staff consists of nine full-time employees, with a Board of Directors made up of 15 community leaders. The 1980 budget of $150,000 (which includes services to displaced homemakers) came primarily from the Comprehensive Education and Training Act (CETA) of the Department of Labor, with one third of the funding stemming from other sources, including private individuals and United Way.

Even this brief account of one program illustrates how comprehensive a model program can be. Although the emphasis on job training is at least partly a reflection of the priorities of the funding source, it is reflected in many other shelter organizations that share the goal of CASA "to identify and implement services that will enable the abused person who so desires to become self-sufficient financially and emotionally" (U.S. Department of Labor, 1981, p. 19).

At the present time, the BUMED Instruction responds to only one element, that of "shelter care," references to which are ambiguously mixed with references to "foster care," presumably appropriate only for children. Hospitalization is recommended in overseas situations if necessary.

The Instruction, as well as the DoD Directive, emphasizes utilization of civilian resources, but fails to recommend what linkages might be established between a shelter and the military community in terms of case management. Nor is the military responsibility for spouse abuse cases in the absence of civilian resources delineated. The Director of CASA, in a recent phone conversation, reports that they have lost all of their CETA funds since October of last year, and have had to curtail their services. Because part of their clientele is drawn from a nearby military installation, the impact of the loss of such funds directly affects the military community.

Issues in Service Delivery

The impact of chronic funding problems, and the need for institutionalization of services, may conflict with maintaining a defined program identity. Combining spouse abuse with child abuse and neglect programs is a major example of the potential blurring of program focus and victim needs.

Debate over which clients are best served by limited resources and who should provide them polarizes the needs of victims and offenders. This controversy extends beyond gender issues to philosophic considerations about the efficacy of the criminal justice system offering treatment as a alternative to prosecution or incarceration.

Reporting, confidentiality, and jurisdictional issues are also pivotal points in the interplay of the human service and criminal justice systems, as well as within the Navy system. Protection of the rights of the victim and the offender, maintenance of professional codes of ethics in providing service, and support of client choice are dilemmas in policy formulation and implementation.

Resolution of these and other problems are hampered by the lack of formal or systematic program evaluation, understaffing, changes in program leadership, and lack of program visibility.

In addition to having to face these issues, the military community and chain of command need to address the stresses inherent in the lives of military families. Some specific concerns of the directive have been raised. Some of the potential problems identified include (West, Turner and Dunwoody, 1981):

- Maintenance of program focus on battered women;
- Use of a medical model in providing services;
- Framing the DoD Directive's goal as restoring family functioning, which may limit responses to the needs of individual family members;
- Specialized training for all personnel handling spouse abuse cases;
- The need for specific programs for offenders other than, or in conjunction with, disciplinary action; and
- The absence of confidentiality in the doctor-patient relationship.

The Navy structure, with its high degree of organization and clear lines of authority, is a potential strength in the implementation and management of service delivery. The many support systems the Navy provides for its families have the potential for helping to reduce family stress and reduce or prevent spouse abuse. These support systems include:

- Guaranteed income, in spite of illness or other crisis;
- Comprehensive medical care for all military members and their families;
- Legal services and consultation;
- Chaplains' services, including counseling and social activities;
- Child care facilities;
- Family service centers, which provide information and short term counseling for families; and
- Extensive recreational facilities, youth centers, service clubs, and young-married organizations (National Center for Child Abuse and Neglect, 1980).

The organizational structure of the Navy is also conducive to formal program evaluation and data analysis to determine program impact, as well as information on the nature and extent of the problem in the military within the United States and overseas.

Many of the barriers discussed point to future directions in programming for the Navy. Careful consideration of the anticipated problems cited and identified in the literature could help prevent the undermining of effective program development. In addition, suggestions to consider for future programming include:

- The establishment of programs at all bases supported by the commanding officer of that base;
- Assurance of command support at the base level through briefings on spouse abuse to the command and immediate staff, utilization of the command in establishing programs to ensure their continuance, and documentation of spouse abuse incidents on and off base;
- The establishment of an advisory coordinating board or committee composed of key personnel from both the military and civilian community;
- The establishment of full service programs, including 24-hour crisis intervention and emergency shelter;
- Spouse abuse programs located in nonmedical settings to avoid an overly medical perspective--placement should be near housing to facilitate outreach;
- Written guidelines for maintaining confidentiality between counselors and abuse victims and/or disclosure of limits of confidentiality;

- The establishment of programs for male service members who batter that focus on rehabilitation rather than punitive measures;
- The provision of training to all military personnel involved in handling spouse abuse cases, including military police and JAG officers, and community education on spouse abuse to all military members of all levels and their families;
- The development of protocols and a commander's guide detailing judicial and nonjudicial options available in dealing with spouse abuse cases;
- Inclusion of information on spouse abuse in the curriculums of military academies, officer training schools, PCO and PXO training, and other training activities; and
- More research on the incidence of spouse abuse and contributing factors in the military within the United States and overseas.

G. CHAPTER SUMMARY

The issue of spouse abuse and marital rape received public attention somewhat later in both the civilian and the military sectors than did child abuse. Although prevention and treatment programs for spouse abuse are being initiated, information on its trends and dynamics is still thin and inadequate, especially in the military services.

This chapter has reviewed what is known about the incidence and consequences of spouse abuse, as well as theories about why it occurs and in what circumstances it happens. It has pointed out program elements that are seen as necessary for effective response, as well as some of the important resources that the military in general, and the Navy in particular, have already developed. Some of the difficulties in responding to this problem have also been cited.

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Chapter III

Sexual Abuse and Rape

Chapter III
SEXUAL ABUSE AND RAPE

The military communities are similar to civilian communities in a number of respects, one of which is the problem of rape, a crime which is not limited by geographic, political, or social boundaries. It is a crime of vital interest to the military for two primary reasons. First, it directly affects women in the military. There are over 150,000 women in combined military services; they comprise 7.4% of the armed forces. In the Navy and Marine Corps alone, women comprise 7.7% and 3.5% of the force, respectively (AFIS, 1982). This is more than 45,000 members for both forces combined. These women have an unquestioned right to personal safety, and rape is a violent, traumatic violation of that right. Second, rape can impair the ability of the Navy and the Marine Corps to perform their missions. Impairment can include actual physical and emotional injury, as well as lowered morale and poor performance due to a climate of fear. Sexual assault affects not only female personnel, but also members of the victims' families. Men can be affected by the sexual assault of their spouses or children. For the Navy, this means that more than 289,000 members (54% of active members) can be potentially affected by rape (Orthner & Nelson, 1980). For the Marine Corps, this number is more than 64,000 members (34% of active members) (AFIS, 1982).

The occurrence of sexual assault and rape also can have wider range implications than its direct affect on the victim and members of the victim's family. Sexual assault and rape also may affect the morale of friends and associates of the victim and the family and can threaten the safety and well-being of the military community.

Rape as a phenomenon is not well understood. Further, rape in the military has received even less study. Aspects of the military community that might contribute to the occurrence of rape or inhibit sexual assault have not been identified. This chapter uncovers factors that affect the occurrence of sexual assault in the civilian community and explores their relevance to the military, especially to the Navy and Marine Corps.

A. BACKGROUND

Research on Rape

Although it is safe to say that rape and other sexual assaults against women have gone on throughout history, practically all of the research on rape has been done within the past 10 years. The research has uncovered demographic, attitudinal, and psychological aspects of rape. Many of the longstanding beliefs and "truisms" surrounding the causes, incidence, and effects of rape have been exposed as being little more than myths and falsehoods.

The research has generally come from studying victims, who have come from rape crisis centers or police files, and offenders who were convicted of rape. In both cases, these groups are probably not representative of the larger group of victims or rapists in the general population. A large percentage of rape victims choose not to report the assault to either police or medical facilities for fear of reprisals, stigmatization, or the trauma of reporting the details of the assault. Convicted rapists represent a small percentage of actual rapists. Many rapists may not be apprehended, or, if they are, may not be convicted of rape due to plea bargaining or because they are released for lack of evidence.

There are gaps in the research on rape. More information is needed on the demographic characteristics of rapists (e.g., age, marital status, social class, religion). Evidence is needed on the relationship between specific occupations (e.g, occupations that involve violence or the threat of it, such as police work or the military) and the likelihood of committing rape. Research is needed on the sex role commitment (e.g., compulsive masculinity) of rapists, as is information on psychological correlates of rapists (e.g., self-esteem, authoritarianism, aggressiveness). No research has been done on how stressors (work, children, divorce) affect rape tendencies, nor has anyone examined whether the disruption of community and family ties, common to the military, is related to rape.

The research on effects of rape on the psychological and emotional well-being of the victim, along with the best methods for treating these problems, is not substantial. There have been few follow-up studies of rape victims to determine how rape affects the sexual and social relationship of the rape victim and her family (King & Webb, 1981). Even on issues that have been studied, the applicability of the findings to the Navy and Marines is unknown and must be inferred.

Definition of Rape

The concept of rape as either a crime of sex or a crime of violence has been debated for several years. According to the sex crime view, the rapist has extremely volatile and highly explosive sexual desires. When not viewed as sexually deviant, those accused of sexual assault may be defended by emphasizing that the alleged rape victims acted or dressed improperly, thus inviting sexual violation. This results in victims being made responsible for their own assaults. Those who argue that rape is mainly a crime of violence claim that rape is an assault that is motivated primarily by a desire to hurt, demean, and degrade women (Brownmiller, 1975; Sanday, 1981).

Legal statutes have been biased in the direction of defining rape as a sexually motivated crime. This bias is shown by the fact that a rape conviction must be based on demonstrating that victims resisted their attacker. This emphasis on the responsibility of the victim has led to lack of cooperation among victims in reporting their assaults or pursuing cases legally.

In 1974, the State of Michigan enacted a major rape law reform that went into effect a year later. The new statute defines both males and females as victims or offenders, and enlarges the definition of sexual contact, and makes it unnecessary to prove that the victim resisted the offender. It also excludes information on the victim's sexual history as admissible evidence. The precedent set by Michigan has encouraged many states to relax and, in some cases, eliminate their corroboration requirements. Schram (1978) reports that between the years 1973 to 1976, rape statutes were reformed in 36 states. During the same four year period, 13 additional states proposed legislative reforms. Future reform measures are expected to further lessen the need for a separate sex crime statute and integrate rape into the assault code.

Regardless of the local statutes concerning rape, there are three basic elements that need to be present in order to charge forcible rape (LEAA, 1978a):

- Sexual penetration. To prove penetration, a timely medical examination is indicated. Even if no ejaculate is detected, a physician can testify that penetration occurred based on the condition of the victim, if she is examined shortly after the assault.

- Lack of victim consent. In cases in which victims and assailants are acquainted and in a few stranger-to-stranger cases, proving lack of consent is the most important issue. Evidence of violence, including injuries to victims or assailants, and evidence gathered at the scene of the crime can provide corroboration of lack of consent.

- Identification of the accused. Identifying the assailant is generally only an issue in stranger-to-stranger cases. That suspects are identified in so few stranger-to-stranger cases indicates that a number of methods must be used to identify the assailant.

Navy Definition

Rape and sexual assault are defined in the BUMED Instruction 6320.57, which created the Family Advocacy Program:

- Rape is defined as sexual intercourse by a man with a woman who is below the statutory age of consent, or nonconsensual intercourse by a man with a women who is not his wife. The term also includes so-called homosexual "rape," as well as "rape" of a woman who is the assailant's wife, if applicable State law so provides. Otherwise, those concepts are deemed to be included within the term "sexual assault."

- Sexual Assault is a nonconsensual act of noncoital sexual contact.

- Harm can refer to a sexual offense, whether it is assaultive or nonassaultive, accomplished or attempted.

B. INCIDENCE

Chronological Incidence

The number of reported rapes has increased with alarming regularity. FBI statistics in the Uniform Crime Reports (FBI, 1981) show that in 1980 there were more than 36 reported rapes per 100,000 persons. Between 1933 and 1980, the rate of reported rapes increased 884%. This rate of increase is larger than for any other category of serious crime (Hindelang & Davis, 1977). At the same time, victimization studies have shown that rape is one of the most underreported crimes. Comparisons of the results from the Uniform Crime Reports and the National Crime Survey (LEAA, 1978b), a probability sample of 136,000 respondents who resided in more than 62,000 households, show that there were five to eight times more rapes reported between 1973 and 1977 in the National Crime Survey than in the Uniform Crime Report. If one were to estimate that only 20% of all rapes are reported, this means that in actuality 1 in 400 women is a victim of rape each year. If this figure is used for the Navy and Marine Corps, this means that over 100 female Navy personnel and 19 female Marines are sexually assaulted each year. For Navy families, this means that almost 600 families are involved with sexual assault per year, and for the Marine Corps the number is over 160 families per year.

Geographical Incidence

Reports of rape also vary regionally and across states. The Western States have the highest rate of reported rapes (49 per 100,000 people), followed by the Southern States (36 per 100,000), the North Central States (29 per 100,000), and the Northeastern States (26 per 100,000).

The states that have Navy and Marine installations vary with regard to rates of reported rape. For 1980, the Uniform Crime Report shows the District of Columbia (76 per 100,000), California (58 per 100,000), Florida (57 per 100,000), and Washington (53 per 100,000) as the first, fourth, fifth, and sixth ranked states, respectively, with regard to the occurrence of reported rape. Other states with a concentration of Navy or Marine installations have the following rank: Hawaii (35 per 100,000, 19th rank), Virginia (27 per 100,000, 30th rank), Illinois (27 per 100,000, 32nd rank), North Carolina (23 per 100,000 39th rank), and Connecticut (22 per 100,000, 41st rank).

Even within states, rape rates vary. In more densely populated areas, such as central cities, there is a higher rape rate. In 1980 there were 43 reported rapes per 100,000 persons in central cities with a population of more than 50,000. In suburban areas, the reported rapes for the same year

were half that of central cities, or 21 per 100,000 persons. Rural areas had the lowest rate, with 16 per 100,000 persons (U.S. Bureau of the Census, 1981).

C. CONSEQUENCES

Rape trauma syndrome has been identified as a consequence of rape. Victims were found to sustain both physical and emotional injuries from the assault (Burgess & Holmstrom, 1974, 1976). Victims reacted in one of two ways. One reaction took the form of emotional expression, whereby victims exhibited pain, fear, and humiliation by crying or sometimes laughing. Other victims reacted by inhibiting their feelings and showing little distress.

- Short-term Effects (Acute Phase): Often victims are in pain from bruises and lacerations. Some victims have problems sleeping (especially those attacked while in bed), vaginal pain, or stomach problems. Emotional reactions include fear, anger, shame, guilt, and mortification.

- Long-term Effects (Adjustment and Reorganization Phases). During these phases, victims develop strategies to cope with the personal disruption caused by the rape and seek ways to reintegrate themselves into everyday routines and activities. Sometimes victims' fear and anxiety are so extensive that they experience nightmares, sexual problems, or develop a number of phobias. Other victims become so frightened that they have their phone number changed or move to a new residence or town.

