Domestic Violence in the Military: Women's Policy Preferences and Beliefs Concerning Routine Screening and Mandatory Reporting

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Objectives: This study describes active duty military (ADM) women's beliefs and preferences concerning domestic violence (DV) policy in the military. Methods: Telephone interviews were completed with 474 ADM women from all services, 119 of whom had experienced DV during their military service. Results: A majority (57%) supported routine screening. Although 87% said the military's policy on mandatory reporting should remain the same, only 48% thought abuse should be reported to the commanding officer; abused women were significantly less likely than nonabused women to agree with this aspect of the policy. ADM women's beliefs were similar to those of women in a previously studied civilian sample, except that 73% of ADM compared to 43% of civilian women thought routine screening would increase women's risk of further abuse. Conclusions: ADM women recognized both advantages and disadvantages of current DV policies. More research is urgently needed about actual outcomes of screening and reporting policies.

Introduction

There is increasing recognition that active duty military (ADM) women, like their civilian counterparts, are at risk for domestic violence (DV) defined as physical and/or sexual assault or threats between sexually intimate partners.[1,2] Estimates of DV in military populations from central registries of official reports made to the Family Advocacy Program (FAP) of the Department of Defense (DOD) are limited by the definition of DV as "spouse abuse" and by the lack of confidentiality in the military system.[3] Population-based surveys have reported perpetration rates of 23% among ADM males and 31% among ADM females in the year before the survey,[4] and victimization rates among ADM and veteran females of 28%[5] and 30%,[2] with rates during military service of 22%[2] and 48%.[6] Given the devastating toll of DV on women's health status,[5–9] such abuse could also adversely affect military readiness.

A DOD policy states that DV will not be tolerated.[10,11] There are clear policies in each service to deal with the issue through the military police, FAPs, and the command structure.[11–14] Most military health installations have not instituted routine screening, but DOD requires health care provider training in recognizing signs of DV, making inquiries based on indicators, and offering services. Victims are offered services through either a FAP DV advocate and/or FAP clinical staff. For ADM perpetrators, a variety of sanctions may be applied, such as required batterer intervention programs with career threatening sanctions for not attending regularly. For civilian perpetrators, the installation commander may bar the perpetrator from the installation and institute agreements between military base installations and civilian law enforcement agencies to support perpetrator accountability. Family support programs have also been established. Any victimization is reported to the woman's commanding officer either through FAP or through the military police. This lack of confidentiality for victims has been identified as an area requiring attention by the services.[13,15]

Although attention is being directed toward the problem of DV among ADM personnel, we could find no study of the preferences and beliefs of ADM women themselves. Such information can help formulate sound policy and develop effective programs. Our survey of ADM women from the four services (Army, Navy, Marine Corps, Air Force) in the greater metropolitan Washington, DC area addressed this gap.[2] The purposes of this part of the study were to: (1) describe women's beliefs about the consequences of routine screening and mandatory reporting of DV in health care settings; (2) describe ADM women's policy preferences for how the military should handle DV; and (3) compare beliefs and policy preferences between abused and nonabused ADM women and between women who did and did not disclose their abuse. These data come from a larger study in which we also interviewed a sample of civilian women enrolled in a large health maintenance organization (HMO) in the Washington, DC area.[8,16–18] A secondary aim of this study was to compare opinions of ADM and these civilian women.

Methods

Survey Procedures

Data were collected from January 1998 to October 2000. Using the Defense Enrollment Eligibility Reporting System database, 16,540 Army, Navy, Marine Corps, and Air Force women

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in the greater metropolitan Washington, DC area were contacted with an introductory letter which described the study as addressing "the health effects of stress and women's relationships." For safety, the letter was intentionally vague about the purpose and we used work addresses whenever possible. After two mailings, 2,179 women (13.2%) requested the full consent forms.

The Johns Hopkins Institutional Review Board and those of each service and each installation in the study approved this study. To comply with the institutional review board requirements across all services and installations, the final consent form was four pages long and included an explicit reference to DV as the topic of the study, a witness signature, and a statement that a woman's commanding officer could review her survey responses. This statement limiting confidentiality of the results was a deterrent to consent, because several women contacted the investigators to say that was the reason they decided not to participate.

A total of 779 women (36%) who received the consent form signed and returned it; 616 (79%) of these women completed the telephone interviews. Those who consented but could not be reached for the telephone interviews were women who had been deployed overseas, transferred to an unknown location, or had left the military. All consent forms included referral phone numbers for DV services. The telephone interview protocol included help screens for DV queries, signs of potential danger, and referral sources.

