

Susan Speaker: This is an oral history interview with Dr. Jacquelyn Campbell of Johns Hopkins University School of Nursing. We're going to be talking today about the origins and evolution of the domestic violence prevention movement in the 1970's, 1980's and beyond. I'm Susan Speaker, a historian at the National Library of Medicine. The date is November 2, 2012 and we are at Dr. Campbell's home--or outside her home in the lobby, because she's having renovations done--in Baltimore, Maryland. I wanted to start out by asking you where this all came from. How did you get into nursing and what sort of set you on this path?

JC: Well, I grew up in the 50's and my father, who had never gotten to go to college himself--he was a child of the Depression--was very invested in his children going to college. And as the girl, I was told--there were two of us at that point; I later had a younger sister--but I was told that I had the choice of two professions. I could either be a teacher or a nurse, because then if my husband died, or for some reason I needed to make a living, I would be able to get a job.

SS: Okay. (Laughter)

JC: And so, my mother was a teacher and I didn't want to do what she did, and so I decided I needed to go into nursing. And he was also very prescient in terms of saying that I needed to go to college to go nursing, not-- we had a local hospital--

SS: Just a two year degree.

JC: Right, a local hospital that had a nice diploma program, and he said, "No, no, you have to go to a college," and he-- we lived in a small town, Jamestown, New York. He went off and talked to our family physician and I don't know who else, and came home and said, "These are the three choices you have of places to go." (Laughter) And he said, either Duke University or University of Rochester, or at that time another good school of nursing was University of Michigan, those are your choices. So, I looked into all three. Duke was far more beautiful in terms of the campus. Plus it was far enough away that I could get away from home as well. So that's why I picked Duke. And I was lucky enough to get a scholarship and it was actually relatively inexpensive then. The tuition was less than either the University of Rochester or the University of Michigan. And I really did love my nursing education. I really liked doing all of it. And then when I graduated, I had gotten married after my junior year. And my husband then got a job at Inland, which is one of General Motors' plants in Dayton, Ohio.

[It was a] Small town, so I-- and I actually didn't even go ahead of time to try and get a job. I put some applications in at the hospitals. And I'll never forget, because I was offered a position in one of the hospitals for three dollars an hour, that was in 1968. And I said, "Well, I have a Baccalaureate degree, don't you have a differential?" He said, "Oh, that's right, three dollars and one cent an hour differential." (Laughter)

SS: Oh, boy, I bet you were excited.

JC: Yeah, right. So, I worked there. It was a small hospital, a very different nursing atmosphere from Duke, where we were encouraged to be autonomous and think for ourselves and really carry on a different nursing role from the physician's role. But at that hospital it was very much that nurses were at the-- we did whatever the physician told us to do, more or less. And nursing

care was a separate thing at that point in that hospital. So, I wasn't very happy in that although I loved-- it was a pediatric floor and I loved taking care of the kids. So, I got a job at an inner city high school, in part, because it had much better hours instead of the day shift. You know, you got weekends off and you didn't have to work at night, and also it was close to my now ex-husband's work, so we could go in together. We only had one car. You know, so it was practical; and ahead of time people were saying, "Oh, that's really the-- that's the rough part of town. That's, you know-- that's-- are you sure?" You know, they would say to him, "Are you sure you want your wife to be working there?" and it was an all black high school in the inner city on the other side of the river--we didn't have tracks, we had a river--but I loved it. I loved working there. I loved [it] you know, because I was my own boss. I got to decide what my priorities were. I mean we were part of school nurses in that city, and we had people we reported to. But you really got to set a lot of your own priorities, and I really got to do all kinds of things that I thought were incredibly important working with the students there and with the faculty, and did a whole bunch of things. That was great. So, I did that for four years. I would have stayed there the rest of my life, the rest of my career if life hadn't intervened. But, I was pregnant and so I-- (Laughter) I left to have my first child. And I was being urged at that point by my supervisor in the school nursing world to go back and get my Master's. So, I was kind of thinking about that and about three months after Christy was born, I decided that actually I didn't do well as a full-time mother (Laughter) plus, we couldn't afford it. That was a problem too. So, I decided I needed to get back into working and I did some childbirth education for a while, that was great. I then worked for an adolescent psychiatrist and did intake for him. Then I did some teaching part-time at our community college and I really liked that in nursing, but that was, you know, sort of a part-time thing. And then I became a therapist for an inner city community health agency, I mean a community mental health agency and I loved that; that was in the same neighborhoods where I'd been a school nurse. So, I was very connected with that community and I really loved that. And then I started back to school. So, I'm getting my Master's and we were--and I'm working part-time and raising by then a second child, so two little kids, and so our--the Master's program and I picked it only because the closest one that had a Master's program in nursing was--

SS: Where was this?

JC: In Dayton, Ohio. So, it was Wright State University. It turned out to be a very good program and I had fabulous faculty. And Peggy Chinn was one of them, Joann Ashley, who, both of them guided me incredibly well. So, one of my assignments was to go out into the community and do some prevention work with an identified group. So, I knew that a lot of the young ladies who had graduated from the high school I worked at were living at the downtown YWCA. And back then--and that was-- by then it was like 1975, I think and so, that was a place where they could live independently. They didn't have to have a whole lot of money, but they could be away from home.

SS: I remember the YMCAs and YWCAs--

JC: And YWCAs, yeah. And so, I knew a lot of them were living there because I kept in touch with a lot of them, and so, I formed a small group and I figured I'd be working with them to prevent something. So, you go to the mortality tables, and I'm trying to find out what is the

number one cause of death for young African American women, and it was homicide. And I was like oh, well, I don't know what to do with that. I'm a nurse; you know, that's criminal justice stuff or whatever. So, I said, you know, what's number two? And you know, maybe I could prevent that. And my faculty who were very wise, they said--the line I always use is "No, no sweetheart. You don't get to go to number two. You get to find out how to prevent homicide, if that's the number one cause of death for these young women. You better figure out something about it." And so I read what I could. I tried to figure out what's going on, and there wasn't much in the literature and there certainly wasn't anything in the health literature about homicide of women, homicide of young women. And so, my wise faculty said, "Well you have this thesis you have to do, so why don't you find out some more for your thesis?" And so, I did my Master's thesis in nursing in the Homicide Department in Dayton, Ohio. And I reviewed all of the records where women had been killed or had killed somebody. There weren't that many, and I did sort of a combination, now we call it mixed methods combination, qualitative and quantitative [analysis]. I read all of the records and the homicide records and looked at whether-

SS: This was for the City of Dayton?