Other studies (Kilpatrick, Resick, & Veronen, 1981) found that many women who have been raped develop life-restricting fears, such as the fear of unfamiliar men, a reluctance to leave their home, a fear of darkness, and anxiety when left alone. Although the anxiety level, degree of fear, mood state, sense of disorientation, and pathological personality symptoms of the rape victim improved over a one year period, the results indicated that at the end of study the rape victims were significantly more anxious, frightened, emotionally unstable, confused, and distrusting than a matched nonvictimized group. The effect of rape differed depending on the stage in the life cycle of a rape victim (Burgess & Holmstrom, 1976). Some women found it difficult to continue with their jobs, while others were unable to take care of domestic chores.

Further, rape does not directly affect just the victims; it also affects their families and spouses. Ellis, Calhoun, and Atkenson (1980) found that between 10 and 20% of rape victims developed sexual dysfunctions subsequent to the rape. Rape has been shown to have a direct emotional and psychological effect on victims' husbands and lovers. Divorce rates are higher, and victims who are mothers may become overprotective of children, especially daughters.

The evidence clearly indicates that rape traumatizes victims and their families physically and psychologically. Victims of rape are likely to have work and domestic patterns disrupted and suffer from the real or imagined fear that they will again be attacked. It has been shown that the effects of sexual assault are long lasting. The daily activities and options of women are limited and the whole family is affected. The rape of military female personnel could lead to the erosion of job effectiveness, heightened levels of fear, suspicion, and anxiety, and a high dropout rate among recruits. Furthermore, these same effects could be expected to some degree among husbands and fathers of rape victims.

D. ASSOCIATED FACTORS

A number of factors, while not causative, are found to be associated with sexual assault. These include demographic, individual, situational, and relational factors.

Demographic Factors

Victims

Victims of rape are usually young and single. Over half the victims are 20 years of age or younger, and another quarter to one-third are under 25 years of age. However, women of all ages are at risk: 15% of reported rapes involved women over 30 years of age (LEAA, 1978a).

Although women of all races report rapes, minority women are more likely to be sexually assaulted, with both black and hispanic women over-represented when compared to their numbers in the general population.

Offenders

Most convicted offenders are estimated to be in their twenties, and on the average, four to five years older than their victims. In general, racial minorities are overrepresented in the offender population. In areas where the minority population is relatively small, the number of minority offenders identified by reporting victims is four to five times their number in the population as a whole. There is nothing particularly unusual about their physical characteristics.

Interracial Rape

For some time now, it has been a well established assumption in the field of criminology that rape is primarily an intraracial phenomenon. Amir's widely cited study of forcible rape in Philadelphia (1971) concluded that only 3.3% of all cases known to the police in 1958 and 1960 involved black defendants and white victims. Similarly, only 3.6% of the sample involved white offenders and black victims. Studies since the late 1960s show the rate of black offender/white victim (BW) rape has been increasing

(BW rapes were 3.3% of Amir's 1958-60 sample, 5.0% of Reiss' 1965-66 sample, and 19% of the 1977 NCS rapes). After 1967, the proportion of all rapes that were BW was never below 12.9% (LaFree, 1980). However, this interracial rate is still greatly overshadowed by the occurrence of intraracial rape.

In order to look at differences in the characteristics of interracial and intraracial rape, LaFree (1982) analyzed the National Crime Panel data. These analyses (and also Agopian, Chappell, & Geis, 1977) showed that BW rape was overwhelmingly a stranger-to-stranger crime.

Group Rape

Although rape is predominantly an attack of one-against-one, some evidence indicates that the rate for group rape is more frequent than is generally recognized. In studies cited by MacDonald (1971), 16% of the victims in a Denmark study, 18.5% in Denver, 43% in Philadelphia, and about 66% in Finland were raped by groups of two or more men. The potential for increased violence and danger to the victim in group rapes makes it an issue worthy of serious investigation.

The Philadelphia study conducted by Amir (1971) showed that multiple rapes were primarily intraclass, intraracial, and committed by men between 15-24 years of age. Group rape, Amir added, is generally an intra-neighborhood event that is more likely to be planned than other rapes and is likely to entail greater sexual humiliation and violence toward the victim.

Individual Factors

The Likelihood of Raping

Several investigators have claimed that belief in rape myths is related to the inclination to rape. Malamuth (1981) found that convicted rapists had a greater acceptance of rape myths and relatively high sexual arousal to depictions of rape. Comparing convicted rapists with a non-incarcerated group of men, those nonincarcerated men who indicated higher likelihood of rape were more similar to convicted rapists both in their beliefs in rape myths and in sexual arousal to rape depictions. In the laboratory, a higher likelihood of raping was associated with greater aggression against women.

Pornography and Rape

A closely related issue concerns the effect of pornography on the acceptance of rape myths and the proclivity to rape. In order to test the effect of violent pornography on viewer's behavior, several experiments have used rape depictions in which the victim ultimately becomes sexually aroused (Malamuth & Check, 1980a, 1980b, 1981; Malamuth, Heim, & Feshback, 1980; Malamuth, Haber, & Feshback, 1980). In each study it was found that the males who were exposed to rape depictions in which the victim

became sexually aroused, became more sexually aroused than those exposed to rape depictions in which the victim loathes the assault. Similarly, Donnerstein and Berkowitz (1981) found that previously angered males who had viewed a violent pornographic film delivered higher levels of shock to female targets than to male targets. They also found that regardless of whether male subjects had viewed positive or negative outcomes in violent pornographic films they increased the levels of violence toward the female target. Together these studies indicate that the exposure to violent pornography increases the likelihood of rape.

Situational Factors

Rape, as with other forms of antisocial behavior, is context dependent. That is to say, there are certain social circumstances in which rape is more likely to occur than others. Several situational correlates of rape are discussed below.

War

Historically, sexual assault has been a common feature of war (Brownmiller, 1975). Conquering soldiers have sexually assaulted women as part of the general looting and plundering. Rape has also been used as a method of military retaliation or reprisal. Evidence of rape accompanying war dates back to Greek and Roman times. During World War II, the Germans used mass rape as retaliation against the French resistance fighters. An American missionary in Nanking, China, estimated 1,000 cases of rape a day during the Japanese invasion of the Chinese capital.

Rape has also accompanied more recent wars. Estimates of the women raped in Bangladesh by Pakistani soldiers during the nine months of war range from 200,000 to 400,000. There were also many reports of systematic gang rapes of civilian women by the American soldiers in Vietnam. Nonetheless, the U.S. Army tried only 86 men for rape from January 1965 to January 1973. Rape, as an association with war, may be important in the model of normative behavior in some circumstances for the military. Further research needs to be done investigating role behavior within the Navy and Marine Corps and proclivity to rape.

Rape and Additional Crimes

Very litt'e research has been done on the relationship between rape and other crimes of violence. Amir (1971) found that 85% of the rapists in his sample used some form of physical force or the display of a weapon. Hindelang and Davis (1977) found that a third of the rape victims they studied reported that the rapist used a weapon. Other estimates on the use of weapons by rapists range from a fourth (LaFree, 1982) to over 60% (Queen's Bench, 1976). The 1977 National Crime Survey found that in cases when weapons were used, over a third of the time firearms were used, and knives were used almost half of the time. Other weapons, such as bottles, rocks, and cigarette lighters, were used 17% of the time. .Most victims

reported being overpowered and held; chokings and beatings were not uncommon. Some threat was used in 60% of reported cases. These threats were usually made against the life of the victim.

The Law Enforcement Assistance Agency (LEAA) study of forcible rape (1978a) reported that about half of all women who are raped report being victims of additional offenses, including other sex crimes. Almost a quarter of the victims were kidnapped or abducted. Theft is involved in 20% of rape reports. In the area of additional sex acts, about 30% of victims are forced to commit fellatio, and 10% reported cunnilingus and anal intercourse. A quarter of the victims report being forced to commit multiple acts of vaginal intercourse.

Alcohol

Few rapists are caught, and very few are caught immediately after the rape; this makes it almost impossible to determine the extent to which alcohol was a contributing factor in the assault. The studies that have been done are based on the self reports of convicted rapists. The Queen's Bench study (1976) found that the use of alcohol and drugs was high among rape offenders. They found that 62% of their sample had been drinking at the time of the offense, and 38% had used drugs of some sort. Amir (1967) found a high correlation between alcohol use and the degree of violence used against the victim. A study of 77 rapists at Atascadero State Hospital found that 50 percent had been drinking at the time of the offense (Rada, 1975).

Location

Taking precautions against rape does not always guarantee protection, even when the precautions entail remaining at home. Hindelang and Davis (1977), using National Crime Survey data from 13 cities found that 20% occurred in the victim's home, and 14% took place nearby in the yard, garage, or driveway. One half of the rapes in this sample occurred outside. LaFree's (1982) study of interracial rapes found 46% occurred in a private residence, and 54% occurred at a public location. In addition, in most rapes the assailant and the victim came from the same neighborhood (Amir, 1971). A study of rapes in the Air Force revealed that 17% of the victims and offenders met in military clubs and civilian taverns (Mace, 1982).

Amir and Nelson (1977) have examined rape within the context of hitchhiking. They note that hitchhiking is a popular form of travel for certain groups, particularly young men and military personnel. Amir and Nelson found that hitchhike rapes accounted for 20% of the reported rape complaints in Berkeley, California. Although this research is limited, it is possible that as more women enter the Navy or Marine Corps and rely on hitchhiking as a means of transportation, the hitchhike rape may become more prevalent.

Isolation

The victim's being alone seems to be an important factor. Hindelang and Davis (1977) found that in almost all completed or attempted rapes, the victim was alone at the time of the assault. Chappell and James (1977) found that 96% of the sample of 100 rape offenders said that they always checked to see if the potential victim was by herself.

Planning and Forethought

Rape is sometimes believed to be a spontaneous act, carried out in response to something the victim does or the way she is dressed. Research indicates that this notion is false. Amir (1971) found in almost three-quarters of the cases, the rape was planned in advance, although the selection of the victim was left to chance. The Queen's Bench study (1976) found that over half of the rapes committed by the inmates they studied were planned.

Victim Precipitation

The National Commission on the Causes and Prevention of Violence (Mulvihill et al., 1969) defined victim precipitation as occurring when the victim agreed to sexual relations, but retracted before the act, or when she clearly invited sexual advances by her mode of dress, speech, or behavior. In spite of this broad definition, there was less victim precipitation of rape than of other crimes. The Commission found that victim precipitation (the victim was the first to use physical force) was a factor in 22% of the homicides and 14% of the assaults. For robbery, victim precipitation (the victim did not use reasonable self-protection measures, e.g., flashed large sums of money about) was 12%. For rape, the victim precipitation rate was only 4%.

Relational Factors

It is a popular conception, supported by some empirical research, that most rape victims are attacked by men who are complete strangers to them. The Queen's Bench Foundation's (1976) study of incarcerated rapists found that the majority of rapes (78%) involve strangers; the National Task Force on the Causes and Prevention of Violence discovered that over half of victims and attackers are total strangers; and McDermott (1979), citing data from the National Crime Panel, indicated that three-quarters of rapes are perpetrated by strangers.

Although the evidence seems convincing, the reality of victim-offender relationships is obscured by a severe underreporting bias, common to both crime statistics and victim surveys. The reluctance of victims to disclose assaults by men known to them makes "rape among intimates" perhaps the most underreported category of crime (Finkelhor & Yllo, 1980). In fact, Gelles (1977) claims that ". . .women who are raped by boyfriends, dates, lovers, ex-lovers, husbands, relatives, and other men they know might represent the

tip of an iceberg which reveals a more extensive pattern relating intimacy with forced sexual relations" (p.339).

The prevalence of non-stranger rape was suggested by several early studies of rape victimization. Amir (1971) found that almost half the offenders were known to their victims (of whom 11 were boyfriends and 2 relatives). MacDonald (1971) found that four out of ten offenders were known (12% were friends and 10% were relatives, employers, and other non-strangers). In a study of rape among Air Force members, fewer than half the rape cases involved stranger-to-stranger contact. Thirty percent involved co-workers or casual acquaintance (Mace, 1982).

E. EXPLANATIONS

Research on the causes of rape has not been characterized by explicit attention to theory. However, investigations have been guided by implicit theories about sexual violence. Some of these explanations include the view of rape as assault, psychopathology, lack of control, response to frustration, or learned behavior.

Rape as Assault

Rape is seen as mainly an act of violence or assault, with sexual motivation playing a minor role (if any). It is seen as growing out of the social relationships between men and women. The research of the past decade has increasingly supported the view that rape is a form of assault.

Rape as Psychopathology

This view considers men who rape as suffering from some psychological abnormality. In this view, the rapist is typically portrayed as a sexual psychopath who is motivated by desire for sex, a desire which manifests itself through violence (Gagnon, 1977).

Rape as Lack of Control

Rape occurs when a man's inner controls are removed. It is assumed that rape results from a weak conscience or superego. Sexual and aggressive tendencies are seen as part of human nature, and rape is believed to follow the erosion of inhibitions. A common assumption is that the use of alcohol or drugs produces a disinhibiting effect.

Rape as a Response to Frustration

According to frustration-aggression theory, aggression is seen as a natural response to a frustrating situation. Rape, then, is one type of aggressive response to the frustration of sexual desire (Shorter, 1977).

Rape as Learned Behavior

Some psychologists argue that rape is a learned phenomenon. In order for rape to occur in society, individuals would have to be exposed to rape depictions or taught that rape is an acceptable form of behavior. Research has shown that certain types of pornography promote aggressive behavior (Donnerstein & Berkowitz, 1981).

F. PREVENTION AND INTERVENTION

Most of the recent attention on rape and sexual assault has been stimulated by citizen activist groups and women's organizations concerned with the status of women's rights. These organizations focused public awareness on the experience of violent victimization and the inadequate response of the human service, criminal justice, and law enforcement institutions.

Rape crisis centers were established, and gradually more traditional organizations undertook rape related projects. Training and education on rape was provided to police officers, prosecutors, and medical personnel to help improve their response. Efforts were directed to reform various laws, improve medical treatment, provide counseling, and revise police and prosecutor procedures in the investigation and prosecution of rape cases.

The military community has begun to look at the problem of rape, the current responses to it, and the need for new program development and implementation (e.g. Mace, 1982). Gains in the civilian sector can pave the way for Navy and Marine programs to assist victims and their families and to deal with offenders.

Goals and Philosophies

Political identification has been a central factor in determining goals for rape programs; programs with an orientation toward women's rights may have as an additional goal helping women to help themselves and each other. Establishment-oriented programs tend to be more willing to work closely with community agencies and usually have more access to political power. In addition, organizations with broader based service delivery goals usually have more financial and human resources (Bryant & Cirel, 1977). Programs have gained community support and recognition by working with and within established agencies to build understanding (Harvey, 1982) for example, the Alburquerque Rape Crisis Center, New Mexico, and the Stop Rape Crisis Center in East Baton Rouge Parish, Louisiana. The predominant objectives in program planning include:

- Providing supportive services in response to victim needs;
- Instituting institutional reform and supporting victim rights;

- Educating the public on rape related issues and available services; and
- Establishing system links through membership or affiliation with many diverse networks.

Program goals are influenced by:

- The level of community awareness of rape;
- Existing laws and agency procedures; and
- Financial resources.