Abuse Definition

Women were screened for physical and sexual abuse using a modified Abuse Assessment Screen.[19,20] Women who answered yes to any of the following three questions were considered to have been abused: (1) "Have you ever as an adult been physically abused by a husband, boyfriend, or female partner?" (2) "Have you ever been hit, slapped, kicked, pushed, or shoved or otherwise physically hurt by a current or previous husband, boyfriend, or female partner?" (3) "Have you ever, as an adult, been forced into sexual activities by a husband, boyfriend, or female partner?" Dates of the abuse and dates of military service were used to create a variable assessing whether the abuse occurred during the period of military service. Women who were abused during their period of military service were compared to those who answered no to all three questions.

Measures

In addition to standard demographic variables, the survey measured women's beliefs. This was introduced by reading the following text, "We are interested to know how active duty women who experience abuse can be assisted. Every woman's perspective is unique and valuable. Please tell me if you agree or disagree with the following items."

Beliefs about the consequences of routine screening were measured by reading women eight items that began with the text: "If doctors or nurses routinely asked all active duty women if they are being abused. . . . " (Table I). Women's policy preferences for routine screening were ascertained with a single yes/no item, prefaced with an explanation of the reporting policy that was in force at the time of the study: "When an active duty woman's safety is an immediate issue, doctors and nurses are required to report the partner abuse to the Family Advocacy Program who then report it to the active duty woman's commanding officer. Do you think doctors and nurses should ask all women at all visits if they are being physically or sexually abused?"

For beliefs about the consequences of mandatory reporting, women were reminded of the military's reporting policy as stated above and then asked, "When doctors and nurses are informed by active duty women that they are being abused, do you agree or disagree that the following things happen," followed by seven items shown in Table I. Women's policy preferences for mandatory reporting were ascertained by four dichotomous (yes/no) items listed in Table I. Finally, abused women were asked whether they had ever talked about their abuse with a health care provider.

Statistical Analyses

Because abused and nonabused women were significantly different on certain sociodemographic characteristics (Table II), all comparisons of these two groups accounted for these differences, using the following methods.

Regression

All statistical testing for differences in beliefs and policy preferences between abused and nonabused women is based on the results of multiple logistic regression, which allowed us to examine the association of abuse status while adjusting for the demographic variables on which the two groups differed. All regression models contained binary indicator variables for abuse status, military pay grade (enlisted or officer), number of children, and marital status. Because officers and enlisted ADM women expressed differences in beliefs and preferences, we stratified the logistic regression analyses by military pay grade. Odds ratios (OR) and 95% confidence intervals (CI) are presented for statistically significant variables. Comparisons of abused women who talked to a health care provider about their abuse versus those who did not employed χ^2 statistics computed on the unweighted data.

Adjustment

When calculating proportions for the two groups of women, we used methods of direct adjustment to a standard group to balance differences between the two samples in military pay grade, number of children, and marital status. For this adjustment, we chose the combined sample ($N = 474$) as the standard group. Weights were developed for each observation in the two abuse groups to eliminate the differences by making the two groups comparable in distribution to the standard group. The weights were obtained by stratifying on abuse status (abused or not abused) and on three unbalanced variables: military pay grade (enlisted or officer), number of children (two children or other), and marital status (married or all others). For each abuse category and the standard population, the number of persons within each of the three strata (military pay grade, number of children, and marital status) was determined. Strata-specific ratios of the number of observations in the standard group to the number of observations within each of the abuse classifications were calculated. Weights were created separately for each abuse category by applying the strata-specific ratio to each person within the strata. All proportions presented for the