JC: The City of Dayton, and I still, in fact, I gave to the National Library of Medicine--I have the spreadsheets that I filled on each case and checked on, you know, identified common factors amongst them and checked it off and wrote copious notes from it. And all of them had photographs and I could still tell you about some of those photographs. You know they really are seared in my brain. And I remember all of those cases incredibly well, and what I found, which is not a newsflash now, but the major commonality amongst them was that women were being killed and it was whether they were white, black or purple, you know. We didn't have any purples (Laughter) but anyway, we mostly in Dayton had white and black. They were being killed or killing intimate partners and you know its husbands, boyfriends, ex-husbands, ex-boyfriends. And the major common feature beforehand is that there had been some notation there was domestic violence beforehand. And the police had been called and they had gone out, or someone that they had interviewed, a family member, said that the man had beaten her up before she killed him or vice versa. The man had beaten her up before he killed her. And it was domestic violence against the woman that was so striking.

SS: How many cases were in this first study? Do you--

JC: It was actually 49. You know, 25 women who were killed and 24 who killed.

SS: That evenly divided? That's interesting.

JC: And that's one, yeah--back then when you look at the national data back in 1976, which it goes back to, that's exactly what we see is it's almost equal between men killing women and women killing men. Now we have more like a four to one or five to one ratio, there's far more women being killed. That's also interesting in terms of what's contributed to that decline, especially in men being killed. But yeah, and it was just so striking though that the women who killed their partners also had been beaten up before they killed anyone. So it didn't matter which way it went and I lived in Dayton, Ohio as I said. And about three or four years after I did that study and published it, the governor of Ohio, who was Governor [Richard] Celeste back then,

actually did a project, an Innocence Project type of thing for the women who had killed their batterers. And a few of the women in my caseload actually were released from jail after they did a better review of the circumstances leading up to it. That was exciting. That was sort of my first foray into the policy realm. Because I was able to contribute some information to their--when they were reviewing those cases. I wasn't actually on the commission that reviewed them, but that was very exciting and really felt like something I did made a difference. And so that, that was very important.

SS: Do you think your advisors kind of knew what you were going to find when they pushed to do this? Or was it just--

JC: I don't think so. You know, Joann Ashley was a historian. And that was--she did research on history, so she helped me apply some historical methods to what I was looking at. Peggy [Chinn] was a feminist--but the whole domestic violence thing really wasn't on a landscape back then when I first got started. It only started to be as I was reading for my thesis. There were some books that came out that were incredibly relevant and some articles that came out like Evan Stark and Anne Flitcraft's article came out when I was writing my thesis. I remember discovering it and being just thrilled that someone else in the health field was thinking about these things. And [Russell P.] Dobash and [R. Emerson] Dobash's famous book came out during that time. Also during that time there started to be domestic violence shelters being formed. So, you know I decided and--I mean it was amazing to have a thesis that that clearly gave me a roadmap for the rest of my life. So, there were also some notations in the interviews that some of these women had been in the emergency department before they were killed. So, clearly number one, I needed to absolutely reform the healthcare system. (Laughter) Change it so that we did a better job of identifying abused women; and I needed to, if I was going to continue to teach nursing, I needed to get it into the curriculum and nurses needed to know about domestic violence. And I also needed to volunteer in shelters, get to be helpful from that standpoint because that was clearly what was going to provide some safety for abused women in this country. So, it was very exciting to have the shelters be starting and when I-- then my husband was transferred to Detroit as I was finishing up my thesis. And my last class was a teaching practicum, so I did it at Wayne State University and then I got a job at Wayne as beginning faculty once I finished my Master's. And I started volunteering in the shelter there in Detroit, and I led the support group for years. And we tried, myself and another colleague that has worked with me in the field ever since, Janice Humphreys--we tried to set up some healthcare services in the shelter for women and children and basically that was she and I. (Laughter)

SS: The lone rangers.

JC: [We'd] Volunteer for a few hours every week and see women and children for healthcare problems. But it's a model that many shelters have adopted and other shelters around the country were starting to use nurses in that capacity. So, we weren't by ourselves entirely. Then we decided that we ought to be teaching a course about family violence in our school of nursing. And our Dean was very supportive of putting that on the books, and so as we were developing the course, we were like, "What are we going to use as a textbook?" And we said, "Well, there isn't one."

SS: “We'll have to write one.”

JC: (Laughter) So, we'll have to write it. And you know looking back at it (Laughter) you know it's great to be young and ambitious and think, you know, “Well, we just have to change this world, don't we.” And the other thing that was amazing about this was that along the way we were in contact with other nurses, a few around the country that were doing this, and we got in contact with Anne Flitcraft and Evan [Stark], in terms of trading ideas on how to fix the healthcare system.

SS: Yes, I was going to ask about how the idea spread and what kinds of professional networks you were able to develop. Did you—well, you said you started out with nursing and--

JC: Yeah, but also medicine, and Anne [Flitcraft] is the first example of one of the physicians, but I've since gotten to know other physicians in the field that have provided leadership for the medical field. There were relatively few of us back then, so we really all did get to know each other quite well. And we would go to different meetings and those kinds of things and we-- when I went back to school again to get my PhD, because I'd figured out that if I was going to stay in academia--and I really did love the teaching nursing and being able to combine that with my service to shelters, etc., that was considered very legitimate and could combine that with an area of research. So, I clearly needed to go back and get my PhD and again, followed my husband to Rochester, New York, which is the University of Rochester, which is where I got my PhD. And I was able to find there an advisor, Carol Anderson is her name, who encouraged me to do my dissertation on domestic violence. So I was able to continue following my passion. And while I was there the Surgeon General, [C. Everett] Koop-- the backdrop to that is first of all, the attorney general at the time who was, I'm blanking on his name, but anyway the attorney general at the time did this task force and held hearings all around the country around family violence. And although it was the domestic violence movement, a lot of the governmental figures were a little nervous about that because it really was very feminist in the orientation, and the founders of the shelters, etc. And so, the family violence umbrella, which is certainly incredibly important, the child abuse issues had already been on the map but--and we do see intergenerational transmission of violence and we see elder abuse too. So, yeah, the family violence [focus] makes sense. So, the attorney general held these hearings all around the country and they came out with a report on--and it was like the Attorney General's Task Force on Family Violence. And I think, really, that Koop, who was a wonderful-- he was a pediatrician originally, and you know he did tremendous things for public health--but I think in part it was his convening of-- it's the Surgeon General's Task Force. The attorney general the name is something different, but Koop convened this task force of his own in terms of violence as a public health problem. And there seemed to be a little bit of rivalry between the two--you know, “don't take it totally out of the health field,” which was great. I mean, I'll be forever grateful because it was the first time that it became officially a public health issue. And I was lucky enough to get invited. One of the faculty at University of Rochester was an expert in child abuse and she got me, she wangled me the invitation.