Organizational Structure

There are two basic program models: freestanding programs and those housed within institutional settings or affiliated with agencies. Many have evolved from small groups with strong interpersonal ties to a more formal structure. An important characteristic of program structure is the clarity of goals as well as clarity of decision-making processes. Common elements in organizational structure include:

- A director and advisory board who share authority;
- Active participation by all organization members;
- Use of both professional and advocacy staff who have credentials and volunteers who are either professionals and/or advocates of women's rights;
- Debate and search for consensus; and
- A capacity for internal change.

Staffing Patterns and Support

Size, composition, and patterns of staffing vary with programs, program setting, and funding. General characteristics of staffing include (NILECJ, 1975):

- Strong leadership, often provided by directors or founders who see themselves as political activists;
- Female staff members;
- Attempts to include some minority women and bilingual staff members;

- Reliance on volunteers as both generalists and specialists; and
- Former victims as staff.

Staff need the ability to tolerate high stress and ambiguity. Salaries are usually limited. Training volunteers is a prerequisite for delivering services, and periodic group meetings with a supervisor are important. Training is directed towards increasing skills in assisting victims and in preparing counselors to cope with their own feelings.

Sensitivity to Diverse Clientele

Case characteristics differ according to program location, affiliation, and referral network. Victims tend to be younger than 25 years of age. Minorities are more likely to be victims and also less likely to report the rape (Feldman-Summers & Ashworth, 1981). The victim's relationship with the assailant and the victim's family relationships also may be an issue.

Programs may also serve a variety of victims in addition to rape cases. Client populations can include battered women, sexually assaulted children, incest victims, assailants, and members of the victim's family. One interesting program is MOAR (Men Organized Against Rape) in Pennsylvania. This program operates a hotline for male friends and relatives of rape victims. It also disseminates information and conducts training that enables male friends and relatives to help a rape victim.

Direct Services

Because many programs began as a support system, providing support is an underlying principle in delivering services (NILECJ, 1975). Direct services include:

- 24-hour hotline and in-person crisis services;
- Emergency room support services;
- Accompaniment and advocacy;
- Counseling and support groups;
- 24-hour shelter and crisis nurseries;
- Referral and information; and
- Transportation, child care, and other supportive services.

Some communities have effected anonymous or "third party" reporting for filing police reports. Voluntary, outpatient offender treatment programs for rapists are generally not available, except in cases of child sexual assault and incest.

Identification and Assessment

Depending on the type of intervention, procedures for identification and assessment vary. Special protocols for medical and police contacts have been developed. Rape crisis centers also have established guidelines and techniques for initial response to victims. Sensitivity to the victim's needs, careful and considerate questioning, and a generally supportive attitude are stressed.

Additional Services

Medical Services

The two basic reasons for medical treatment are:

- Treatment of injury, VD prophylaxis, and pregnancy testing; and
- Collection of evidence for possible prosecution of the rapist.

Rape victims most often go to public hospitals. Some hospitals have special programs for treating rape cases; many do not. Trained personnel are necessary to ensure adequate response to victims. Treating rape victims as an emergency is desirable due to the level of trauma. A separate room for waiting is also recommended.

Special protocols for medical facilities recommend procedures such as:

- A team approach with an initial support person (usually a nurse or social worker), emergency room nurse, mental health consultant, and a physician who is available for possible trial testimony;
- Explanation of tests and procedures to the victim, including consent forms and confidentiality and their effect on subsequent release of information;
- Use of sexual assault kits and other procedures that ensure protection of the chain of evidence;
- Follow up; and
- Coordination with police and prosecutors.

Counseling

Counseling focuses on:

- Reducing the victim's trauma during the immediate post-crisis period;
- Easing the victim's return to normal life; and

- Supporting the victim and her family through all criminal justice proceedings.

Short and long-term counseling for the victim can be useful to overcome the extreme psychological trauma. Including family members can be a significant part of the process. Support groups can facilitate victims' dealing with their feelings, fears, and sense of shame. Too few centers provide follow-up counseling.

Law Enforcement

Protocols and procedures for police investigation have been developed; however, implementation varies considerably.

There are three basic models for police intervention:

- The traditional model, in which patrol officers respond;
- The patrol specialist model, in which the officers have been specially trained; and
- The special unit model, in which investigations are conducted by sexual assault specialists.

Factors that contribute to effective police intervention include:

- Availability of female officers;
- Specialization in handling rape cases; and
- Training recruits and officers to increase their sensitivity to victims.

The investigation of rape cases involves interacting with a number of outside agencies, such as victim service agencies, medical facilities, and prosecutor offices. Coordination can be encouraged through interaction on specific cases, in formal training sessions, and in general discussion.

Criminal Justice

The percentage of prosecuted rape cases is low due to the necessity of having three elements present in order to press charges:

- Sexual penetration;
- Lack of victim consent and/or threat or use of force; and
- Identification of the assailant.

Suggested principles for management of rape cases by prosecutors include:

- Sensitivity, concern, and competence by office members;
- Entering the case early;
- Keeping the number of different prosecutors involved with victims to a minimum;
- Having support persons available to the victim and witnesses during the court process;
- Providing the victim with information on case status; and
- Streamlining investigation and trial procedures.

It has proven beneficial to establish separate units within prosecutor offices. Other effective interventions and procedures include the use of legal aids to coordinate and deliver information on case status to the victim and to provide other supportive services. Close coordination between prosecutors and the police increase effective responses to the victim and preserve her privacy and dignity.

Coordination and Liaison

The purpose of coordination is to maximize service delivery and obtain resources, establish support for services, and gain community acceptance.

Coordination can be achieved through various means, such as:

- Providing ongoing consultation to staff of other agencies to help them manage any changes that are introduced;
- Offering in-service training to other agencies and organizations;
- Establishing system links; and
- Establishing working relationships with the district attorney's office.

Follow Up and Program Evaluation

Follow up is important in assisting the victim. If medical follow up is provided, it is desirable to have the initial support person be responsible for handling arrangements and remain in contact with the victim through such methods as:

- Calling to remind the victim of appointments and encouraging her to come to appointments;

- Providing information on mental health consultation or other available services; and

- Providing referral services.

Program evaluation has many functions: recordkeeping, generating data for program design, assessing program activities, and documenting the problem in a given community. The latter can also be useful obtaining funding.

The purpose of program evaluation is to:

- Generate descriptive information concerning characteristics of victims, assailants, and incidents;

- Evaluate services provided in terms of client characteristics;

- Assess the impact of treatment; and

- Evaluate effectiveness of community outreach and educational activities.

Community Education

Education is a goal of service programs, women's rights organizations, and other more traditional women's organizations. Outreach efforts include activities such as:

- Conducting special assemblies for schools, either in response to a crisis or to provide general information;

- Providing speakers for civic groups;

- Conducting in-service training;

- Conducting television and radio discussions; and

- Disseminating pamphlets, brochures, and newsletters.

There are three foci to prevention activities:

- Modifying of the conditions in which rape is rooted;

- Making the community aware of attitudes and behaviors that support rape; and

- Educating people about strategies to avoid rape and strengthening individual capabilities and/or decreasing individual vulnerabilities.

Issues in Service Delivery

Although safety measures are important, rape prevention involves a paradox. It implies that a woman could have avoided rape by taking certain precautions. This position suggests the woman is somehow at fault if she is sexually assaulted. In addition, emphasis on avoidance also reinforces in women a sense of helplessness and fear, which creates anxiety. Finally, a dogmatic approach to avoiding or resisting rape is potentially dangerous. For example, most women would be unable to successfully use unarmed physical force to repel an attack.

Debate over the question of encouraging victims to report rape persists within programs. Inadequate or inappropriate responses by law enforcement officers, prosecutors, and criminal justice personnel can increase a victim's sense of victimization. Court proceedings can also increase her anxiety and negatively affect her perception of herself as can the reactions and responses of the victim's friends and family.

A program's ability to provide assistance to victims depends on its relationship to the community. The militant and anti-male tone of some programs interferes with this relationship and contributes to the general reluctance to provide funds for programs dealing with sex-related issues.

G. CHAPTER SUMMARY

Rape is complex and not well understood. This is especially true within the Navy and Marine Corps. However, several points regarding rape are germane to the Navy and Marine communities.

- Rape more closely resembles violent crimes such as assault and robbery than it does sexual intercourse with a consenting woman. It is especially important that all victims, families, commanding officers, and others be made aware of this point.

- Because of the demands of their careers, many military women lead lives that involve traveling, working at night, and other activities that make them vulnerable to sexual assault.

- Although it is often presumed that women "ask" to be raped because of imprudent behavior, most rapes have been found to occur regardless of women's behavior.

- There is a real need for education on the problem of rape and the experience of victimization for both men and women in the Navy and Marines.

In treating rape victims and their families, both the kinds of services and the methods of providing them need to be considered. Effective delivery can be facilitated by integrating civilian successes with Navy and Marine resources. Some suggestions include:

- Promoting continuity of service delivery through the use of counselor/advocates and outreach methods for victims and their families;

- Providing alternative settings in which counseling services can be provided and in which client-counselor confidentiality can be maintained;

- Establishing links between existing resources such as chaplains, military wives' organizations, legal services, community and family services, and child care facilities; and

- Using community volunteers in program development and staffing.

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Chapter IV

Military Family Advocacy

Chapter IV
MILITARY FAMILY ADVOCACY

A. BACKGROUND

The official establishment of family advocacy programs in the military paralleled growing public concern over reports of increases in child and spouse maltreatment in our society, combined with doubt that strategies and resources for coping with these problems were adequate. It was generally recognized that such abuse posed a serious threat to family life and, within the military community, compromised military preparedness by reducing the readiness and performance of individual soldiers (McCullah, 1978).

In both the civilian and the military community, pressures for new legal and other responses concerning child abuse and neglect preceded demands for addressing spouse abuse by approximately 10 years. As published reports emerged in the public sector during the mid-1960s and early 1970s calling for responsive countermeasures to child abuse and neglect, similar expressions and appeals appeared in the military community. During this time, estimations of the incidence of child abuse and neglect in the military were based on limited data and experience and often were compared with civilian estimates. These estimates ranged from "relatively slight" to "abundant" and, when compared to the civilian population, from "similar to that in the general population," to "over four times greater than in the general civilian population" (Bain et al., 1965; Children in Peril, 1972; Miller, 1973; Wichlacz et al., 1975). Despite the questionable validity and reliability of these early estimates, the magnitude of the problem prompted base-level medical personnel within the services to establish formal child abuse programs.

Chapter Overview

This chapter traces the development of the family advocacy movement from the early emergence of public concern about child abuse and neglect to the establishment of formal family advocacy programs in the military services, under guidance from the Department of Defense (DoD). The presentation moves chronologically, describing early child abuse initiatives and legislation; the creation of child advocacy programs in the military service branches; and the evaluation of the military response by the U.S. General Accounting Office (GAO). It tracks the development of concern with domestic violence, the public response to this issue at state and federal levels, and the mounting concern with family advocacy as reflected in the series of conferences and developments in the military services. The chapter then reviews the culmination of this movement in the policy directive establishing a Family Advocacy Program in the Department of Defense and the current responses to this Directive in the military services.

B. EARLY CHILD ABUSE INITIATIVES AND LEGISLATION

One of the first child abuse programs was established in 1967 at the William Beaumont Army Medical Center in Texas. By 1970, programs and procedures for addressing child abuse were in place at two-thirds of the Army's CONUS installations. During this same period, similar programs also were being formalized by local medical personnel at Air Force and Navy installations. In these original activities, the medical aspects of child maltreatment cases were the primary concern. Intervention was restricted largely to the immediate medical needs of the abused and to punitive action against the abuser. Still, it was recognized that a comprehensive approach was essential to maximize program effectiveness. Hence, programs expanded to include the total social picture of the maltreatment problem with education, prevention, intervention, treatment, and follow-up components, as well as close collaborative links with local state and county entities.

The growth of independent base-level programs in each branch of the military, combined with recognition of the comprehensive requirements of an effective approach, made evident the need for department-wide policies and procedures for implementation of child advocacy programs. With participation from representatives of all three services, members of the military section of the American Academy of Pediatrics in March 1973 presented recommendations meeting this need. They urged:

- Developing a directive at the DoD level to establish a consistent method for management of abused children and their parents;
- Developing prevention programs at each post or installation in the United States and overseas that has dependent children;
- Using research to develop more effective methods for recognizing, managing, and preventing child abuse; and
- Establishing a central registry for abused children and their parents (U.S. General Accounting Office, 1979, p.10).

In July 1973, shortly after these recommendations were issued, representatives of the Office of the Assistant Secretary of Defense for Health and Environment met with representatives of each branch of the military services and an eminent authority on child abuse (Dr. C. Henry Kempe) for a discussion of maltreatment programs for military children. However, no decisions or actions emanated from this meeting.

Heavy impetus was added to the national child advocacy movement in January 1974, with Congressional Enactment of Public Law 93-247, the Child Abuse Prevention and Treatment Act. The Act included a definition of the term "child abuse and neglect" and identified a child as one ". . . under the age of eighteen, or the age specified by the child protection law of the State in question . . . ." (Section 2(b), p.6). The Act also established the National Center on Child Abuse and Neglect (NCCAN) and

asked it to initiate a study to determine the national incidence of child abuse and neglect and the extent to which incidents of child abuse and neglect were increasing in number or severity. The center awarded a contract for conducting this study in 1976, but excluded the military base community from its scope. The center not only anticipated methodological problems in surveying the military population, but also believed that the military population might have special characteristics that could affect the incidence and types of abuse and neglect.

However, NCCAN suggested that it might be feasible to develop incidence estimates of child abuse and neglect in the military by developing a unique methodology and using resources available on military bases. Efforts of the offices of the military Surgeon Generals to obtain support and resources for initiating such a survey were unsuccessful.

The Act also required appointment of an Advisory Board on Child Abuse and Neglect. This board was to include representatives from federal agencies with responsibility for programs and activities related to child abuse and neglect. Representatives from the Office of the Assistant Secretary of Defense for Health Affairs and from the Army, Air Force, and Navy have served on this Board since its inception.

In June 1974, the American Medical Association (AMA) held a conference on child maltreatment in the military. Recommendations from this meeting included the suggestion that DoD select a group of experts in the field of child maltreatment to provide specific guidance on the implementation of military child abuse programs. In addition, the AMA representatives suggested that priority should be given to:

- Recognizing at the DoD level and at the higher echelons of each military service that a problem exists;
- Providing official recognition at the highest management level that the child advocacy program is mandatory;
- Developing a comprehensive regulation that is as consistent as possible among the military services;
- Allocating funds and professional personnel in the areas of protective services; and
- Developing a central registry to record and analyze all child abuse reports as a means of assessing the total problem within the DoD (U.S. General Accounting Office, 1979, p.10).

In January 1975, a Tri-Service Child Advocacy Working Group was established in the Office of the Assistant Secretary of Defense for Health Affairs. The group was formed to monitor existing programs in the service branches. It had no management authority or advisory responsibilities. Meeting only occasionally, its membership was comprised of staff from the services' manpower communities and the offices of the Surgeon Generals. These individuals participated on a part-time, collateral-duty basis.

C. THE CHILD ADVOCACY PROGRAMS

The Air Force Program

The Air Force was the first service to organize an official Child Advocacy Program. Established under Air Force Regulation 160-38 dated April 25, 1975, the medical service was given primary responsibility for the program. Under the regulation, a child was defined as:

> An unmarried person whether natural child, adopted child, foster child, stepchild, or ward who is a dependent of the military member or spouse and who either (1) has not passed his or her twenty-first birthday or (2) is incapable of self-support . . . .