TABLE I

WOMEN'S BELIEFS AND POLICY PREFERENCES CONCERNING ROUTINE SCREENING AND MANDATORY REPORTING, WEIGHTED PROPORTIONS

	Agree with Item (%)		
	Total Sample (n = 468)	Abused Women (n = 119)	Non-Abused Women (n = 349)
Consequences of routine screening[a]			
Women would be offended or embarrassed	59.5	63.2	58.3
Women who are not being abused would be insulted	37.3	41.2	35.9
It would be easier for abused women to get help	76.7	73.5	77.8
It would put women at more risk for being hurt	72.9	74.1	72.5
Women would be glad someone took an interest	45.3	46.8	44.8
Women who are being abused would be more likely not to inform the HCP	81.9	76.9	83.6
Women would fear a negative effect on their military career if they disclosed the abuse	64.3	64.9	64.0
Women would fear a negative effect on their partner's military career if they disclosed the abuse	73.8	77.0	72.7
Consequences of mandatory reporting[b]			
Women would find it easier to get help	84.1	83.1	84.5
Women would be at greater risk for being abused	64.1	63.4	64.3
Women would like having someone else be responsible for calling the police	80.4	77.7	81.4
Women would be less likely to tell their health care provider about the abuse	70.4	62.4	73.2
Women would resent losing control over when to call the police	52.8	47.7	54.6
Women's career would be damaged	47.7	49.1	47.3
Partner's career would be damaged	92.0	92.1	92.0
Policy preferences[c]			
Agree that HCPs should ask all women at all visits if they are being physically or sexually abused	57.0	60.2	55.9
Once the FAP has received a report of abuse, they should routinely refer this to the police	56.9	54.0	58.0
Once the FAP has received a report of abuse, they should routinely refer this to the ADM's commanding officer	48.1	35.1	52.6
Once the women has disclosed the abuse to HCP, it would be helpful if there was no mandatory reporting and all info remains confidential with HCP	34.2	46.6	29.8
The military's policy on mandatory reporting should remain the same	87.3	77.6	90.5

[a] Sample varies between 428 and 464 because of elimination of refused, don't knows, and missing values.
[b] Sample varies between 392 and 459 because of elimination of refused, don't knows, and missing values.
[c] Sample varies between 432 and 458 because of elimination of refused, don't knows, and missing values.

TABLE II

SOCIODEMOGRAPHIC CHARACTERISTICS

	Abused Women (n = 119)	Non-Abused Women (n = 355)	Total Sample (n = 474)	Weighted Sample (n = 468)
Education (% college graduate)	51.3	73.1[a]	67.6	68.0
Ethnicity (% Caucasian)	68.9	81.1[a]	78.1	77.4
Marital status (% married)	62.2	74.9[a]	71.7	71.4
Household income (% >$50,000/year)	57.8	71.3[a]	67.9	67.6
Age (% <40 years)	56.3	56.3	56.4	56.4
Number of children (two children)	16.8	21.4	20.3	20.7
Military pay grade (enlisted)	61.3	36.6[a]	42.8	43.4

[a] $p < 0.05$ by χ^2 testing.

abused and nonabused women are based on the weighted data. Because the weighted data yield a sample size that is different from our actual sample, statistical tests based on the weighted sample would result in incorrect CI. Therefore, reported statistical significance and CI are based on the results from multivariate logistic regression using unweighted data as described above.

Results

Sample

Abused women were less likely to be college graduates, Caucasian, married, and to have an annual household income of $50,000 or more per year (Table II). Abused women also were more likely to be enlisted personnel than officers (61.3% vs. 36.6%).

Beliefs about the Consequences of Routine Screening and Mandatory Reporting

A majority (59.5%) agreed that women would be offended or embarrassed if asked about abuse during routine screening (Table I). Among nonabused women, 35.9% thought that routine screening would be insulting to women who are not abused, a somewhat smaller proportion than among the abused women (42.2%). Close to three-quarters of abused women (73.5%) thought routine screening would make it easier for abused women to get help, although 74.1% thought it would put women at more risk for being hurt. High proportions of abused women also thought that routine screening would make it less likely that women would disclose their abuse (76.9%) and that it would have negative effects on their military careers (64.9%) as well as on their partner's military career (77.0%).

Regarding the consequences of mandatory reporting, the majority of abused women thought women would find it easier to get help (83.1%) and that they would like having someone else be responsible for calling the police (77.7%). However, a substantial proportion also thought that mandatory reporting results in putting women at greater risk (63.4%), would make it less likely that women would disclose their abuse (62.4%), would result in resentment at the loss in autonomy (47.7%), and would damage their own (49.1%) and especially their partner's career (92.1%).

A slight majority of the sample (57.0%) agreed that health care providers should ask all women at all visits if they are being physically or sexually abused. Among abused women, 60.2% supported routine screening compared to 55.9% of nonabused women. A total of 90.5% of nonabused women thought the military's policy on mandatory reporting should remain as it is compared to 77.6% among abused women. Even though the policy at the time of this study was that FAP reports all DV to command and military police, only 35.1% of abused women thought that FAP should report the abuse to the commanding officer, compared to 52.6% of nonabused women. With regard to reporting abuse to the police, more than one-half of both abused (54.0%) and nonabused (58.0%) women agreed with this policy. On the other hand, 46.6% of abused women and 29.8% of nonabused women thought that there should be no mandatory reporting and that the health care providers should keep all information about abuse confidential.