SS: What year was that?

JC: That was in 1985. And that report really did put the whole issue on the landscape, plus it brought together all of us in the health field that had really started to write about it, think about it, do studies on it, care about it. So, we got to know each other also. And I'll never forget the nurses had sort of a side meeting while we there to make sure that our voices got into the report and Ann Burgess--who did incredibly groundbreaking work on rape in 1976--also wanted to make sure that it was "violence" writ large, so that rape and sexual assault would be part of the conversation as well as the domestic violence and the other forms of family violence. So, that was also incredibly important. And those of us, the nurses that were together, we decided we needed to have our own organization, by George. And again, there was--let's see there must have been twelve of us there, fifteen of us there, and we had our own conference and started our own organization, the Nursing Network on Violence Against Women International. Chris King is actually the founding mother of that. Our first meeting was at U Mass Amherst, and we've been meeting every other year since then. So, at that first meeting then we met some other nurses and many of us were writing our dissertations at that time or just finishing. So, we were all relatively junior in our careers, and there were only relatively few of us and we were scattered all over the country. So, we really became very close and we still are. I'm very close to all of those people.

SS: I think the battery might be getting low on this.

JC: Sure.

SS: Let me pause here just for a minute and we'll pick it up after I put new batteries in this little beastie.

[Interview pause]

SS: Okay. So, it's the mid 80's and you guys have all been sort of working on this and you're coalescing into a real organization and—

JC: Can I go back?

SS: Do you want to finish that thought?

JC: 'Cause there's one piece of the early stuff that I forgot to tell.

SS: Okay.

JC: When I was a school nurse, one of the students at that school that I became very close to whose name is Annie, or was Annie, got pregnant while she was in high school and her parents were very distressed about this pregnancy, so she ended up getting her own place, which is very unusual for a young black women then and still now. And so--and back then, girls had to quit school if they got pregnant. So, we actually were able to get through this new policy and we were able to keep the girls in school. And I actually taught some prenatal classes, I remember when I was pregnant myself, that was fun, (Laughter) it was fun. But--so, we were able to keep Annie in school so that was really important to her and to me and the other girls too, but I was

particularly close to her. And I also knew the father of her baby--her boyfriend, Tyrone--very well, a charming young man and just very charismatic, very popular in school. And so she--when I left, when I was pregnant, I knew where she was and we kept in touch, et cetera. And I would see her every few months and I knew that she and Tyrone were having some disagreements. She talked a little bit about their--that they were not on the best of terms through that. Her baby was born, I was actually godmother to the baby and the little one was [named] Tyree. And when I was--ironically you know, the fates conspire sometimes--but while I was writing up that thesis, Tyrone killed Annie. And when I looked back at it, you know, I thought, well, he was abusing her, you know. I saw bruises a couple of times and I was just too dumb. And when she would tell me about the arguments--it makes me cry still, you know--I just wasn't smart enough to, you know, find out more. And so that was just one of those things that make me sure that's what I had to do for the rest of my career, was to work on those issues and help us in the healthcare system identify the women who are abused. Okay. So, we're back to the 80s.

SS: Yes, and I want to sort of backtrack and ask what were you guys up against in terms of the healthcare system and also, of course, the police and the court system?

JC: Right. Several challenges, one of which was, as I mentioned, that the whole domestic violence movement was considered very much a feminist movement. Part of the issue around that was--both for nursing as well as for medicine--that feminists were considered ideologues, et cetera. And those that were leading the domestic violence movement *were* very radical feminists, perceived of as strident in some ways. And those of us in nursing very much collaborated with them. But there was some uneasiness, and there is from both sides around the domestic violence movement, folks not wanting to medicalize the problem. You know, in other words, not to--if he's a substance abuser as well as a batterer, not to blame it on the substances, not to excuse him because he's mentally ill, you know, none of those things; that it needs to be confronted as violence and around power and control of women around the--

SS: Patriarchal.

JC: --Unequal--the patriarchal kinds of notions. So, they were a little suspicious of us because we were very much interested in some of the health outcomes for women particularly, and also what some of the health issues were for the abusers. We also--when we worked with abused women, oftentimes women would say, "I don't want to leave him. I want to help him get over this violence business and, you know, and be different. I want him to continue to be the father of my children." And this is still true. And they would often times say, "Well, yeah, maybe he does control me in certain ways but, you know, that's not the major issue. I still love him." And many in the domestic violence movement would say, "Well, she just doesn't understand." You know, (Laughs) you know, "If we just helped her understand..."

SS: Yes, I can remember hearing that.

JC: All right, the power and control kinds of things. Then she would understand she needs to leave--and their major solution for each battered woman was that she left him. And that he be held accountable for abusing her which oftentimes mimicked a criminal justice kind of solution.

And she's saying, "Well, you know, I don't want him to be arrested." And especially, that's even more true now when there's so many--especially for African-American women--there's so many black men incarcerated. It might be his third strike, you know, there's many issues with that lens. And sometimes, they do need, by George (Laughs) criminal justice action, but not always. And we want to try some other things first, I think, and that's what women want. So there was that kind of tension in terms of the challenges.

We also had challenges from the medical establishment in terms of--many times, physicians would think that they need to lead this healthcare response. But they weren't sure that it was really a physician's job to do this. And nursing research in the field didn't always get to the policy realms. It wasn't always as large or as well funded as some of the research from psychology, or from sociology, or those kinds of fields. So, that was a challenge too. And also to get funding for the research continues to be a challenge for nursing. To have it be a legitimate part of the nursing discipline, the nursing body of knowledge was a struggle, I think, that one we've achieved well.