It also stated that:

> It is Air Force Policy to prevent child abuse and neglect and their attendant problems and to identify, treat, and rehabilitate the abuser or neglector as well as to treat the abused child. . . . The Air Force will endeavor to provide all available and appropriate assistance to alleviate the underlying causes of child abuse or neglect (AFR160-38, p.1).

Policy and program responsibility for the Air Force program was given to the Surgeon General. The Surgeon General was charged with providing policy and program guidance; establishing a headquarters Child Advocacy Committee and identifying a chairman; and coordinating the medical, psychological, and sociological aspects of the program with other relevant federal agencies and professional organizations. The headquarters committee was given responsibility for evaluating and coordinating program activities at the headquarters level and recommending policy and program changes. Committee membership included representatives from the Office of the Surgeon General, the Deputate of Personnel Plans, Chief of Chaplains, the Judge Advocate General, the Inspector General, and the Chief of Security Police. Each committee member was charged with providing collaborative assistance from their respective areas of responsibility.

The regulation extended responsibility for program monitoring and management to Major Commands, with direct responsibility delegated to the Command Surgeon. At the local base level, responsibility for the program resided with the Base Commander, with designation of this responsibility to the Director of Base Medical Services (DBMS). It required establishment of a Child Advocacy Committee at each base, chaired by the DBMS or the Chief of Hospital Services. The committee was comprised of individuals representing those units directly responsible for implementation of program components: the Child Advocacy Officer, Staff Judge Advocate, Director of

Personnel, Chief of Security Police, Chaplain, and Special Services Officer. The chair was advised to encourage representatives of the local civilian child protection agency to attend meetings in an advisory capacity, insofar as he considered this to be appropriate.

The Army Program

The Army Child Advocacy Program was formulated by a special committee appointed by the Army Surgeon General. Although it was initially conceived primarily as a medical program, the approach was broadened to include the social aspects of the problem. The original directive (AR 600-48) was issued on November 26, 1975, with the Deputy Chief of Staff for Personnel directly responsible for program implementation. Under the directive, a child was defined broadly as a dependent younger than eighteen.

Overall program management was delegated to the Adjutant General in early 1977. This change, along with refinements and more detailed specification of the duties and responsibilities of involved personnel, was issued as AR 608.1 dated October 1, 1978. As a result, the program was placed under the auspices of the Army Community Services Program.

The comprehensive nature of the Army's Child Advocacy Program was reflected in its objectives, which stated in part:

- To identify, use, and strengthen military and civilian community resources to enhance the general welfare of children;
- To ensure command and staff personnel are aware of their responsibilities for preventing child maltreatment and for identifying, reporting, treating, and protecting children who are victims of alleged maltreatment;
- To assist parents to recognize causes of child maltreatment and to become effective parents; and
- To prevent and control child maltreatment by educating and training all personnel... in the recognition of the causes and consequences of child maltreatment (AR608-1, p. 7-1).

Unlike the Air Force, the Army's objectives made no direct reference to treatment and rehabilitation of the abuser or neglecter.

At the headquarters level, the Surgeon General was required to support the program with resources and technical assistance related to providing health services; establishing a system for collecting data on cases of maltreatment; and supervising the medical and psychosocial aspects of identifying, preventing, and treating maltreatment. At this level, the Chief of Chaplains was charged with supporting program activities concerning the morale and morals of the installation community. Also the Chief of Public Affairs was responsible for coordinating information about

the program, and the Judge Advocate General was charged with providing legal advice in program matters.

At each installation, the commander was required to appoint an Army Child Advocacy Program (ACAP) Officer to monitor and provide staff supervision of the program and to serve on the Child Protection and Case Management Team (CPCMT). The regulation stated that normally this appointee would be the local Army Community Services (ACS) Officer or social worker. The installation Medical Treatment facility officer was required to appoint (subject to the direction of the commander) and supervise the multidisciplinary CPCMT in providing evaluation, diagnosis, treatment, and disposition of child maltreatment cases. The team would consist of a pediatrician, psychiatrist, psychologist, social worker, nurse, lawyer, the ACAP Officer, and the ACS social worker. It was suggested that the team might also include law enforcement personnel, civilian child protection workers, chaplains, and occupational therapists, as well as other personnel who might make contributions. Program related duties were specified for the Installation Chaplain, Staff Judge Advocate, and Staff Provost Marshall.

The Navy Program

On February 4, 1976, the Navy Bureau of Medicine and Surgery issued BUMED Instruction 6320.53A. This instruction provided policies and guidance for the establishment of a Child Advocacy Program within the Navy Medical Department. It defined a child as: "An unmarried person whether natural child, adopted child, foster child, stepchild, or ward who either: (1) has not passed his/her twenty-first birthday; or (2) has not become legally emancipated; or (3) is incapable of self support. . ." (p.1). The definition was later changed, lowering the age limit to children younger than eighteen.

According to a 1979 report from the GAO, Navy pediatricians, participating in an American Academy of Pediatrics project looking at the problem of child abuse in the military, made an effort to establish a Navy Child Advocacy Program in 1973. As a growing number of child maltreatment incidents surfaced in the Navy, the Surgeon General of the Navy became convinced that an official program was needed. This report stated further that:

> Officials from the Bureau of Medicine and Surgery believed that child maltreatment needed to be addressed not solely as a medical problem, but also as a social problem. With this objective in mind, Navy medical officials attempted to persuade senior Navy officials to designate the Bureau of Personnel (BUPERS) as the organization responsible for the program. Because BUPERS actions affect all Navy

personnel, regulations to implement a BUPERS program are issued by the Secretary of the Navy and require Navy-wide compliance. BUPERS questioned whether a serious child maltreatment problem existed and convinced senior Navy officials to deny BUMED's request. As a result, BUMED began organizing its own program in 1974 (U.S. Government Accounting Office, 1979, p.8).

The need for a Navy-wide child advocacy program with centralized control and guidance was apparent in the proliferation of local initiatives at base medical facilities. By 1975, all 14 regional Navy medical centers had developed child maltreatment policies or child advocacy regulations. Similar action had taken place at 19 of the 21 smaller Navy hospitals.

The BUMED instruction outlined procedures for protecting children who were abused, neglected, or abandoned. It further directed commanders to ensure that services for children receive careful evaluation and monitoring, consistent with approved local community standards.

Under the BUMED Instruction, the Navy Surgeon General had responsibility both for the Child Advocacy Program and for establishing a headquarters Child Advocacy Committee. This committee was charged with overseeing the program throughout the Navy. Although the instruction was limited to stations having medical personnel, a broader scope was implicit in specifying the membership of this committee. Even though nonmedical activities were not required to comply with the regulation and installation commanders were not responsible for the program, the regulation specified that the central committee would include representatives from BUPERS, the Judge Advocate General, the Chief of Chaplains, and the Surgeon General. In conjunction with its overseeing responsibilities, the central committee was charged with establishing and maintaining a central registry of confirmed cases of child abuse and neglect; performing case counting and incident rate analysis; and submitting recommendations to the Chief of BUMED for developing proposals which identify and provide means to rectify the problems of child abuse and neglect.

The broader intent of the program was also apparent in the responsibilities assigned to commanding officers of medical facilities. Each of these officers was required to establish a local Child Advocacy Program Committee. This committee was charged with reviewing suspected cases of child maltreatment and evaluating the quality of services rendered. It was also responsible for making plans for definitive management of individual situations and community problems contributing to child abuse and neglect. According to the instruction, the committee might include representatives from the following specialty areas: Pediatrics, Social Work, Red Cross, Public Affairs, Chaplaincy, Local Dependents School Nurse, Psychiatry, Security, Nursing, Staff Judge Advocate, Psychology, Navy Relief, Civil Engineer Corps, and appropriate local civilian agencies.

In addition to establishing the Child Advocacy Program at the installation level and establishing a Child Advocacy Program Committee, the commander of the medical facility was responsible for appointing a senior member of his staff to chair the local committee and serve as installation Child Advocacy Representative (CAR). As such, this person served as the point of contact for the command on all child advocacy matters within the command and satellite activities. Officers in charge of other medical facilities were required to appoint a CAR to serve as the point of contact for those commands on all child advocacy matters.

The instruction specified the responsibilities and duties of the installation committee, the Child Advocacy Representative, and medical treatment personnel. It also described reporting requirements for confirmed cases, case tracking procedures, and efforts directed to education and prevention and to maximizing child welfare services.

Evaluation of the Child Advocacy Programs

In May 1979, the GAO issued a report to the Congress entitled: Military Child Advocacy Programs--Victims of Neglect. The purpose of the report was to critique current efforts within the military services to deal with child abuse and neglect.

The report began by justifying military child maltreatment programs on the basis of published estimates of the magnitude of the problem throughout society and the higher prevalence in the military community of stress factors allegedly leading to child maltreatment. Following evaluation of existing military programs, the report presented conclusions and recommendations for improving program effectiveness.

The GAO concluded that the independent development of programs within each branch of the military, without overall guidance from the Department of Defense, had led to inconsistent policies, such as:

- Placement of child advocacy programs within the organizational structure of each service;
- Age differences in the services' definition of a child; and
- Organization and management of child advocacy programs at the installation level (U.S. Government Accounting Office, 1979, p. 21).

The need for centralized guidance was recommended in coordinating military programs with local civilian social welfare organizations, particularly with respect to the issue of jurisdiction. Further improvements recommended at the installation level included:

- Higher program priority and greater resources;

- Additional staffing to augment existing collateral duty efforts;
- Expanded education and training for all members of the military community aimed at identification and prevention of child maltreatment; and
- Procedural training for persons dealing directly with maltreatment cases (U.S. Government Accounting Office, 1979, p. 21).

To improve the organization and operation of the programs, the GAO recommended that the Secretary of Defense establish a small centralized group to serve as a focal point for:

- Bringing consistency to the services' child advocacy regulations;
- Developing education and training materials for improving child advocacy programs at the installation level;
- Providing guidance to the services regarding how to handle the difficulties posed by exclusive jurisdiction installations when dealing with child maltreatment problems; and
- Communicating with military installations and the National Center on Child Abuse and Neglect regarding child advocacy matters in general (U.S. Government Accounting Office, 1979, p. 22).

Additionally, the Secretary of Defense was advised to direct the Secretary of the Navy to place responsibility for its child advocacy program at a level high enough to encompass all Navy installations and personnel.

The concluding section of the GAO report was directed to problems surrounding development of military child maltreatment reporting systems. The GAO report alleged that child maltreatment registries currently maintained by the individual military services were incomplete and ineffective, both for developing meaningful statistics on military child maltreatment problems and for maintaining information on prior maltreatment reports that could be used for assessing whether a child is in danger. It was pointed out that the legality of these registries, as well as any future centralized tri-service registry, would be affected by a forthcoming Supreme Court decision (Moore vs. Sims) involving the issue of maintaining and using information on suspected abusers.[1] Because of the sensitive

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[1] In 1978, subsequent to issuance of the GAO report, the U.S. Supreme Court in Moore vs. Sims, 47 U.S. L.W. (4693) overturned a Texas Federal District Court decision that ruled: "Maintaining and using information on suspected child maltreatment cases without a judicial determination of abuse or neglect is a violation of due process of law and an individual's right to privacy." However, the Supreme Court decision was based on technical grounds that the case in question should not have been heard at the Federal Court level, hence, the question of unconstitutionality was not settled. As a consequence, sensitivity to issues of maintaining and using information has been heightened.

nature of child maltreatment information, the different report systems maintained by the military services, and the reluctance to report child maltreatment incidents, the GAO recommended that the Secretary of Defense establish a single DoD policy for collecting and using information on suspected and confirmed cases of child maltreatment.

D. THE DOMESTIC VIOLENCE ISSUE

For many decades there have been sporadic protests from family action groups and the legal community challenging traditional responses to the problems of domestic violence. These protests intensified with the revival of the feminist movement.

As with child abuse, the traditional response to domestic violence had been predominately crisis oriented. Intervention was largely tertiary, with attention primarily directed to the immediate medical needs of the victim and prosecution of the perpetrator. During the 1970s, demands increased for expanded social services and for new civil and criminal protection for abused wives, as well as for children. In the military, conferences were held that included discussions on family advocacy issues; some existing Child Advocacy Programs were expanded to include policy and guidance on spouse abuse. The focus broadened to include not only the treatment of domestic violence cases, but also education and prevention efforts. In addition, a military family resource center was established and specialized training was conducted for human service professionals handling domestic violence cases.

Federal and State Initiatives

Between 1975 and 1980, 44 States passed new legislation addressing domestic violence. Most of the statutes created new civil and criminal remedies for persons abused by household members. Some were directed to the powers and duties of police answering domestic disturbance calls. Others required agencies providing services to violent families to maintain records and case reports. In 29 of these States, the new laws allowed the courts to evict an abuser from a residence shared with the victim. Many state and local governments appropriated special funds for shelters and other services related to family violence (Lerman, 1980).

At the federal level, the Department of Justice, through the Law Enforcement Assistance Administration (LEAA), launched a Family Violence Program in 1977. A basic assumption of this program was the importance of the criminal justice system in reducing family violence. The program supported more than 30 comprehensive demonstration projects involving relevant public and private agencies. These projects provided resources to courts, police departments, and prosecutor's offices to develop and test ways in which the criminal justice system could become more responsive and effective in handling domestic violence cases.

In the fall of 1979, the Department of Health and Human Services established the Office on Domestic Violence. Its purpose was to coordinate research and social services related to domestic violence in what was then the Department of Health, Education, and Welfare. In addition, it was to establish an information clearinghouse and provide technical assistance to organizations developing programs at the local level. However, funding inadequacies hampered the effectiveness of this office. In 1981, the office was closed and its outstanding grants and contracts were transferred to the National Center on Child Abuse and Neglect (Santos, 1981).

In February 1981, a "Domestic Violence Prevention and Services Act" (H.R. 1651) was initiated in the House of Representatives. The bill was referred to the Subcommittee on Select Education under the House Committee on Education and Labor. The broadening of national concern from the medical and legal aspects of domestic violence to the social aspects of the problem is reflected in this proposed legislation. This is apparent in the stated purposes of the Act:

- To increase the participation of states, local public agencies, local communities, nonprofit private organizations, and individual citizens in efforts to prevent domestic violence and to provide immediate shelter and other assistance for victims and dependents of victims of domestic violence;

- To provide technical assistance and training relating to domestic violence programs to states, local public agencies, nonprofit private organizations, and other interested groups, officials, and persons seeking such assistance;

- To establish a federal interagency council [including representatives from the Department of Defense] to coordinate federal programs and activities relating to domestic violence; and

- To provide for essential information gathering and reporting programs relating to domestic violence (H.R. 1651, 1981, pp.2-3).

Despite the failure of the House to act on this proposed legislation, continued Congressional interest in domestic violence is reflected in a companion bill, containing identical objectives, that was introduced in the Senate on September 8, 1982 (S2908). This bill was referred to the Subcommitee on Aging, Training, and Human Services under the Committee on Labor and Human Resources.