Logistic Regression Analysis

Regarding consequences of routine screening, differences in beliefs between the two abuse groups were apparent only among officers (Table III). Abused officers were almost twice as likely as officers who were not abused (OR = 1.81, $p = 0.10$) to believe that routine screening would offend or embarrass women. They were twice as likely (OR = 2.06, $p = 0.03$) to think that nonabused women would be insulted by routine screening. Regarding consequences of mandatory reporting, the only difference between abused and nonabused women was among enlisted women; abused enlisted women were less likely (OR = 0.59, $p = 0.09$) to believe that women would resent losing control over when to call the police.

Regarding policy preferences, there were substantial differences among enlisted women between those who were abused and those who were not. Abused enlisted women were signifi-

TABLE III

MULTIPLE LOGISTIC REGRESSION ANALYSIS OF WOMEN'S BELIEFS AND POLICY PREFERENCES CONCERNING ROUTINE SCREENING AND MANDATORY REPORTING, COMPARING ABUSED WOMEN VERSUS NONABUSED WOMEN, STRATIFIED BY PAY GRADE

	OR for Abused Versus Not Abused (95% CI)[a]	
	Enlisted ADM Women ($N = 203$)	Officer ADM Women ($N = 271$)
	OR (95% CI)	OR (95% CI)
Consequences of routine screening (Odds of agreeing with item)		
Women would be offended or embarrassed		1.81 (0.90–3.65) $p = 0.10$
Women who are not being abused would be insulted		2.06 (1.07–3.97) $p = 0.03$
Consequences of mandatory reporting (Odds of agreeing with item)		
Women would resent losing control over when to call the police	0.59 (0.32–1.09) $p = 0.09$	
Policy preferences (Odds of agreeing with item)		
Once the FAP has received a report of abuse, they should routinely refer this to the police	0.52 (0.28–0.95) $p = 0.04$	
Once the FAP has received a report of abuse, they should routinely refer this to the ADM's commanding officer	0.54 (0.30–0.99) $p = 0.05$	
Once the women has disclosed the abuse to HCP, it would be helpful if there was no mandatory reporting and all info remains confidential with HCP	1.75 (0.95–3.24) $p = 0.07$	
The military's policy on mandatory reporting should remain the same	0.39 (0.15–1.01) $p = 0.05$	0.42 (0.18–0.99) $p = 0.05$

[a] All models adjusted for number of children and marital status.

cantly less likely than nonabused enlisted women to agree that a report of abuse should be referred to the police (OR = 0.52, p = 0.04) or to the ADM woman's commanding officer (OR = 0.54, p = 0.05). They were also more likely to agree that once the abuse was disclosed to a health care provider it should remain confidential with no mandatory reporting (OR = 1.75, p = 0.07).

Both abused officers and abused enlisted women were significantly less likely compared to their nonabused counterparts to think that the military's policy on mandatory reporting should remain the same. Abused enlisted women were 0.39 times less likely (p = 0.05) and abused officers were 0.42 times less likely (p = 0.05) to support the military's policy on mandatory reporting.

Disclosure of Abuse by Health Care Provider

Of the 119 women who reported experiencing abuse, 115 answered questions concerning disclosure and 52 (45%) had disclosed their abuse. There was little variation in abused women's beliefs by disclosure status (Table IV). Women who had not disclosed were significantly more likely to report that they would resent losing control over when to call the police if there were a mandatory reporting policy (59.6% vs. 34.0%, p = 0.01), and they were significantly less likely to support a policy of routine screening (54.8% vs. 75.0%, p = 0.03). No differences were found in mandatory reporting policy preferences by disclosure status.

Comparison to Civilian Sample

The previously reported study of 442 civilian women (231 abused, 202 nonabused) recruited from enrollees in an HMO using the same study methods[16] provides a civilian comparison group. The definition and prevalence of abuse were comparable between civilian and ADM women;[2,17] however, the military sample had somewhat higher proportions of women who were Caucasian (77% vs. 53%), married (71% vs. 58%), and college graduates (68% vs. 47%).