SS: When you first started working these things into the curriculum, did you find a lot of denial and pushback from your students or from, indeed, some of the doctors that you were working with?

JC: Students, never, and where I have been, I've not had any trouble getting it into the curriculum. And there's been some--you know, there always is in nursing, there's so much to teach our students. You know, the field keeps changing, there's something like, "Well, we don't have enough time for this." But we've been able to--in most of the schools of nursing and there was actually a survey done, there's at least some attention to domestic violence in the curriculum, there's at least a few lectures and everything. And what's been interesting, I mean, and this is both a challenge and an opportunity. One of the things I realized early on is that there is much more concern around the abuse during pregnancy piece because, you know, there's an innocent child.

SS: Another life is involved.

JC: Involved, you know. There's a baby here. And so, that's oftentimes been the wedge by which we get on all of the different maps and in the--like the obstetrics-gynecological medical field has always been on the forefront of all of this. And so that's been a wonderful collaboration between nurses and physicians. And because nurses do a lot of the prenatal care, work hand in hand with physicians in doing prenatal care, those alliances have been in place for a long time already. And the Association of Obstetricians and Gynecologists was on the forefront in terms of saying, "This is a healthcare problem, this is something we need to address." And that's been a wonderful collaboration over time and continues to be. But in other parts of the healthcare system there's been, you know, continued, "[We're] not sure we have enough time to spend the time asking about domestic violence, not sure there's the evidence that it's really helpful", and everything is about cost-benefit ratios and all that kind of thing now. So, there continues to be some pushback on that. We've recently made some fabulous inroads but part of it has been the research that we've done that's documented these healthcare problems and that's been very much interdisciplinary research. Also, nursing and other public health [fields] and the medical profession have all worked together on that body of knowledge. I'd say, as I



mentioned, one of the big challenges has been to get funding for this area of research from the National Institutes of Health because the NIH is very much organized around organs and diseases.

SS: Bioscience.

JC: Yeah, (Laughs) you know, so yeah. And violence research used to be funded under NIMH [National Institute of Mental Health] but now, they're very much more [saying] either it has to be a major psychopathology or it has to--the genetic kinds of processes are much more part of it. So, NICHD [National Institute of Child Health and Human Development], thank goodness, has recognized violence as a major health problem for children and childbearing families, so they're very supportive of it now. But like the National Institute of Nursing Research does not fund violence research per se. And it's in part because each of the institutes has to pick their priorities and they don't want to overlap.

And we're supposed to be all interdisciplinary now. But it has--the funding for the research has been a challenge over time. And it's been difficult many times for some of the other investigators to get funded in the field.

SS: And yet, this is the same research that you really need to do to be able to support your case.

JC: Right, to document--

SS: This is a major--

JC: --Health problem, yeah.

SS: --health problem on all kinds of different levels, yes.

JC: Right, yeah. One of the new things that we're working on is traumatic brain injury as a result of domestic violence and that some of our new data is very supportive in that, we're trying to get some funding to look at that. But again, one of the challenges is, well, we have a real problem with traumatic brain injury with our returning veterans. And so people really want to focus on that; and rightfully so, that's okay, or athletes, you know, and yeah, that's very important too. But you just think about, I mean, it just makes perfect sense. We know what happens to boxers when they get hit over time and we know that women oftentimes have choking—"nonfatal strangulation"—against them with periods of anoxia to the brain. We know that abused woman, we have several different epidemiological studies showing that they have more central nervous system symptoms, memory problems, those kinds of things, and you're like--(Laughter).

SS: "Hello, yoo-hoo!"

JC: You know, so when an abused woman comes to the emergency department with a fractured jaw or a black eye, we should be doing a post-concussive workup on her. We should see what other head injury she's had; but those protocols are not yet really being applied to abused women. So that's one of the new areas that I think nursing is particularly well suited to look at,

because we've always been holistic. We think about the neurophysiology as well as the behavioral, as well as the, you know.

SS: Yes, you're not just looking at the immediate presenting problem. And you are--

JC: Exactly, and it's not only--and this was what my dissertation was all about, is not only about helping her achieve safety. Absolutely, you know, that's something we want, to decrease the violence. We want to help her figure out how to do that. But it's also addressing her health problems that she's had as a result of being abused, and how do we intervene appropriately with those, and help take care of her health while we're either helping him be less violent and/or she goes through a process of leaving. So, you know, and the other thing we're working on is the HIV /domestic violence intersections. And that's been recognized for a while but it's been mainly around behavioral. You know, it's obviously very difficult if not impossible to negotiate safe sex with somebody who's beating you up and/or forcing you into sex. But what we're also realizing now is that continued stress on the physiology results in some immune system dysfunction. And because women who are abused have much more STIs [sexually transmitted infections]. I loved when you said "VD," [in a pre-interview conversation]; that's my language from way back, but anyway, you know, [it's] the STI language now. We know that also has some immune system downstream result. And then, by George, the immunologists have taught me that the HIV virus actually crosses the vaginal tissue much more easily if there is immune system--autoimmune system stuff going on, which abused women have both from STIs and/or the stress stuff. And so, is that part of it-- not just that she's not negotiating safe sex, but is that part of that easy transmission? Is that why we see abused women with so much more HIV? And there's some evidence that at least women in Africa proceed more quickly from HIV positive [status] to full-blown AIDS? And that immune system dysfunction that's going on for abused women, is that part of that, and is that why women are dying so much more of HIV? And we see that in this country too, for the young black women that, you know, now--it used to be homicide, now, HIV/AIDS is the number one cause of death. Number one cause of death for young black women; and you're like, "Whoa," you know. And I'm not saying domestic violence is all of that picture, I'm saying let's think about, is it not a piece of that picture? And if we're not working on that angle as well as the other angles, we're missing the boat.

So, you asked about challenges--there have been many but there's also been such incredible rewards. I mean, seeing the laws change, seeing the police response so much better, seeing the healthcare system much more responsive to the issue. They're at least not saying, you know, "Oh, that doesn't happen." The data is clearly--

SS: Or "it's her fault" or, you know.

JC: Yeah, nobody does that anymore, thank goodness; that there is recognition. We're seeing a lot of domestic violence in the healthcare system. There's increasing recognition of how it is related to various healthcare problems. Part of it is like the ACE [Adverse Childhood Experiences] study that was done at CDC [Centers for Disease Control], the adverse childhood events that really showed that, in terms of when you experience violence and trauma, you know, affects your health for the lifetime. So, although the challenges have been there, the changes have been monumental and I always like to think that I've had some small piece in making all that happen.