Navywide Family Awareness Conference: 1978

A Navywide Family Awareness Conference was convened in November 1978, jointly sponsored by the Chief of Naval Personnel and the Navy League. More than 700 individuals, representing active duty personnel, retirees, Naval Reservists, Navy dependents, and civilian observers and resource persons participated in the conference.

Proceedings of the conference were compiled by the Family Support Program Branch in the Office of the Chief of Naval Operations. In the introduction to these published proceedings, the Navy's past approach to meeting the needs of its families was described as:

> . . . . greatly fragmented and at times piecemeal. Numerous organizations outside the Navy structure, i.e., the Navy League of the United States, Navy Relief, the International Red Cross, and others have contributed significantly to the welfare and support of the Navy Family. Various organizational echelons within the Navy structure have initiated efforts to address specific problems. These efforts have been, and will continue to be, invaluable in identifying and solving the myriad and sometimes complex family problems arising from the uniqueness of the Navy's demands on its personnel. It has become increasingly evident that a concerted effort has to be made by the Navy to draw on all resources available and to better define what, in actuality, are the requirements of Navy Families (Navy Family Program Branch, 1978, p.i).

Workshops at this conference produced more than 200 recommendations. Those related to domestic violence included:

- Expand the Navy's Family Advocacy Committee (FAC), which deals with child abuse, spouse abuse, and rape, to serve the entire Navy;
- Provide trained and fully qualified counselors for marriage and family counseling and crisis intervention at overseas stations; and
- Conduct a Navywide family needs asssessment, including questions on child care, crisis intervention, special need families, and parent education programs (Navy Family Program Branch, 1978, p.13).

Recommendations from this conference contributed significantly to the establishment of the Navy Family Support Program in January 1979 and the issuing of BUMED NOTE 6320 (February 29, 1979), which established policy and guidance for handling spouse abuse.

The Air Force Conference on Families: 1980

Recognition of changing family needs among Air Force personnel prompted the Office of Chief of Chaplains in 1978 to launch a series of studies to investigate contemporary trends and dynamics in Air Force family

life (Carr et al, 1980; Orthner, 1980; Orthner & Bowen, 1982). Overall, these studies documented the changing composition of the Air Force from a single to a married force and underscored the important contribution of families to the military mission.

In July 1980, recognizing the inextricable link between family well-being and mission readiness, the Air Force established the Office for Air Force Family Matters within the Directorate of Personnel Plans. Shortly thereafter, in September 1980, an Air Force Conference on Families was convened at Randolph Air Force Base, Texas. The summary proceedings of this conference stated that:

> By the summer of 1980, Air Force leaders had become more aware of the increasing complexity of family issues and understood that meeting the needs of families contributed to the retention, productivity, and morale of Air Force members. A variety of studies and programs have been implemented to define and begin meeting family needs. However, these efforts were functionally oriented and, to a large extent, fragmented and did not have broad support across the entire Air Force. A mechanism was needed to share information and ideas about functional family issues and programs among the various Air Staff offices with family-related responsibilities as well as with the Major Air Commands (Office of Family Matters, 1980, p.11).

That required "mechanism" was identified as the Office of Air Force Family Matters. The dominating theme of this conference was the need for change in addressing the needs of military families. Among the recommendations produced at this conference, two were related directly to child maltreatment and domestic violence:

- Establish on-base parenting training to emphasize parental responsibilities; and
- Provide professional care for family members with alcohol, drug, or domestic violence problems through the Family Assistance and Support Team (FAST) concept and other programs (Office of Family Matters, 1980).

In September 1981, the Air Force Office of Family Matters sponsored a second conference on families in Washington, D.C. One purpose of this conference was to inform conference attendees of the current status of recommendations made at the 1980 Conference on Families. Included in the conference report was an update on family advocacy programs in the Air

Force. According to the report, the Child Advocacy Program was expanded in August 1981 to include the entire family. This new program added a "spouse abuse" component to the previously existing child maltreatment program.

The Army Conference on Families: 1980

In October 1980, the Army Officers' Wives Club of the Greater Washington Area and the Association of the United States Army jointly sponsored a symposium in Washington, D.C. The theme of the symposium was "The Army Family: Analysis and Appraisal." One of the primary goals of this conference was to provide a platform for the identification and exchange of ideas concerning issues facing the Army family in the eighties.

The concerns, needs, and problems of Army families were reviewed in thirteen conference workshops. From the workshop addressing specific family problems, conference attendees concluded that:

> Societal pressures, in conjunction with the unique aspects of Army life, may impact negatively upon the normal development of a family unit. The result for some families is individual dysfunctioning and family disintegration . . . . Mobility, financial pressures, and family separations are factors that may contribute to family dysfunctioning. Alcoholism, drug abuse, divorce, spouse abuse, delinquency, intergenerational conflicts, and child abuse are only some of the symptoms displayed by families in distress. The functioning of individuals who are part of a troubled family unit is usually adversely affected. Job performance declines, organic complaints can be exhibited, and last but not least, aggressive/violent behavior toward other family members can result. Although some services do exist to address these problems, there is a serious shortage of professional personnel available to provide preventive and treatment services to the dysfunctional family (Van Vranken et al., 1980, p.8).

Recommendations from this group included several that were related to child maltreatment and domestic violence. Commands should:

- Establish a Family Advocate (paid position) at each post and aggressively support programs that maximize positive influences on family life;

- Provide a 24-hour crisis "hot line" for families in trouble;
- Provide command-supported, "safe" shelters for victims of family violence, with treatment resources available to both the victim and the remaining family members; and
- Develop Women's Centers that provide information and education courses on such issues as employment, mental health, legal rights and options, rape prevention/assistance, and parenting. (Van Vranken et al., 1980, pp.8-9)

In addition to these recommendations, conference attendees also recommended that the Army establish a family liaison office within the Office of the Chief of Staff, Army. In response to this recommendation, the Army established such an office in the Fall of 1981, under the Office of the Deputy Chief of Staff for Personnel.

The Military Family Resource Center: 1980

Based on a GAO recommendation to create a resource center to serve the military worldwide, the National Center on Child Abuse and Neglect established the Military Family Resource Center (MFRC) in October 1980, under the auspices of the Armed Services Department of the YMCA. The MFRC was created to support family advocacy in the military services and to assist professionals who provide help to military personnel and their families. Although the center was initially created as a three-year demonstration project under a grant from NCCAN, the MFRC is being incorporated as a permanent part of the Defense Department's overall family support system. The center has three primary goals:

- To raise the professional awareness of family advocacy in the military;
- To provide information and technical assistance to those who serve the military family; and
- To enhance multidisciplinary programs in military and civilian agencies which serve the military family (Crawford, 1981, p. 23).

The Center serves as a clearinghouse and also develops information on military and civilian services showing promise of meeting the needs of military families. Technical assistance is provided on request, including planning, program development, and evaluation of services to military families.

The Conference on Domestic Violence in the Military Community: 1981

In March 1981, a conference on domestic violence in the military community was held in Savannah, Georgia. The conference was jointly sponsored by the Center for Women Policy Studies, Washington, D.C., and the

Family Violence Project of the Coastal Area Community Mental Health Center, Hinesville, Georgia. It was funded by LEAA, U.S. Department of Justice and attended by military personnel, civilian social service workers, health professionals, clergy, and lawyers. Among the themes heard at the conference was the toll that spouse abuse in the armed forces takes on combat readiness, performance, and retention.

Working groups prepared more than 30 recommendations including suggestions that:

- The DoD should both issue a family advocacy directive, and ask Congress to appropriate funds.

- On the local level:
  - Staff on each base should collect statistics,
  - Each base should establish services for battered women, and provide treatment for batterers,
  - Emergency rooms should establish a protocol for treatment of victims and additional social workers should be allocated to hospital staff,
  - Stress management programs should be initiated, and
  - Each military community should have a crisis intervention team.

- Training should be provided to:
  - All military members about the application of the Uniform Code of Military Justice (UCMJ) to spouse abuse,
  - Students at military academies, P-G schools, staff colleges, etc. about the dynamics of spouse abuse and the negative impact on military readiness and mission, and
  - The military community, including dependents, outlining military and civilian resources available to assist the victim and the batterer (Santos, 1981, pp.66-70).

The Coast Guard Family Advocacy Symposium: 1982

In March 1982, the Coast Guard Wives Club of Washington, D.C. sponsored a family advocacy symposium. This symposium was attended by approximately 60 representatives, including personnel from Coast Guard headquarters and wives of Coast Guard members. In July 1982, the Coast Guard initiated the development of family advocacy policy and program guidelines in its Military and Family Services Branch. Three months later, a second family advocacy symposium was convened in Washington, D.C. with 50 representatives present. This meeting, sponsored jointly by the Coast Guard Office of the Chief of Staff and the Coast Guard Wives Club of Washington, D.C., was called to provide support and assistance to the development of a Coast Guard Family Advocacy Program.

Family Advocacy Training Programs: 1982

Earlier this year, Congress appropriated funds for use by military Family Advocacy Programs. Each of the services used a portion of this money for training workshops or conferences in the treatment and prevention of child maltreatment and spouse abuse. Last spring, the Air Force Surgeon General's office sponsored a series of 13 workshops for military professionals who deal with family violence issues. In September, the Navy sponsored ten workshops with representatives from 60 bases. The workshops focused on training Navy professionals involved with domestic violence to develop a coordinated service response. The Marines also held two three-day family advocacy workshops in August and September. The Army dealt specifically with family advocacy issues in an August conference for the European Command, while a CONUS conference was held under the auspices of the Health Service command. A worldwide workshop was undertaken by the Army Community Services.

Evaluation of Spouse Abuse Programs

In 1981, the Center for Women Policy Studies (CWPS) published an extensive study of military spouse abuse entitled: Wife Abuse in the Armed Forces. The study was jointly funded by LEAA and the Administration for Children, Youth, and Families in the Department of Health and Human Services. The objectives of the project were: (1) to investigate the problem of wife abuse in the military and identify some of the elements that may be exacerbating the problem; (2) to examine current military policies and programs that deal with spouse abuse; and (3) to recommend steps for developing and improving programs to better serve military families. Information for the study was drawn from more than 90 interviews with DoD policymakers and other military and civilian social services, legal, and medical officers. In addition, CWPS researchers visited military programs providing service to violent families at six CONUS military installations representing each service branch and six Army bases in West Germany.

Study results pointed to the seriousness of spouse abuse in the military and stressed the importance of a coordinated service delivery response by the entire Armed Forces community and chain of command. Although CWPS researchers complimented the initial efforts of the Armed Services to respond to the needs of violent families, they underscored the need for continued emphasis on policy and program development to ensure a full range of services for battered women and their families. Based on their interviews and site visits to military installations, 37 specific recommendations in six categories were listed for DoD policies on wife abuse, as well as for branch and local program efforts. Identified by category, the following were among those recommendations:

Program Focus

- Clearer distinctions should be drawn between efforts directed to child abuse and spouse abuse.

Staffing and Funding

- DoD should directly fund the Family Advocacy Program.
- Each installation should appoint and fund at least one full-time women's advocate.
- There should be an advisory board at each installation composed of directors from both Armed Forces and civilian social service organizations.
- Each installation should establish a crisis intervention team, available on a 24-hour basis, to respond to battered women.
- The spouse abuse program should be located in, and coordinated from, a nonmedical setting.

Information, Training, and Direction

- Information and training in developing effective spouse abuse programs should be provided to:
  - Military police,
  - All medical personnel,
  - Unit commanders and supervisory personnel,
  - Staff judge advocates,
  - Chaplains, and
  - Students at military academies and officers' training schools.
- There should be a formal, written hospital emergency room protocol for handling spouse abuse cases.
- The services should develop a commander's guide detailing the judicial and nonjudicial options available in dealing with spouse abuse cases.
- Program representatives should conduct community education efforts on spouse abuse.

Programs for Men Who Batter

- Each installation should provide counseling for male service members who batter their wives.

- Mental health workers should be acquainted with the latest techniques for counseling battered women and batterers.

- Drug and alcohol counselors should be trained to recognize and treat batterers.

Military Legal Issues

- Confidentiality should be maintained between military mental health professionals and spouse abuse clients.

- The military should establish a regulation enforcing protection orders obtained in civilian courts.

- The military should establish a regulation requiring a commander to separate a husband from a complainant wife, if she so desires, at the beginning of an investigation.

- Judges should be able to condition suspension of punishment on compliance with a prescribed treatment program.

- Fines or reduction in rank should be eliminated from the range of nonjudicial punishments in spouse abuse cases.

Future Research

- Extensive research should be conducted on the factors that battered wives record as problems and stresses.

- More information should be gathered on the incidence of wife abuse in the military.

- More investigations should be conducted on the nature and extent of the problem overseas.

- The relationship between the combat veteran's experience and battering behavior should be further explored.

E. THE DEPARTMENT OF DEFENSE DIRECTIVE

Stimulated by a recommendation from the GAO, the DoD established a Family Advocacy Committee in 1979 to develop a single policy statement for all services. On May 19, 1981, DoD issued an all-service policy directive establishing a Family Advocacy Program (FAP). This directive mandated that each service (Army, Navy, Air Force, and Marine Corps) create a program to address the prevention, evaluation, and treatment of child abuse, spouse abuse, and child neglect. The Coast Guard, in the Department of

Transportation, also was invited to participate in all DoD family advocacy matters. Chart IV-1 outlines the structure of the DoD Family Advocacy Program.

For administrative purposes, the directive provided several definitions, including:

> Child. An unmarried person, whether natural child, adopted child, foster child, stepchild, or ward, who is a dependent of the military member or spouse and who either:
>
> a. Is 18 or under; or
> b. Is incapable of self-support because of a mental or physical incapacity for which treatment is authorized in a medical facility of the Military Services.
>
> Spouse. A partner in a lawful marriage where one of the partners is a military member.
>
> Maltreatment. A general diagnostic term referring to abuse or neglect.
>
> Abuse. Direct physical injury, trauma, or emotional harm intentionally inflicted on a child or spouse.
>
> Neglect. Acts of omission or commission comprising inadequate or improper care that result or could reasonably result in injury, trauma, or emotional harm (DoD Directive 6400.1, 1981, p.1).

Although the initial draft included spouse neglect as well as spouse abuse, spouse neglect was deleted from the final draft. The Office of the Secretary of the Defense believed that spouse neglect had too many social policy implications, was too difficult a subject to address, and was not amenable to the case reporting form (Gerson, 1981).

As it now stands, the DoD Directive is a policy statement, rather than a working instrument with specific program elements. Although it provides a broad structure for implementing programs within the services, it is a statement of the DoD's recognition of the problem and a commitment to address it (Gerson, 1981). The directive advocates a coordinated, but not necessarily a uniform approach to family advocacy in each of the services. Each of the services implements the directive based on its own requirements and resources.