Overall support for routine universal screening was 57% in the ADM sample compared to 48% in the HMO civilian sample; 60% of abused ADM women and 54% of abused HMO women endorsed this policy. For the HMO sample, abused women were significantly more likely than nonabused women to endorse this policy (OR = 1.53), while in the ADM sample there was no difference. Many women in both studies agreed "women would be offended or embarrassed" by routine screening: 58% of nonabused and 63% of abused ADM women; 48% of nonabused and 60% of abused HMO women.

We could not directly compare policy preferences because of differences in the existing policies. However, there was evidence in both studies of the relevance of confidentiality and autonomy. Among the ADM abused women, 47% agreed that it would be helpful if there were no mandatory reporting and all information remained confidential with the health care provider, and only

TABLE IV

ABUSED WOMEN'S BELIEFS AND POLICY PREFERENCES CONCERNING ROUTINE SCREENING AND MANDATORY REPORTING BY DISCLOSURE OF ABUSE TO HEALTH CARE PROVIDER

	Agree with Item (%) (n = 115)		
	Disclosed (%) (n = 52)	Did Not Disclose (%) (n = 63)	p
Consequences of routine screening[a]			
Women would be offended or embarrassed	68.0	62.9	0.69
Women who are not being abused would be insulted	36.5	41.3	0.70
It would be easier for abused women to get help	74.0	75.0	1.00
It would put women at more risk for being hurt	77.8	69.4	0.38
Women would be glad someone took an interest	40.4	59.6	0.06
Women who are being abused would be more likely not to inform the HCP	74.5	77.0	0.83
Women would fear a negative effect on their military career if they disclosed the abuse	54.0	72.1	0.07
Women would fear a negative effect on their partner's military career if they disclosed the abuse	74.0	78.3	0.66
Consequences of mandatory reporting[b]			
Women would find it easier to get help	74.5	83.9	0.25
Women would be at greater risk for being abused	58.0	65.0	0.56
Women would like having someone else be responsible for calling the police	75.0	83.1	0.34
Women would be less likely to tell their health care provider about the abuse	63.8	65.3	1.00
Women would resent losing control over when to call the police	34.0	59.6	**0.01**
Women's career would be damaged	48.1	46.6	1.00
Partner's career would be damaged	92.2	93.3	1.00
Policy preferences			
Agree that HCPs should ask all women at all visits if they are being physically or sexually abused	75.0	54.8	**0.03**

[a] Sample varies between 107 and 115 because of elimination of refused, don't knows, and missing values.

[b] Sample varies between 96 and 113 because of elimination of refused, don't knows, and missing values.

35% thought abuse should be reported to the ADM woman's commanding officer. Among the HMO abused women, 54% supported a policy under which reporting abuse to the police is the woman's decision. In the multivariate analyses, abused HMO women were significantly less likely than nonabused women to agree that "women would like having someone else be responsible for calling the police" (OR = 0.50). In the ADM sample, although a majority of women agreed with the policy of routine reporting to police (57%), abused enlisted women were significantly less likely than their nonabused counterparts to agree with this policy (OR = 0.52).

A majority agreed that it would make it easier for abused women to get help if there were routine screening (86% in HMO; 77% in ADM) and mandatory reporting (73% in HMO; 84% in ADM). However, there was also the belief that it would put abused women at greater risk for further abuse if there were routine screening (43% in HMO; 73% in ADM) or mandatory reporting (52% in HMO; 64% in ADM). A large proportion also endorsed the belief that women would be less likely to disclose their abuse under conditions of mandatory reporting (67% in HMO; 70% in ADM).

Discussion

Our results suggest that active duty military women, abused and nonabused, are aware of the complexities of the issues associated with health care provider responses to abuse. The vast majority said that they support the mandatory reporting policies in place at the time of this study, and yet recognize that these policies probably have negative as well as positive consequences in terms of safety and autonomy. Regarding safety, while large majorities thought both routine screening (77%) and mandatory reporting (84%) policies made it easier for women to get help, they also thought such policies put women at greater risk (73% and 64%, respectively). Regarding autonomy, while 80% thought women would like having someone else be responsible for calling police, 53% also agreed that women would resent losing control over when to call the police. The findings regarding policy preferences are also somewhat conflicting: 78% of abused ADM women thought the military's policy on mandatory reporting should remain the same, although only 54% thought abuse should be reported to the police and 35% thought it should be reported to the ADM woman's commanding officer, both of which were elements of the policy.