SS: It sounds like you have.

JC: But it's only been some small pieces, by working with--in collaboration with these other entities. And, you know, one of the things that, in terms of my work, has been the Danger Assessment [Screen] which--

SS: Yes, I wanted to talk about that.

JC: Yeah, yeah. So, we can launch into that or I can wait 'til you ask or--[laughs].

SS: No, we can talk about that now because part of the whole history of this is a lot of different people working on not just, you know, saying "the problem is here and we better pay attention to it." But developing the concepts for thinking about how does this happen and why does this happen? And why don't women come out? And why don't they leave their abusers? And all these other very messy social questions, as well as the sort of entrenched patriarchal, if you will, responses that were very typical in medicine and in the judicial system.

JC: Yeah, and part of the challenge--

SS: So, you need the tools, you know.

JC: Yeah, right. And part of the challenge has always been, at least recently, is [the perception] that well, women are equal now in this country, you know, so this patriarchal stuff no longer applies. And, you know, it's not that she's in a position of less power, you know, that's--all of that analysis is no longer relevant and--

SS: So, is it sort of in some ways a victim of its own success and that people assume that, "Oh well, women are liberated and they've got more rights and responses and more resources"?

JC: Right, and then when people count violent acts, actually, women are fairly violent in relationships also. And we have trouble sorting out when it's in self-defense and when, you know. "She started it" and all of those kinds of things. So, there's people that go around counting violent acts and saying "Well, women are as violent, if not more so, than men." So, that challenge continues even though in terms of impact and severe injury and health problems et cetera. There are men who are abused, there are couples who are mutually violent but there are far more women who have serious injury impact and die now from domestic violence than men. So, we need to raise our kids to neither be violent toward each other but we also need to continue to be concerned about women. But the Danger Assessment [Screen] was [from] when I did this study of homicide and I'm talking to more and more abused women, I'm doing a support group so I'm talking to them then, I'm identifying abused women in the healthcare system--

SS: And this is the early 80s?

JC: Yeah, this is early 80s. So I'm talking to abused women in the healthcare system, and I'm usually out there with my students, and they're identifying abused women, and they're--'cause I make them ask. And so they're identifying abused women. I'm actually having students come to me 'cause they hear I know about this stuff, and tell me their stories. And sometimes, when I would hear their stories, I would think, "Oh my goodness, this is too much like some of those homicide cases that I reviewed. This sounds really scary. There are things about this story that she's telling me that really resonate with those characteristics I identified in my thesis. But I seem to be much more scared than she is." And that was the clinical reality that we've since verified with data. That--and domestic violence advocates always nod knowingly when I say this--women oftentimes underestimate their risk, underestimate the severity of the situation. It's very normal, it's absolutely understandable. You can't get up every day thinking you're going to get killed.

SS: Of course not.

JC: Or almost killed, and get through the day and get done what you need to get done. So, you know, they oftentimes would very normally minimize that kind of thing. So, I'm an educator, I work with adult learners, I'm thinking to myself, "Now, how do I get her to see for herself, knowing that's far more powerful than me talking at her?" So, how do I get her to see for herself that this is a highly dangerous situation, that he is really scary? When he IS--without scaring every abused woman I see, you know, talking about homicide all the time. So that's when I developed the danger assessment and I listed out the risk factors that I had found from my homicide study and I took it to the support group and I said, "Okay. So, these are the things that I saw. How would it be best to ask women about this?" You know, what kind of wording should I put? So, that's an--and Diana Russell had done her amazing work both in femicide and also in terms of marital rape. And the question she asked about marital rape is "Does your partner or does your husband or boyfriend ever force you into sex?" And so I asked the women in the support group, "So, if I asked you that, would that get at it? And what would you say in response?" And so, they said, "Yeah, that's, you know, we don't think about it as rape but he's holding me down and/or he's threatening me with a weapon and/or he's saying, you know, if I don't do what he wants me to do in bed, he's going to beat me up, and he beat me up yesterday so I know he's perfectly capable of doing that." You know, so yes, it's rape but they don't use those words.

SS: They don't think of it that way because they're married.

JC: Yeah, because they're married or they're in a long term relationship. He's their boyfriend, or--and they don't think of--certainly don't use words like "sexual assault." So they taught me how to ask and I would verify the wording with them and we talked about how best to ask. I developed with them this calendar idea to help them identify when it happened and how bad it was. Because, you know women would just very typically say, "Yeah, there's, you know we have some pretty bad arguments. And in fact, there's sometimes even some pushing and shoving, but it's not that bad, it doesn't happen that often." And so, with the calendar, she can trace that back. And again, she can see for herself, "Oh, I guess it's not only once in a while." Or "Oh, look at this, I've had him--"

SS: Yes, he's beating her nearly twice a week.

JC: Many would say, "Look at this, you know, it's really pretty often and it's getting worse." And so, you know that in the first risk factor it's "has the violence increased in severity and frequency over the past year?" And if they've done a calendar, they're much more accurate in that and being able to say that. And so the calendar actually, you know, has a numerical scale on how bad it was. And so they can look very easily and see, "Oh, there's a whole lot more "fours" and "fives" now than there used to be at the beginning of the year," and I have them worked backwards." And it's incredibly effective at helping her see the patterns for herself. And of course, you end up with this checklist, and many providers and advocates—not so much advocates, but many of the providers, they just want to do the checklist. They don't want to do the calendar because it's quicker and it seems more objective that way or something. But they, you know, again, the danger assessment is for women to more accurately perceive how dangerous the relationship is, and that's a piece of information they need. I mean, just like in the health care system, we say smokers need to know how dangerous smoking is, how much of a health risk that is. Well, you know that's the information that she needs in making her calculation of what she's going to do from there. So, I developed the danger assessment, you know, I had it as a checklist and started using that with women.

SS: And how did they respond to that?