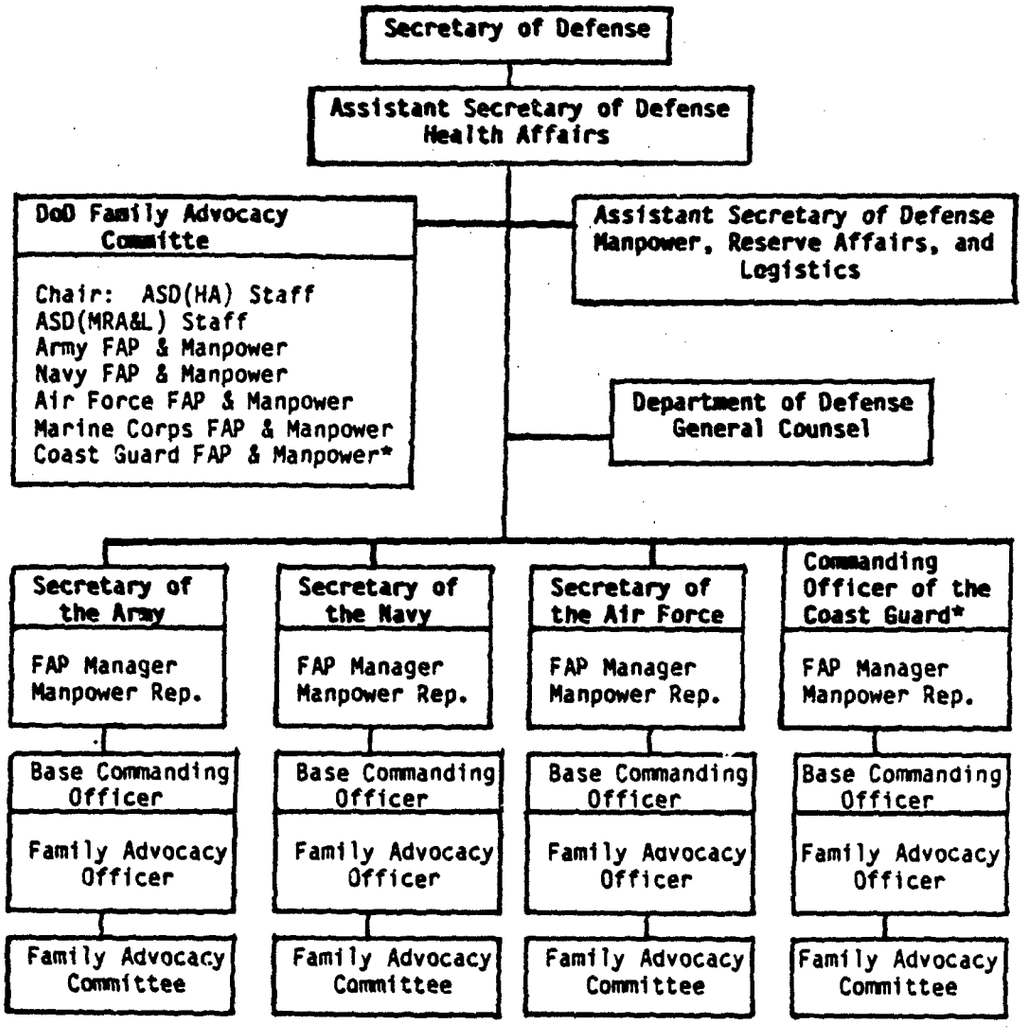
Program Goals

The Directive states, in part, that it is the policy of the Department of Defense to:

- Encourage the development of programs or activities that contribute to a healthy family life, and that restore to a healthy state those

Chart IV-1

STRUCTURE OF THE
DEPARTMENT OF DEFENSE
FAMILY ADVOCACY PROGRAM



*by invitation

families that are suffering from child abuse and neglect or spouse abuse;

- Provide a coordinated DoD-wide family Advocacy Program for the prevention, identification, treatment, follow-up, and reporting of child abuse and neglect and spouse abuse;

- Make specific efforts to serve fully those families living off base as well as those living on base;

- Encourage the Services to combine the management of this program, both centrally and in the field, with similar medical and/or social programs, such as those dealing with substance abuse;

- Identify suspected abusers or neglecters, or both, so that injuries can be prevented, therapy can be instituted for the dysfunctioning family members, and all persons can be treated;

- Cooperate with responsible civil authorities in efforts to address the problems of child abuse and neglect and spouse abuse and in reporting cases as required by state law; and

- Encourage the Secretaries of the Military Departments to exercise their authority . . . to relinquish such legislative jurisdiction as may be required, subject to military needs, to ensure the applicability on military installations of state laws pertaining to child and spouse protection (DoD Directive 6400.1, 1981, pp.2).

Program Components

The Directive requires that the Assistant Secretary of Defense for Health Affairs (ASD-HA), in coordination with the Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics (ASD-MRA&L) to:

- Develop a coordinated approach to family advocacy matters, consistent with provisions of the Directive, recognizing that local needs shall be met;

- Establish a DoD Family Advocacy Committee (FAC) to advise the ASD (HA), which shall be comprised of the Service Family Advocacy Program managers and representatives of the service manpower communities, with similar representatives invited from the Coast Guard, and a representative from ASD(HA) and ASD (MRA&L);

- Appoint a member of ASD(HA) staff to chair the Family Advocacy Committee;

- Consider and identify necessary fiscal and personnel resources essential to coordinate and implement the program; and

- Serve on federal committees pertaining to the program (DoD Directive 6400.1, 1981, pp. 2-3).

The required DoD Family Advocacy Committee was established as the Tri-Service Family Advocacy Coordinating Committee, replacing the earlier Tri-Service Child Advocacy Working Group. A full-time chairman of the committees was appointed in October 1982.

The DoD Family Advocacy Committee is required, in part, to:

- Serve as an advisory body to the ASD(HA) and the Military Departments;
- Monitor, review, and evaluate existing family advocacy programs;
- Ensure that periodic reports, consisting of aggregrated data, are supplied to the FAC by each of the Military Services;
- Use such aggregated data to compile cross-service trends in abuse patterns that can help identify program needs and assess incidence, distribution, and severity;
- Ensure cooperation among Military Service medical facilities;
- Encourage civilian and military exchange of medical information pertaining to abuse, within the limits prescribed by protection of personal privacy;
- Keep informed of relevant research being conducted and recommend additional research;
- Collaborate with the National Center on Child Abuse and Neglect (NCCAN), Department of Health and Human Services (DHHS), toward establishment of the Military Family Resource Center(MFRC), the implementation of a central reporting system, and the development of educational aspects of the program;
- Monitor legal developments concerning privacy and freedom of information affecting the program;
- Explore the possible use of Civilian Health and Medical Program of the Uniformed Services records to identify abuse among dependents, using civilian medical facilities; and
- Develop and implement guidelines and standards for: (1) FAC and NCCAN collaboration; (2) program elements and format necessary for uniform service-wide programs; and (3) a uniform, standard, DoD incident reporting form and formating to be used by all Services (DoD Directive 6400.1, 1981, pp.3-4).

The Secretary of each Military Department is required to:

- Establish broad policies concerning development of Service programs;
- Develop Service-wide documents to implement the program within Directive guidelines;
- Ensure that a Service program is implemented, administered, and managed;
- Designate a Service Family Advocacy Program Manager and appoint a member to represent the Service manpower community to the DoD Family Advocacy Committee;
- Ensure that local commanders designate a Family Advocacy Officer and a local Family Advocacy Committee; and
- Allocate fiscal and personnel resources necessary to coordinate and implement the program (DoD Directive 6400.1, 1981, p. 4).

The Directive describes the local command Family Advocacy Officer as: "A designated officer to manage, monitor, and provide staff supervision of the Family Advocacy Program at the local level" (DoD Directive 6400.1, 1981, p.2). The local Family Advocacy Committee is described as: "A multidisciplinary team of designated individuals, working on the installation level, tasked with the evaluation and determination of maltreatment cases and the submission and coordination of treatment and disposition recommendations" (DoD Directive 6400.1, Enclosure 1, 1981, p. 2).

The headquarters Family Advocacy Program Managers, designated by the Secretary of each military branch, are required to:

- Manage, monitor, and coordinate policy and guidance for their respective Service's Family Advocacy Program;
- Establish a Central Case Management File (CCMF) for proper documentation and treatment tracking of all maltreatment cases, using the standard format to be developed by the DoD Family Advocacy Committee;
- Coordinate with all applicable federal and civilian professional organizations on the operational, medical, psychological, and counseling aspects of the program;
- Report the status, progress, and problems of their respective program to the DoD Family Advocacy Committee;
- Assist in preparing initial and annual budget and manpower requirements; and

- Identify community agencies and organizations that provide services in the area of family advocacy; coordinate activities to avoid duplication and gaps in the provision of services to military families, especially those who live off base; and maintain frequent and regular contact with representatives of these agencies (DoD Directive 6400.1, 1981, pp.4-5).

A Case Management Committee (CMC) is established at the base level and is responsible for reviewing and reporting cases to the Central Case Management File (CCMF).[2] Four categories of case determinations are outlined in the Directive:

- Unfounded. After appropriate investigation by the CMC, a determination has been made that the evidence in a particular case is insufficient to support any suspicion that abuse or neglect did occur. (No report sent to CCMF.)

- Alleged. A sign, symptom, or assertion that maltreatment may have occurred in the absence of any further proof. (No report sent to CCMF.)

- Suspected. Maltreatment may have occurred, but insufficient evidence exists to warrant a determination of established maltreatment. (Report sent to CCMF.)

- Established. After thorough investigation and evaluation by either CMC or another official body (such as court of civilian child protection service agency) that the evidence in a particular case substantiates the belief that maltreatment did occur (Report sent to CCMF) (DoD Directive 6400.1, Enclosure 1, 1981, p. 2).

The Directive was effective immediately. It concluded by specifying that specific program intervention elements to prevent and treat child and spouse maltreatment and to treat and rehabilitate maltreaters should be developed by the DoD Components, based on FAC guidelines.

Response From the Military Services

The Air Force responded to the DoD Directive on November 5, 1981, with a modification of Regulation 160-38, which established their Child Advocacy Program. This regulation was reentitled "Air Force Family Advocacy Program," and the modifications were limited to incorporating "spouse abuse" and "spouse abuser" into the existing child abuse and neglect program regulation. The Army and Coast Guard are now preparing policy

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2 The Case Management Committee is not identified in the text of the Directive. Its diagnostic and reporting responsibilities are outlined in the definitions appended to the Directive. Presumably its membership is comprised of representatives from the local Family Advocacy Committee.

statements and regulations for their respective service branches in fulfillment of requirements under the DoD Directive. The Marine Corps also is developing family advocacy initiatives through its Family Service Program. On July 11, 1979, and prior to issuance of the DoD Directive, the Bureau of Medicine and Surgery (BUMED) in the Navy established a Family Advocacy Program. In fact, there are many similarities between the Navy Instruction and the DoD Directive. The Navy now has in preparation an instruction converting its BUMED Family Advocacy Program into a service-wide program conforming to the DoD Directive.

F. CHAPTER SUMMARY

In the past decade, issues posed by child and spouse abuse have become a national concern. The armed forces have shared in this concern. Response to these problems began with local initiatives directed toward child abuse, and later, spouse abuse. In May 1981, a policy directive was issued at the DoD level. In response to the directive, individual services are now working to expand and to coordinate their family advocacy efforts. Program policies are being issued and modified, and training is being directed toward personnel who deal with family advocacy issues.

The eventual outcome of these policy developments are unknown. One thing is certain, however: policy developments alone will not solve the problem of child and spouse maltreatment in the military. A shortage of funds could seriously jeopardize the best of plans.

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Chapter V

Department of the Navy

Family Advocacy Program

Chapter V
DEPARTMENT OF THE NAVY FAMILY ADVOCACY

A. BACKGROUND

Stimulated to action by the Navy Surgeon General and the medical community, the Navy has been actively involved in family advocacy issues for nearly a decade. Efforts were initially directed toward child maltreatment. Recognizing that child maltreatment involved both medical and social aspects, the Bureau of Medicine and Surgery (BUMED) suggested to senior Navy officials that responsibility for child advocacy be given to the Bureau of Personnel (BUPERS), which would require Navy-wide compliance. However, BUPERS did not take any action and, as a consequence, BUMED began organizing its own program in 1974.

As early as 1975, all 14 Naval Regional Medical Centers (NRMC's) had developed child maltreatment policies and procedures, as had 19 of the 21 smaller Navy hospitals. On February 4, 1976, BUMED Instruction 6320.53 was issued providing policies and procedures for establishment of a Child Advocacy Program within the Navy Medical Department. As concern with domestic violence intensified in the mid 1970s, Child Advocacy Programs at Navy installations were expanded to prevent and treat spouse abuse. On February 21, 1979, BUMED issued BUMEDNOTE 6320 outlining policy and guidance pertaining to spouse abuse. The involvement of BUMED in family advocacy culminated on July 11, 1979, with the issuing of BUMED Instruction 6320.57, creating the Family Advocacy Program (FAP). Chart V-1 shows the structure of the FAP developed at that time, although the current reorganization of the Naval Medical Command will alter this structure.

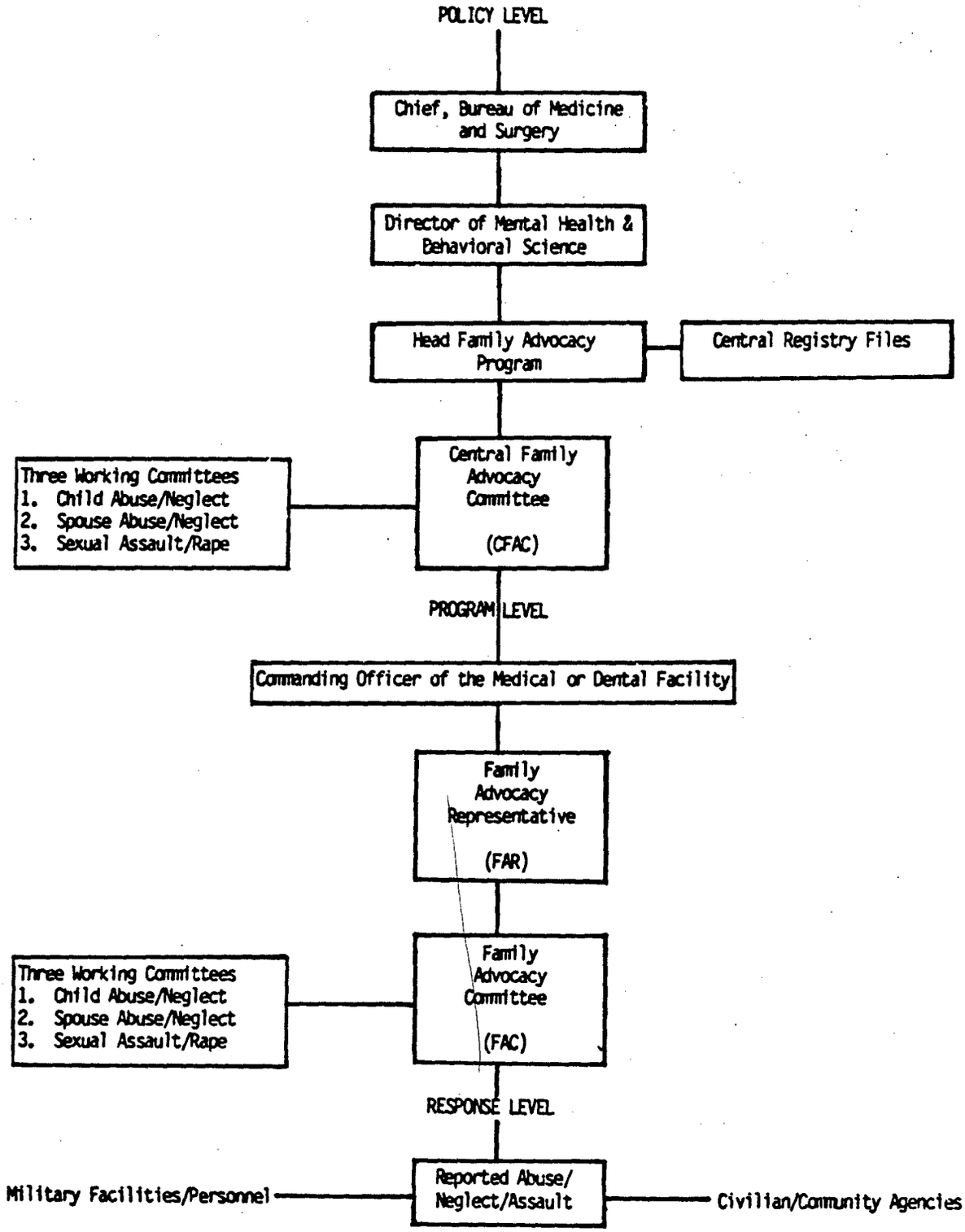
This chapter reviews the scope, organization, and operation of the Navy Family Advocacy Program. It also includes an overview of both the Navy Family Support Program and the Marine Corps Family Services Program. The purposes and histories of these programs are discussed, as are their scope, organization, and role in the Navy Family Advocacy Program.