We cannot rule out the possibility that the women in our sample did not fully understand the current reporting requirements, although our interviewers described the policy before asking the questions. The ambivalence of the women in this sample is echoed by advocates, health care providers, researchers, and policy makers in the field.[21–28] Moreover, the cultural context of the military may help explain some of our apparently conflicted findings. For example, the comparative value of women's autonomy may be quite different in the military context. ADM voluntarily sacrifice some personal autonomy as a condition of military service, which emphasizes other personal values. How this translates to issues such as violence between intimate partners warrants further attention. ADM women may be responding in a seemingly ambivalent manner in some cases precisely because they fully appreciate the reality of their competing personal and professional priorities.

The differences we found in opinions depending on pay grade may be more understandable. Officers compared to enlisted women were more likely to agree with statements about routine screening being embarrassing or offensive, and insulting. Officers may have more concerns about stigma and career issues than enlisted women, or they may have been responding as both the officer to whom abuse would be reported and the abused woman. One striking similarity between officers and enlisted women was the significant difference between abused and nonabused women in their support for the policy. In both groups, abused women were significantly less likely to agree with keeping the policy on mandatory reporting. Although the majority of the sample support keeping the policy as is, this reduction in support among abused women, and the ambivalence in beliefs described above suggest that more needs to be done to fully understand women's policy preferences, especially among abused women who are the central focus of such policies.

Of concern is the finding that women think mandatory reporting (70%) and routine screening (82%) would make women less likely to disclose their abuse to a health care provider. Unfortunately, without routine screening, it may be unlikely that abused women will voluntarily disclose their abuse, given their beliefs that it could put them at more risk for abuse (74%), and could negatively affect their career (65%) and their partner's career (77%). In fact, abused women who had not disclosed their abuse were significantly more likely than those who had disclosed to agree that routine screening would have a negative effect on their career (72% vs. 54%).

It is possible that women's responses were influenced by their knowledge (from the consent process) that their commanding officers could have access to their survey responses, although we would expect this to have had more of an impact on agreeing to be in the study in the first place. In fact, our response rate is a potential limitation to consider. However, the 13.2% response rate to our introductory letter was very similar to the 11.5% overall response rate in our civilian sample.[17] Moreover, 79% (n = 616) of the ADM women who completed the consent form were reached and completed full interviews, which is a completion rate similar to that in the civilian sample (78% of those consenting).[17] Nevertheless, policy decisions in the future would benefit from the collection of confidential data with regard to policy preferences and actual risks and benefits of specific policies for abused women.

The fact that women's screening preferences and beliefs about the consequences of screening and reporting were strikingly similar between the HMO and the military sample is an interesting finding that lends support to the validity of our results. One noteworthy exception is the finding that a substantially higher proportion of military women thought routine screening would increase women's risk of further abuse (73% vs. 43%), which may be related to the military context in which there is mandatory reporting and a lack of confidentiality.

Our results can help inform current discussions and the military offices charged with implementing the recommendations of the Defense Task Force on Domestic Violence (DTFDV). The majority of women in this sample supported the idea that health care system routine screening can help abused women get assistance but are concerned about embarrassment, career damage, and most importantly, increased risk. Until there are

clinical trials that test routine screening and reporting in health care settings, it is impossible to be sure how realistic these concerns are. Such research has been called for in the civilian world[29–32] and is also needed in military settings. Only with such evidence will policy makers know exactly what combination of policies will work to respect women's autonomy, help them obtain assistance, and, most of all, keep abused women, whether military family members or ADM women, safe. Such research carried out in the military must assure confidentiality of the research records to increase response rates and candor. If routine screening is implemented, care needs to be taken to ensure privacy for such screening to minimize embarrassment. Women should be assured that all women are being screened to decrease any perception of being singled out and, thereby, possibly insulted. Implementation of the DTFDV recommendations will also provide training for all military services with special training for command at all levels to help ensure that ADM abused women's careers are not damaged by disclosure, a concern of almost two-thirds of the women in our sample. Although the recommendations do not call for ending the mandatory reporting responsibility of health care providers, they do call for increased research to determine the effectiveness of the policies as implemented. The results from this study underscore the importance of assessing outcomes such as the impact of the policies on women's disclosure, safety, and careers.

Note added in proof. The new DOD restricted reporting policy (33) for domestic abuse incidents provides a DV advocate and health care provider treating an ADM or civilian family member DV victim with more, although not absolute, confidentiality, should address the concerns expressed by women in our sample about the effect of screening and reporting on increased risk for further abuse and negative impact on their careers.

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