JC: Well, I can't say they like it a lot because it's hard to do. And it's hard to do when it's your reality, but really is very eye-opening for many women. And for some women, they say, "See, you know, it's not that bad. See, there's not that many yeses on this and look at the calendar. It's just like I said, it's only every once in a while." Then I can say, "Great, I'm glad to hear that. Now, you know what the risk factors are, you know it can change quickly. If something happens, it could really, you know, bump up your score." But, you know, this helps us do some more realistic safety planning and I don't have to be-- Because so often, I see women outside of shelters now. I don't have to be scared to death that you say you're going to stay and you're going to, you know, he is going to do something to improve the situation. And I don't have to like, "Oh my goodness, that's not a good idea." So, you know, I have some way of determining how much I should be worried when she walks out that door, how much I need to be really assertive with her around what we're going to do, reaching out, et cetera. And, hopefully, she has that more accurate appraisal and there's--many of the women say, you know, when I say "Oh, this is a really within extreme level of danger" or something like that, she'll say "I knew that. You know this is not a news flash to me but I'm glad to have this kind of evidence that I'm not making it up, that I'm right to be scared. And so now, I feel like I can really push on to something now that I have that information." So I would not say that they like it, because it is hard to do, it's sometimes very painful to go back and think about these things but women find it very useful, and say that it really has either opened their eyes or confirmed their worst suspicions or, you know.

SS: Do these danger assessments ever make it into evidence in court cases?

JC: They do, and now that it's been validated because we did this national femicide study and now that we have some good validation, yeah, it's sometimes used in court. And one of the

things I love is I'm back working with the criminal justice system and that LAP [Lethality Assessment Program] is the shortened version that's being used in many police jurisdictions by first responders. And, you know, all of that is, you know, I feel like I've developed something that's useful both to women and to the system. And that the risk of lethality is such an important piece and stems directly from that early research and my early concerns.

SS: So what happens to a woman who arrives in the emergency room now? It sounds like there is just this whole large protocol involving a lot of different professionals that is set to operate now that wasn't in place 30 years ago.

JC: That's absolutely true. In most emergency departments in the United States now, if a woman comes in with an injury and/or something else, presents with something else that makes people think there might be domestic violence, she is asked directly, you know, "Is someone hurting you?" There's a variety of different questions that have been developed to ask. In many emergency departments--and this is what I like the best--every woman is asked about domestic violence, not just the ones that come in with an injury that's suspicious of domestic violence. It's difficult if she's elderly, if it's a car accident or if somebody is really severely injured 'cause then you have to wait and do it at a later time and sometimes it gets missed. But I would say, in most emergency departments, there's far more recognition of domestic violence and there's protocols that people follow in terms of making sure. And it depends on where you are, but making sure that she's at least offered domestic violence resources either through the social work department of the hospital and/or getting in contact with domestic violence advocacy organizations in the community. It's a variety of things that people do but there's generally a protocol. And actually, JCAHO requires that there'll be some sort of protocol for--

SS: What's JCAHO?

JC: Joint Commission on the Accreditation of Hospital Organizations, which is what goes to each hospital and/or medical organization and makes sure that they have good safety standards and that they're doing the right thing. And so, it's one of the things that we worked on back in the 90s. One of the policy initiatives--and again, that really isn't a royal "we", I certainly didn't do it by myself--but we worked with a bunch of other people in terms of trying to strengthen those provisions in JCAHO. So, emergency departments have to have a protocol. We used to laugh that it sat up in a binder, you know under a desk cover in the emergency department. Now, in many places, it's electronic. So, you know, they--if somebody says "Yes, I'm abused," they can just click on [it] and a box jumps up and tells you what to do.

SS: And how did they deal with the spouses and boyfriends that accompany them into the emergency room?

JC: It's one of the challenges.

SS: This is so often the case.

JC: Exactly.

SS: I can remember seeing this happen in ERs at various times, where the woman comes in and her--she's got a broken arm or other injuries and she's got this fellow who's with her--

JC: Hoverer, we call them the hoverers.

SS: Yes, he hovers around and he's got his arms crossed and he's looking very grim and he's looking at her like "You better not tell them."

JC: Right. Well--

SS: And is this still--

JC: Part of those protocols are that she has to be asked about domestic violence when alone. And so, what we recommend is that the hospital figure out a system--either triage is by themselves, no family members around. Oftentimes, that's kind of hard to arrange but if, you know, the ideal situation, if the triage nurse is unable to ask about violence, then the note is given in back. And somewhere along--and he's told, you know, "You can go back and join your wife in just a few minutes but we need to get her comfortable in the unit." You know, so there's some policy of separating people for at least a short time while that can be assessed. It takes teamwork but usually, when you first go back into the emergency department unless, obviously, there's--it's a gunshot or, you know, there's something life-threatening, immediately life-threatening. The nurse calls you into your cubicle or whatever and does a brief kind of a history and it needs to be done then if you weren't able to do it at triage. So, that has to be part of the protocol. But that is a continuous challenge, because the more likely he is to be abusive, the harder it is to make him sit in the waiting room for you for five minutes. We're also thinking about using--we call them COWs in the emergency department, the Computers on Wheels. (Laughter) So it's a computer, it's a station that is actually for the physicians and nurses to put things in the record, but it could be used to take it to the patient. The patient could do that while you've got him or her elsewhere do the history form. And if it's embedded in the middle of a history form, chances are, whoever it is, even if they do sneak in back while you're not looking, is not going to look at every answer to every question that she's doing so, you know, that's one of the other strategies. But it's always implementing these policies. You have great policies but you got to implement them.

SS: Yeah, you've got to make it part of the whole process.

JC: That's right.

SS: Or it's just the binder on the shelf that you were talking about.

JC: That's right.

SS: I was reading the article that you published in the *Lancet* in 2002 and somewhere in there you say that even at that time, a lot of healthcare providers are not looking for domestic violence. So clearly, there's more work to do.

JC: Yeah, right. Especially in the conditions that aren't an obvious injury type thing, you know.

SS: Why aren't they? If I can ask a bold question.

JC: Well, yeah. You know, right. I think in part because the premise was originally presented as that we needed to find out about domestic violence to get her into a safer place; versus the connections with the different healthcare conditions and that it would make a difference. One of the early on studies that I did was on depression and abused women. And I'll never forget proudly presenting this at [Johns] Hopkins Hospital to the psychiatry department. And saying that women who are abused are much more likely to be depressed. And you--us providers--we need to be finding out about the domestic violence when we're seeing a depressed woman. And I'll never forget one of the high-up psychiatrists in the room said, "You know, Dr. Campbell, you're absolutely right. We probably do have a lot of abused women amongst our depressed women that we see in this hospital and in our out-patient mental health units. But what you don't understand is that that's irrelevant to their treatment for depression." See? The notion that--I know, that was crushing, crushing. (Laughs) The notion that we have to treat their depression and whether, you know, we have good protocols for treating depression, we have good antidepressants and so it doesn't really matter that she's abused, we just need to treat that depression. And--

SS: So it's this extreme focus on whatever the specialty is?