B. THE BUMED PROGRAM

Scope

The Navy established the Family Advocacy Program (FAP) in July 1979 that provided policy for handling child maltreatment, spouse abuse, sexual assault, and rape among Navy and Marine Corps members and families. The new Program was issued as BUMED Instruction 6320.57 and replaced previous policies for child abuse (BUMEDINST 6320.53A) and spouse abuse (BUMEDNOTE 6320). It also referenced OPNAVINST 5300.1 (dated August 16, 1978) for sensitive handling of rape victims.

Chart V-1
NAVY FAMILY ADVOCACY PROGRAM



Under the program, all BUMED facilities in the United States and overseas were mandated to establish Family Advocacy Programs. The purpose of these programs was to provide strategies for the identification, evaluation, intervention, treatment, and prevention of abuse, neglect, sexual assault, and rape. The need for prevention as well as treatment is clearly reflected in the Instruction:

> An effective FAP not only provides for intervention and treatment for victims of abuse, neglect, sexual assault, or rape, but also provides a preventive program involving identified "high risk" individuals and families, as well as primary prevention of abuse, neglect, sexual assault, and rape. . . (BUMEDINST 6320.57, 1979, p. 1).

Although the Instruction was limited to BUMED facilities, it recognized the importance of interaction between Navy and civilian resources to ensure the success of the program. This point was made clear in the discussion section:

> The nature of family advocacy intervention requires cooperation among various agencies and professional disciplines. Navy consultants and resources associated with medical, line, and civilian agencies must be utilized. These complex interactions were considered in establishing the FAP and developing a program procedures manual. . . (BUMEDINST 6320.57, 1979, p. 2).

For purposes of the Directive, abuse, neglect, sexual assault, and rape were divided into the following categories:

- Physical abuse
- Sexual abuse, assault, and rape
- Physical neglect
- Psychological abuse, and
- Psychological neglect.

Physical and sexual abuse, assault, and rape are applicable both to the maltreatment of children and spouses, as well as to single members, but physical neglect and psychological abuse and neglect are applicable only to children and spouses. Section 1 of the BUMED Instruction provided definitions of terms relevant to the program.

Organization

The Instruction designates the Chief of the Bureau of Medicine and Surgery as responsible for establishing broad family advocacy policies throughout the Navy Medical Department. It also established a Central Family Advocacy Committee with membership comprised of representatives of the Surgeon General, Judge Advocate General, Naval Military Personnel Command, Commandant of the Marine Corps, Chief of Chaplains, and the appropriate commands. An individual at BUMED headquarters is identified as the head of the program.

The Central Family Advocacy Committee is required to convene no less than quarterly and submit recommendations concerning program management and expansions through the program head to the BUMED Chief. It is subdivided into three working committees, each with a chair:

- Child Abuse/Neglect
- Spouse Abuse/Neglect, and
- Sexual Assault/Rape.

Each month the working committees are responsible for reviewing all incidents of suspected or known abuse, neglect, sexual assault, or rape that the Navy or Marine Corps has reported to BUMED headquarters. They also are responsible for submitting recommendations concerning disposition of cases to the BUMED Chief.

The head of the program is required to:

- Ensure that all BUMED activities establish a FAP in accordance with the instruction;
- Assist local commands in implementing the instruction;
- Maintain statistical reports on all suspected cases of abuse and neglect without identifying individuals;
- Maintain a central registry of all established cases of abuse and neglect; and
- Submit program recommendations to the Chief of BUMED.

At the local level, commanding officers of Navy medical and dental treatment facilities are responsible for implementing the Family Advocacy Programs. The Instruction requires commanding officers of Navy medical centers and hospitals to:

- Establish local policies and directives necessary for implementing the local program;
- Designate a social worker or a senior member of the command as the Family Advocacy Representative (FAR), with the primary duties of implementing and managing the local program;
- Establish a standing local Family Advocacy Committee, consisting of the following members, one of whom must also be a member of the command's drug/alcohol program staff:

  - Chairman
  - Lawyer (if available)
  - Pediatrician
  - Gynecologist
  - Psychiatrist or Clinical Psychologist
  - Chaplain (if available)
  - Dental Officer (if available)
  - Social Worker (if available)
  - Pediatric Nurse
  - Health Care Administrator
  - Others deemed appropriate

- Establish a Duty FAR Roster, to assure that a Duty FAR (DFAR) is available to provide guidance and assistance to Medical Department personnel responding to abuse, neglect, and sexual assault incidents; and

- Ensure that all medical facilities subordinate to their installation establish appropriate local directives and reporting procedures in support of the program.

Each local Family Advocacy Committee is required to:

- Convene no less than once quarterly;

- Review management of individual and community problems relating to child and spouse maltreatment and sexual assault incidents;

- Submit recommendations and reports of actions taken to the commanding officer; and

- Divide into three working committees, each with a chair:

  - Child Abuse/Neglect,
  - Spouse Abuse/Neglect, and
  - Sexual Assault/Rape.

Each of the working committees is required to:

- Act as a body and meet not less than once a month to review suspected cases and evaluate the quality of services rendered;

- Ensure that each reported incident of abuse/neglect is reviewed in a timely manner and determine which of the following conditions is applicable:

  - Unfounded maltreatment,
  - Suspected maltreatment, or
  - Established maltreatment.

- Make plans for definitive management of individuals and community situations relating to their respective areas of concern;

- Submit recommendations concerning disposition of cases to the commanding officer;

- Submit reports on suspected and established cases to the Chief of BUMED through the Head of the FAP; and

- Make recommendations to the local Family Advocacy Committee regarding program management.

Naval regional dental centers and dental clinics are also charged with identifying and reporting suspected cases. In addition, they must designate a dental officer to serve on the family advocacy committee of the supporting medical facility.

Operation

Appended to the Instruction is a Family Advocacy Program Enclosure, which provides guidance for program operation. The guidance varies from program suggestions to detailed requirements under federal, state, and local laws, as well as requirements under other military directives. The review of this guidance is presented in seven major categories:

- Case Identification
- Intake and Assessment
- Intervention and Prevention
- Linkage and Interagency Cooperation
- Follow-up Procedures
- Case Reporting
- Program Evaluation

Case Identification

The Enclosure states the belief that community education programs will be a significant factor in identifying incidents of maltreatment and potential cases of maltreatment. General awareness among all command personnel of family maltreatment problems and the existence of a program to deal with these problems is expected to stimulate identification of cases where program assistance is needed. Hence, the Family Advocacy Representative and members of the Family Advocacy Committee at each installation are instructed to:

> . . .establish a continual education effort directed at insuring involvement on the part of all command personnel. This shall include a briefing of the essential elements of the FAP. . . . Briefings should emphasize the importance of this effort and the need for involvement of all personnel within the command (Enclosure, p. 5).

Further, it is stated that public awareness and education campaigns encourage individuals to refer themselves for assistance before they act on abusive feelings. The enclosure stresses the importance of such campaigns in communicating that it is acceptable to ask for help.

The Enclosure emphasizes the need to identify individuals, families, and groups for whom the risk of maltreatment is high. This is considered essential both for initiating preventive intervention as well as for identifying existing cases of abuse and neglect. Among those

considered highly vulnerable are families where the father is absent from the home because of duty at sea or elsewhere. Families experiencing a high level of stress due to illness, disease, trauma, or emotional dysfunction, and familes with a history of abusive behavior, are also considered to be "at risk."

The Enclosure also contains detailed instructions for identifying and monitoring the outpatient medical records of children and spouses determined to be highly vulnerable to maltreatment. It prescribes special training for medical, law enforcement, and other professional personnel to increase their sensitivity to, and handling of, cases where maltreatment or neglect is suspected or has been observed.

Intake and Assessment

The Enclosure requires that each suspected or alleged abuse or neglect incident be reported or referred to the FAR or DFAR. This person then brings the case before one of the Family Advocacy working committees. After reviewing all available case evidence, the committee then diagnoses one of the following conditions: (1) unfounded maltreatment, (2) suspected maltreatment, or (3) established maltreatment. If the committee finds that the report of abuse/neglect is unfounded, a report is made, pursuant to state law, indicating that the committee's investigations revealed no probable cause to believe that abuse, neglect, or assault occurred.

These are the grounds for suspecting maltreatment: "(1) Sufficient evidence exists to warrant a report to appropriate authorities in accordance with applicable statutes. . . (2) A Family Advocacy Committee has reviewed reported evidence and made a collective judgement that maltreatment may have occurred, but insufficient evidence exists to warrant a diagnosis of established maltreatment" (Enclosure, p. 2).

If maltreatment is established, this indicates that a Family Advocacy Committee has collected sufficient information and made a collective judgment that maltreatment has indeed occurred. The Enclosure points out that:

> In addition to the patient's physical condition and information received from family members or collateral contacts, a diagnosis of established maltreatment must be based upon the results of investigations conducted by the Naval Investigative Service; military, state, county, or local child welfare or protective agencies; military law enforcement groups; or those conducted in accordance with the JAG manual. (Enclosure, p. 2)

In cases of established maltreatment, the Family Advocacy Working Committee develops a plan of action, including the medical and other needs of the patient. The Enclosure notes that:

> Abusive and neglecting families are often multi-problem families requiring a carefully developed treatment plan that addresses all of the identified problems. Required services should be ranked according to priority, with treatment at any one time being limited to the ability of the client to realistically become involved and benefit. It may be determined that the abuse/neglect is secondary to other problems and that intervention should focus on the primary areas while assuring the ongoing protection and safety of the victim (Enclosure, p. 5).

The working committees are encouraged to reach a consensus concerning both diagnosis and treatment.

In cases of suspected or confirmed maltreatment, a case file is required. The file must contain a brief statement indicating whether the abuse or neglect was intentional or unintentional, a description of the type(s) of abuse or neglect, and details concerning diagnosis and treatment recommendations. In addition, recommendations for treatment are to be made available to supervisors and civilian agencies. The guidelines stress the importance of interagency cooperation concerning treatment recommendations.

With respect to intake, the Enclosure provides details for handling cases involving hospitalization of victims of abuse and neglect, stressing the dual medical and legal aspects of these cases. In the section dealing with medical investigation of alleged or suspected sexual assault and rape, the Enclosure points out that sex offenses, including rape, are criminal offenses, may be associated with serious injury, and may result in pregnancy or venereal disease. The medical management of cases involving sex offenses, therefore, must be a joint medical-legal function involving appropriate military and civilian criminal justice personnel.

In cases where an abused child requires hospitalization, the Enclosure provides instructions for handling situations in which parental/sponsor authorization to provide medical care is unavailable. Procedures stress the importance of obtaining photographs of injuries or other conditions of suspected victims of abuse, neglect, sexual assault, and rape . When children are hospitalized and abuse or neglect is suspected, procedures stipulate the limitation of examinations and interviews, and the surveillance of visitors.

Intervention and Prevention

Operational guidelines that cover the broad area of family advocacy intervention and prevention are patterned after the medical model. There are three levels of program implementation: primary, secondary, and tertiary. Primary intervention efforts help individuals and families maintain adequate functioning levels. Individuals and families under intense stress also are targets for primary intervention.

Primary prevention activities include community education and publicity efforts that explain how general family problems can lead to abuse and neglect. They also tell where Family Advocacy Program assistance can be found when these problems arise. The Enclosure suggests that certain facilities and programs at military installations should be evaluated and modified to improve their effectiveness in meeting family needs. Examples cited are child care, religion, recreation, health, and dental care.

Secondary intervention is directed toward individuals and families that have been identified as high-risk but have not yet been involved in abusive or neglectful behavior. Services and programs should be geared toward assisting these families to overcome areas of dysfunction that place them in a high-risk category. Families subjected to intense stress include those in which the father is on duty away from home, families where a new birth has occurred, families where limited bonding is observed between parent and child, and families with members recovering from illness, trauma, or emotional dysfunctions.

Tertiary intervention provides services to individuals and families when abuse and neglect have already occurred. At this level, the FAR is advised to learn the full range of treatment resources available in the local civilian and military community and to make maximum use of them.

Throughout the Enclosure, instructions for implementing the various components of the program are interspersed with advice concerning appropriate and effective intervention. One treatment strategy suggested for dealing with stress and conflict is behavior modification. Working with relatives and friends and encouraging both victim and perpetrator to be involved in the decisionmaking process concerning treatment also are recommended.

For established cases of sexual offenses, one intervention responsibility is contained in the Naval Military Personnel Manual. Issued under NAVPERS Instruction 15560, where reasons for discharge are specified, the manual states:

> In cases of sexual perversion, including but not limited to (1) lewd and lascivious acts, (2) sodomy, (3) indecent exposure, (4) indecent acts with or assault upon a child, or (5) other indecent acts or offenses, immediate processing for discharge is mandatory, unless the nature of the offense constitutes an incestuous relationship. In those situations, treatment in the Family Advocacy Program is appropriate (Naval Military Personnel Manual, 1982, Section 34-45).

Thus, certain established cases involving sexual offenses would be removed from the purview of the Family Advocacy Program, whereas established cases of incest would be subject to FAP intervention.

Linkages and Interagency Cooperation

Throughout, the Enclosure stresses the need to establish cooperation among service agencies and linkages between program services. Cooperation is essential to effective program implementation, and it is legally mandated in many areas of the program. In the area of reporting identified incidents of suspected or known abuse, neglect, sexual assault and rape, the Enclosure states:

> The policies and responsibilities of each local FAP will be determined, in part, by the State and local laws and procedures concerning abuse and neglect reporting. All States have reporting laws concerning child abuse, while some may not have such laws concerning spouse abuse. . . The FAR or DFAR, as a representative of the military community will report the incidents to the appropriate local or State agency (Enclosure, p. 25).

Cooperative interaction is necessary because of complex jurisdictional issues and because of the need to rely on civilian agencies that have no military counterpart.

In the discussion of medical investigation of alleged or suspected sexual assault and rape, the Enclosure points out that such cases are criminal offenses. Hence, they are a joint medical-legal matter requiring liaison among appropriate military and civilian legal investigative and protection agencies. The Navy manual specifies the appropriate action for removing a child from a dangerous situation:

> The medical officer, DFAR, or FAR usually lack the authority to remove the victim from a dangerous situation against the will of the parent, guardian, or caretaker. If it is determined that such action is necessary, the appropriate law enforcement agency, family/youth court, and state or local protection agency shall be notified and petitioned to remove and escort the victim to an appropriate facility for medical attention and/or protective services (Enclosure, p. 15).

The Enclosure also discusses the special nature of links and interagency cooperation at overseas sites. Reliance upon JAG recommendations is necessary because of international legal agreements. The JAG should advise appropriate medical and command authority as to what, if any, notification should be made to legal authorities.

Follow-Up Procedures

Follow-up procedures are an essential component of planning for the delivery of medical, legal, or social services. Thus, they should be

incorporated in all FAP Working Committee case files containing treatment recommendations and implementation plans. They also should be contained in reports to the commanding officer covering actions taken. This requirement is mentioned specifically in the Enclosure where the responsibilities of the FAR and the FAC are delineated. The requirement specifies that the FAR and FAC members shall establish internal reporting and follow-up procedures relating to abuse, neglect, sexual assault, and rape incidents. Furthermore, follow up is an intergral part of the manual's recommendations concerning identification, maintenance, and review of outpatient records of children and spouses considered to be high-risk individuals. Additionally, the provisions that require forwarding case records to the receiving command assure a continuation of follow up in these circumstances.

Case Reporting

Three forms are provided in the operations manual for reporting cases of suspected and established abuse, neglect, and sexual assault or rape to the BUMED Central Registry. Where the evaluation of a reported incident results in a decision that the allegation is unfounded, no report is sent to the Central Registry. Cases diagnosed as suspected incidents of abuse, neglect, sexual assualt, or rape are reported to the Central Registry on NAVMED Form 6320/15A. Suspected incident reports are for statistical and planning purposes only, and contain no individual identifying information. All incidents of established child abuse and/or neglect are reported to the Central Registry on NAVMED Form 6320/15, and established incidents of spouse abuse and/or neglect on NAVMED Form 6320/21. No separate form is provided for reporting established incidents of sexual assault and rape, although reporting such incidents to the Central Registry is required.

With respect to local reporting requirements within a installation, the Enclosure specifies that:

> Each command shall develop a means by which abuse, neglect, and sexual assault incidents shall be recorded by the DFAR. These reports are to be the basis for providing the FAR with pertinent information relating to the incidents. The gathering of information must be in accordance with the Initial Clinical Interview Guidelines . . . . The FAR will utilize these reports in establishing working files and determining the course of action for each incident reported (Enclosure, p. 7).

Additionally, the Enclosure requires that all reports of suspected abuse neglect, sexual assault, or rape received by the FAR shall be entered in the Family Advocacy Incident Log immediately upon receipt and shall include the following information: Case Number, Date of Report, Name of Victim, Name of Person Making Report, and Reporting Agency. Identification of the

perpetrator is not specifically required. Also, recording or reporting requirements at the installation level include documenting the diagnosis and treatment recommendations, and the intervention actions taken, reporting this data to the installation commanding officer, and placing this data in the local case files.

The Enclosure states that the Chronological Record of Medical Care (SF600) shall be used to document only medical actions taken and determinations made in each case. It provides instructions for identifying the status of each incident and the file pertaining to it, i.e., working, active, inactive, and closed files. Instructions are also given for forwarding patient files to the appropriate medical facilities in the event of transfers to another military installation.

Program Evaluation

Evaluation of the Navy's BUMED Family Advocacy Program is provided for at six operational levels in the organizational structure. Among the required duties specified at each of these levels is responsibility for assessing program operation and management, and passing recommendations upward through the organizational structure. The six levels are:

- The three local FAC Working Committees
- The local Family Advocacy Committee
- The local Family Advocacy Representative
- The three Central FAC Working Comittees
- The Central Family Advocacy Committee
- The Head of the Family Advocacy Program.

C. THE NAVY FAMILY SUPPORT PROGRAM

Purpose and History

The Navy Family Support Program was created by action of the Chief of Naval Operations in January of 1979 under OPNAV Instruction 1754.1, with the following mission: "To improve the Navy's awareness of and access to reliable and useful information, resources, and services that support and enrich the lives of Navy families and single Navy service members" (p. 1). Its numerous antecedents date back many years, encompassing both official and unofficial entities providing assistance to Navy personnel and their dependents, including the Chaplain Corps, Medical Corps, Dental Corps, Career Information and Counseling Program, and Human Resources Management, as well as Navy Relief and Navy wives clubs. In the early 1970s, additional support for these efforts was provided through the Family Ombudsman Program established under OPNAV Instruction 1750.1A, and the Personal Services Centers established under OPNAV Instruction 1740.IA. The Navy Family Support Program was established in response to major recommendations that surfaced at the 1978 Navy-wide Family Awareness

Conference. Its purpose was to integrate available assistance efforts into a formal program and to improve the delivery of comprehensive services through a Navy-wide network of Family Services Centers (FSCs) at selected CONUS and overseas naval shore installations. Currently there are 22 funded Family Service Centers, with a total of 62 planned by fiscal year 1984. The Navy Family Support Program Branch provides overall policy direction and technical assistance to the local Family Service Centers in accordance with OPNAVINST 1754.1.

Scope

Family Service Centers are mandated to serve not only active duty military personnel and dependents, but also retired personnel and families, the widows and widowers of active duty personnel, and overseas DoD civilians. The primary services offered are comprehensive referrals and information. In addition, the Centers offer personal counseling on a short-term basis, relocation assistance, deployment briefings, and a variety of additional programs, which may vary somewhat from base to base. The latter might include stress-management instruction, parent-effectiveness courses, financial counseling, assistance with income tax forms, or other programs that meet local needs.

Organization

The Deputy Chief of Naval Operations for Manpower, Personnel, and Training is designated as the focal point for family matters in the Navy. The responsibility for developing and implementing plans and policies belongs to OP-15, Director of the Human Development Management Division, in conjunction with OP-156, the Family Support Program Sponsor.

Each of the Centers is administered by Directors drawn from the line officer community, usually O4s-O6s, assisted by both enlisted personnel and civilians. A Chaplain is assigned to a number of the larger Centers. Volunteers may represent a significant proportion of the staff resources. In many cases, ombudsman, who constitute an official link between commanding officers and families within the command, interact closely with Center staff.

Involvement in Family Advocacy

The Family Advocacy Program is being re-examined and reorganized. These changes are occurring because of three factors:

- The issuance of DoD Directive 6400.1 and subsequent DOD funding;
- The existence of the Family Services Centers, which did not exist when BUMED assumed responsibility for family advocacy; and

- The reorganization of the Bureau of Medicine into the Navy Medical Command.

The DoD Directive suggested that responsibility for family advocacy matters should originate at the level of the Secretary of the Navy, and a SECNAV Instruction is now being drafted. Operational responsibility will thus come from the OP-NAV level, as it does now for the Family Support Program. Within OPNAV, the sponsor of that program, OP-15, already has been charged with coordinating policies and guidance concerning family advocacy in conjunction with BUMED; OP-15 also has a more general mandate to provide comprehensive family-related information/programs/services for Navy families and single service members (OPNAV Instruction 1754.1, p. 1). A draft instruction, which will replace 1754.1 when issued, suggests that Family Service Centers will take on additional responsibilities for family advocacy. In particular, the Centers will:

- Play a key role in the FAP;
- Assist in initial counseling and referral of cases;
- Provide or sponsor preventive programs;
- Provide counseling and support programs;
- Provide inservice specialized training for FSC staff; and
- Maintain a working relationship with other related Navy and civilian personnel concerned with family advocacy issues.

None of these proposed or ongoing changes suggest that the Navy Medical Command will cease to play a critical role in responding to victims or perpetrators of abuse and neglect. It simply means that their services are to be augmented and complimented by additional ones, and that compliance with the SECNAV instruction will be a Navy-wide responsibility.

D. THE MARINE CORPS FAMILY SERVICE PROGRAM

Purpose and History

In March 1980, the Marine Corps established a Family Service Program which was to coordinate the creation of Marine Corps Family Service Centers (MCFSC's) at major field commands. This program is administered by the Family Program Unit (Code MPH-25) at the Headquarters level and was established by White Letter 7-80 (March 14, 1980) in which the Commandant required commands at 15 locations to establish Marine Corps Family Service Centers by year's end using their own local funding, personnel, and facilities. This program was in keeping with an earlier White Letter 9-79 in which the Commandant expressed concern for the Marine Corps Family by emphasizing the importance of maintaining "an atmosphere within the Marine Corps in which family life can prosper. . ." (September 13, 1979). The

Marine Corps Family Service Centers were to address two major problem areas: (1) lack of family awareness of available services and (2) lack of Marine Corps awareness of family needs.

Scope

By 1981, there were 17 MCFSCs in operation. Their primary functions, similar to the Navy's FSC's, are information and referral, personal and financial counseling, deployment briefings, family enrichment programs, and relocation assistance. In addition, MCFSC staff are to participate on all community advisory committees that deal with Marine Corps family needs.

Organization

Large MCFSCs have eight staff members, smaller ones have six. The large centers are administered by majors (O-4s), the small ones by Captains (O-3s). The staffs include assigned chaplains, staff NCO's, enlisted, and contract civilian social workers. It is estimated that the MCFSCs now serve 85 percent of Marine Corps families. For those on independent duty who are not in close proximity to a Center, there are two toll-free information and referral telephone lines to referral specialists at Quantico and Camp Pendleton.

Involvement in Family Advocacy

Because the Marine Corps is served by Naval medical facilities, their link to the existing Family Advocacy Program is similar to the Navy's: MCFSC personnel sit on Family Advocacy Committees both in local areas and on the Central Committee at the National Naval Medical Center in Bethesda, Maryland. In August and September of 1982, the Family Program Unit sponsored training workshops for Marine Corps personnel in family advocacy areas.

MPH-25 is at this time drafting an order that will considerably expand the scope of MCFSCs in awareness and prevention aspects of child and spouse abuse. This order includes the appointment of a Family Advocacy Officer, preferably the MCFSC Director or staff member, mandates that orders be written at the local level, and encourages the issuance of concurrent orders by both hospital and base staff in matters pertaining to family advocacy.

E. CHAPTER SUMMARY

The Navy Family Advocacy Program was developed under the auspices of the Bureau of Medicine. Policy was provided for handling child maltreatment, spouse abuse, sexual assault, and rape among Navy and Marine

Corps personnel and families, and program guidance was offered in the areas of case identification, assessment and follow up, as well as prevention and interagency cooperation. The establishment of the Navy Family Support Program and the Marine Corps Family Service Program created additional resources in the form of Family Service Centers, which are beginning to play a major role in family advocacy education and prevention.

The Family Advocacy Program is currently being reorganized. Although the Navy medical community will continue to play a critical role in responding to victims and perpetrators of abuse and neglect, Navy and Marine Corps Family Service Centers will be assuming more responsibility for the program.

Phase I Conclusions

PHASE I. CONCLUSIONS

Phase I of the research completed a reconnaissance of the existing and available literature from civilian and military sources on the subjects of child and spouse abuse and neglect, sexual assault and rape. Data limitations have been discussed in the introduction of the report. In summary, concerning the prevalence and nature of abuse and neglect in the Navy and Marine Corps and the Department of the Navy's response to these problems, the findings indicate:

- Little data exists on the incidence, prevalence, nature, or distribution of child and spouse abuse and neglect, sexual assault and rape in either the Navy, Marine Corps, or other military services and data exists in limited scope and quantity for civilian populations.

- Military studies on need conditions and program responses have been difficult to obtain, shallow in depth, limited in number, and contradictory in findings.

- The Department of the Navy has adopted adequate definitions of child and spouse abuse and neglect, sexual assault and rape to begin and support need identification and service responses.

Concerning the condition of military responses to needs of military personnel and families, the findings indicate:

- A variety of educational conferences and workshops have been conducted in recent years to educate professionals to the sensitive issues of abuse and neglect, but there has been limited professional training to assist military policy and program designers, budget officers, service practitioners, and associated civilian personnel.

- Detailed policies have been issued by the Department of Defense and the individual services providing responsive goals and general philosophies. However, there has been no issuance of specific objectives to be achieved within specified time periods and there has been limited funding to support new or expanded service operations.

- Except for a partial evaluation of the Child Advocacy Program which began several years before the Family Advocacy Program, there has been no program assessment to indicate the success of the military's response to abuse and neglect to date, and there has been little effort to seek out and learn from civilian program models.

Phase II of this research project will collect a limited amount of data on the incidence of abuse and neglect and the types of families experiencing these problems. This information should provide a better basis for determining and examining service responses provided by the

military, although it in no way can substitute for the detailed collection of data on a regular basis which could be made available through a survey of the incidence, nature, prevalence and distribution of abuse and neglect and through required and organized reporting mechanisms operating on all Navy and Marine Corps installations.

Additional data will be obtained to assess need patterns and current service responses through twelve site visits to Navy and Marine Corps bases in the United States, Europe and Asia. Interviews with medical and human service professionals responsible for family advocacy prevention and intervention will be the primary source of data.

Information to be gathered on Navy and Marine Corps program responses will include: structure and organization of the Family Advocacy Program, case identification, intake and assessment procedures, information and prevention strategies, jurisdictional issues, interagency cooperation, follow-up procedures, case reporting and management, training needs, and program recommendations.

Collection and analysis of this new data will be based on preliminary hypotheses which will be tested and refined as the research progresses:

- The incidence of abuse and neglect is at least as common in the military community as it is in the civilian population.
- Factors associated with abuse and neglect in civilian communities will not necessarily have direct application for military communities.
- Various factors interact to create a situation promoting or contributing to abuse and neglect: the occurrence of any abuse or neglect incident cannot be explained by a single factor or indicator.
- Explanations for abuse and neglect behavior will be found in factor combinations of past learning, personal and social stresses, and inadequate community linkages and supports.
- There is a traceable cycle of abuse and neglect in family generations which can be identified, examined, and treated.
- Preliminary profiles of potential abusers and neglecters in military communities can be developed from combining Phase I data with information from the Central Registry Files of established cases of abuse and neglect.
- The success of intervention programs and techniques will be based on the degree that social-medical-legal-judicial service linkages are established and work together in cooperative and coordinated relationships.

- Given the history of the family advocacy movement in the military and the availability of civilian resources to augment military resources, the program responses to child maltreatment at Navy and Marine Corps bases should be more fully developed than those for spouse and sexual abuse.

- Critical follow-up of victims and offenders occurs in direct proportion to the confidentiality of data and privacy of service settings provided to them.

- The level of program support at each base is in direct proportion to the policy goals and resources visibly provided by the commanding officer of that base.

- Benefits to the military and individual families from treatment and prevention program investments can be translated into cost savings information for the Department of Defense and the Department of the Navy.

- Existing civilian and military intervention and prevention models can become training modules for Navy and Marine Corps leaders and professional practitioners.

From the data base obtained in Phases I and II, policy and program recommendations will be provided in the Phase III and final project report.