JC: Whatever the diagnosis is, whatever the evidence-based treatment is. And what I say--and what we really haven't shown well yet though--is that our standard treatments won't work very well for her if she's abused. That, first of all, she's going to keep being abused probably, so however much that is contributing to her depression, that will continue to do so. And/or that, you know, what we know now is a lot of times, that depression is comorbid with Post-traumatic Stress Disorder. And that if we're not treating the PTSD also that it's not going to be as effective. But we've as yet failed to really show that in an evidence-based way, on the outcomes--

SS: I'm a little surprised.

JC: Yeah, you know. We haven't done the clinical trials 'cause we--see, we don't do clinical trials very much anymore with depression because we've done it a lot. With both cognitive behavioral therapy and we've shown that--but, you know, in my spare time or my retirement or something, I would love to get a hold of one of those databases and really look at, do we have information about how many of the women that didn't get so much better with our treatment also had domestic violence that was compiled in this--

SS: I mean it seems like such a no-brainer. (Laughter)

JC: It does to me, too, always did to me too. You have to convince some of the, you know.

SS: Yes. I actually worked for a psychiatrist for five years and even knowing what I knew about psychology and psychiatry and things, I was always surprised at the sort of narrow focus



on getting people just functional again. “Give them the meds, get them back on their feet so that they don't have to be in the hospital anymore, and we've done our job.”

JC: Right, and something like hypertension--you know, one of the things that we've shown is that African-American women who already have a lot of risk factors for hypertension, if they're abused, are more likely to get hypertension at an even younger age and there's a lot of difficulty in controlling it. But, you know, again, we have evidence-based treatment for hypertension. And so, the cardiologists are like “Yeah, but you know, domestic violence doesn't cause her hypertension.” No, I never said it did, but I think it contributes. As we know, the environment contributes a lot to when genetic tendencies and/or things that are expressed, you know, et cetera that that's one of the--just like you that are treating hypertension are also worried if she smokes, because you know it contributes to hypertension. I'm saying the same thing, you know, but it's been difficult, because it's--I think more because it's a psychosocial problem.

SS: And they're messy, they're really, really messy.

JC: Right, right, (Laughter) right. And we don't have a good pill for it. We don't have a good evidence-based short treatment for it yet.

SS: We can't “fix it.”

JC: We can't fix it. So I think that's part of the disconnect and I think that much of the medical world is much more open to it, much more sane. And now, we've run up against “But I don't have enough time.”

SS: I was just going to say that.

JC: “I can only see my patients for eight minutes and they have hypertension, you know, high cholesterol, blah, blah, blah, and I know how to deal with those. And I don't have time to even find out about the abuse and, you know, if I did take the time to find out about the abuse, do you know how long it would take me to deal with that?”

SS: So, a lot of it is not just the specialization, it's the structure of the healthcare system, the way it's been evolving and so on.

JC: Right, right and that--yeah, right.

SS: Yeah. Wow.

JC: So, you know, we continue to have challenges—we've made incredible progress but we continue to have challenges.

SS: Okay. I wanted to, if you've got a few more minutes--

JC: I do.

SS: I'd like to ask about the sort of the broadening of this whole movement, you know, to the international level, because I know that you've been doing a lot more work with populations of women and problems of abuse in other cultures. And I think there's been a lot more emphasis in the global healthcare community, especially since AIDS.

JC: Right, right.

SS: Yeah, and the awareness that it isn't just here, it's all over the place and everybody, you know, rural, urban, whatever country you're talking about is suffering at some level from this. And some cultures, of course, are [still] very, very patriarchal.

JC: Horrific.

SS: I mean, in some of the populations in Africa and the Middle East especially, how is that going?

JC: Well, it's been an incredibly wonderful journey to do that, to be invited to help think about it on a global stage too. And I--very early on from '90 to '93, I was incredibly fortunate to, although it was competitive when I went after it so, you know, (Laughter) I both, you know, deserved it. But anyway, I got a Kellogg fellowship which was a leadership fellowship that supported 25 percent of my time and they very much encouraged us to think globally. So, I made my first international trips. My project was on women's issues more broadly but, of course, I was thinking about the violence stuff when I did that. And so, that's when it became clear that this was happening all over the world. I got to meet with domestic violence advocates, shelter directors in far-flung places like Belize and talked to people that were concerned about violence against women in Zimbabwe and New Zealand. And then I was fortunate enough to be invited to the World Health Organization and be asked to help them design the multi-country study on violence against women and women's health. And from the beginning, it was all about women's health which was partly because there was a lot of us healthcare types that were part of the steering committee. And that study broke all kinds of ground; Claudia Garcia-Moreno at the World Health Organization deserves all the credit in the world. Mary Ellsberg also helped with that, and Lori Heise who actually implemented it. And I was, you know, I was up there and they did the real--

SS: Ground work.

JC:--The nitty-gritty stuff but I always felt like I was definitely a part of the whole thing. And that data has changed the global perspective on the issue, brought it to the United Nations which has also made it a very central part of their thinking. I was in Vienna when we, and again, I had a little itty bit to do with this, but it was a really worldwide convergence on this UN meeting [in 1993] to declare that violence against women was a violation of human rights. And so, that brought another whole perspective to it that was incredibly important, and it was just thrilling to be able to be a part of that. I also joined forces [in the 1990s] with what used to be called the Family Violence Prevention Fund, now Futures without Violence. I'm now the chair of their board, I'm very proud to be a part of them. They've also done just incredible work both globally and in the United States. So, thank goodness for everything that they do plus the WHO

work. It's been amazing to be part of that and I've been able to be part of some research endeavors now, primarily [with] Nancy Glass who used to be a student of mine once upon a time and she was my first research assistant, my first funded violence--big violence project from CDC. So she's now got more research funding than I do and is just doing incredible work. And that's, you know, part of the journey has been all the mentoring I've done and I think my lasting legacy will probably be, other than the danger assessment, will probably be all of the students that I have taught, and PhD students that I have mentored and been part of their process. And I was able to get some funding from and NICHD for T32 pre and postdoctoral fellowships. We're now in our 13th year. Yeah.

SS: Congratulations. (Laughter)

JC: So there's a ton of those out there now, all doing incredible things and many of them doing things on the global stage, which is incredibly important. I've come to the realization that I can only learn the culture of so many countries. I can't do the whole world in-depth, so I've sort of limited my personal arenas to South Africa. And now, the DRC a little bit, and I've worked with New Zealand for a long time in the Maori community there and tried to work with indigenous peoples also. That's one of the other arenas related to some of the historical trauma parts that we see, really shockingly, horrifically high rates of family violence, all kinds of family violence but domestic violence particularly. But like, I say I only know (Laughter) just parts of the world. One of the things that's been interesting is in going all around the world and talking to many different policy makers and many of the people that are empowering government so, I oftentimes talk to the high-ups. And everywhere you go around the world, it's always some "other group" that does that domestic violence stuff. You know, it's that other religious group or that other--those immigrants, or those refugees, or those poor people, or those different cultures, or different race, or--and it's striking how you hear that. I was in Lebanon and Lebanon is a fascinating culture. My daughter-in-law is part Lebanese so I was excited to get to go there and, you know, I read all I could about it all, and then I get there and they're like, "Oh yeah, we have terrible domestic violence issues amongst our Palestinian refugee populations." And they have huge populations, they have actual cities. You know, "That's a terrible problem. Now neither us Muslims nor us Christians who are, you know, we don't do that or at least not very often, or only in very unusual cases, but all of those..." And that's the only place that they've done real research on the issue.

SS: That is interesting.

JC: Isn't that interesting? And when I was there, they passed their first law against honor killing in the congress, and the law against domestic violence had also come up but went down to resounding defeat 'cause it was felt that it really wasn't necessary to get into the family issues 'cause--

SS: So there's a lot of cultural change to support--

JC: Right and, you know, it's always interesting [that] "It's that other group that does that and we don't."

SS: Well, we were the same way thirty-odd years ago.

JC: Are we not? (Laughter) When you think about it, oh yeah.

SS: Sure.

JC: I mean, it's not, no, I'm not saying the United States--

SS: The black people or the poor people or the hillbillies--

JC: Yeah, or the poor people or the other people or the immigrants or the, you know. Oh, and that's what--I mean it's not just us, it's all around the world that we--that people do that.

SS: Yeah, there's still much good work done but much good work left to do.

JC: There's a ways to go. There's a ways to go and that's why a study like the WHO study that did population-based [research] and really were able to document that it wasn't whatever other group you think you have but it's also happening across [populations]. And although it is associated with poverty and lower levels of education, it does happen across the socioeconomic spectrum. It doesn't happen equally across and oftentimes, I think it's because middle class women or highly educated women, depending on the culture, or women with resources are more likely more able to either end the violence by leaving--much more possible, feasible for them--and/or to get the help to bear that helps him end being violent.

So they're able to bring resources to the issue and make sure that he gets what he needs to see the light. Or else, she has that viable alternative. She has the means to leave. So her power, her resources do make a big difference for middle class or well educated women in most places in the world. Now, there's some places in the world that there's enough of a patriarchy still in place that they don't have as many options. Like in Egypt, you know, it's really virtually impossible to leave your husband. You know, it's just not an option.

SS: There are a lot of cases no matter what your status is with, if you're--

JC: Yeah and that's no matter what your status is, yeah.

SS: If you're not married, then--or you're married and you're separated, you don't have an identity.

JC: Right, and you really have to be married to be viable. So that always contributes to the issue. So, the global work has been fascinating, incredibly, I mean, I always feel incredibly privileged to be asked to go somewhere and help with their domestic violence issues, or to be able to get the research dollars to enable us to do that. It's definitely a worldwide problem; there's way too many women dying, maternal mortality, you know, part of that is homicide. Anyway, I just feel privileged to be a small part of that and I think it is incredible worldwide, the women that are working on this issue. I wish more of the healthcare sectors in other countries were being brought to bear, but I think that will come, I think we've planted the seeds. But again, you know, you run into these same kinds of issues we do here as physicians and

nurses saying, "Yeah, but I have all these people dying of AIDS," like in Africa. "So, you know, this domestic violence thing, yeah. But it's got to be a way far down my list," and we understand that.

SS: Yes. Well, I think this is a good stopping point; maybe we can pick this up a little bit later and get into some of the history a little more specifically but--

JC: Okay.

SS: I really appreciate that you're taking the time to do this little interview and I think it'll be an important addition to the materials that you all have given to the library over the last couple of months.

JC: Right and, you know, I think it's incredibly exciting and I think that the domestic violence movement, you know, some of that story has been told in terms of, you know, Suzanne Chester's book. And I'm sure there will be more but I think that healthcare sector side has not as much been told. And I was thinking about Richard Jones that he was an obstetrician who was just amazing on this topic in the, you know, incredibly visionary in the '70s. You know, we've had a couple of AMA presidents that have really put it on the map. Those kinds of people will also--their stories need to be told too.

SS: Okay. Well, maybe we'll keep working on this. [laughs]

JC: Right, yeah, yeah.

SS: And get them all on tape.

JC: Right, Anne Flitcraft and, you know.

SS: Yes.

JC: And so it would be terrific if we could get a little wider--

SS: If we have enough funding.

JC: Yeah, (Laughter) I know, I know. It's always that; I was at the IOM Scholar-in-Residence, the American Academy of Nursing, IOM. It was a wonderful year and, you know, my project was around the intersection of HIV/AIDS and domestic violence and trying to get more known and more research and more into the discussion, et cetera. And you know, I thought that I would immediately be able to conjure up a committee (Laughs) and all that, you know. And of course, now, five years later, we do have the IOM forum on global violence prevention. And, you know, I planted the seeds for that back then but, whoa, it was all about "Do we have the funding? (Laughs) How do you get the funding?" "You raise the money, Jackie, we'll be happy to do a committee." (Laughter)

SS: There's never enough time or money is there?

JC: That's right. Yeah, the resources are always an issue whether it's for battered women or for us.

SS: Okay. Well, thanks again. We can end here.