

**THE
CHILDREN
OF
DOMESTIC
VIOLENCE**



**A Report of the
Governor's Commission on Domestic Violence
of the Commonwealth of Massachusetts**

April 1996
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Acknowledgments

This report is the product of ten months worth of research, drafting, and in-depth discussion among members of the Children's Working Group of the Transition Subcommittee as well as several organizations and individuals whose contributions deserve particular recognition.

First and foremost, this project would not have been initiated, much less brought to completion, without the support of the Massachusetts Coalition of Battered Women Service Groups. Joy Mockbee and Jennifer Marin, then graduate students at the Harvard School of Public Health, spent much of their second semester surveying the literature on the impact of domestic violence on children and gathering much of the data cited in this report and studied for emergent policy initiatives.

At a key point in the drafting process, a number of individuals with special expertise in serving children harmed by exposure to domestic violence participated in a series of meetings aimed at clarifying children's treatment needs. Participants in these meetings included Jetta Bernier of the Massachusetts Committee for Children and Youth, Margo Casey of Help for Abused Women and Children in Salem, Kate Cloud and Diane Purvin of RESPOND in Somerville, Sharon Friedman of New Hope in Attleboro, Betsy McAlister Groves of the Child Witness to Violence Program of Boston City Hospital, Margaret Hampl of the New Bedford Women's Center, Celia Lopez of Daybreak in Worcester, Tandy Mamutse of Alternative House in Lowell, Laura McCloskey of the Harvard School of Public Health, Carrie Pekar of the Children's Charter Trauma Clinic, and Ashley Skyrme of Transition House in Cambridge. The drawing on the cover of this report was made by a child of domestic violence. The picture was drawn while the child was in treatment with a local agency that serves children who witness violence.

The Honorable Arline Rotman, Associate Justice of the Worcester Probate and Family Court, though a member of the Working Group, deserves special acknowledgment for her willingness to help edit several drafts of the report. It is much more concise and readable than it would have been without her assistance.

The report's content and recommendations reflect not only the thinking of the many researchers, clinicians, and service providers who have written about the impact of childhood exposure to domestic violence but also the direct experience of members of the Working Group and the individuals mentioned here, most of whom meet the children of domestic violence in their workplaces every day. Their dedication to creating a healthy future for the children of domestic violence drove the writing of this report from the outset and made its completion possible.

Judith Lennett
Chair, Children's Working Group
May, 1997

Executive Summary

The child trapped in an abusive environment is faced with formidable tasks of adaptation. She must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a situation of helplessness.

Each year thousands of Massachusetts children are exposed to the battering of their mothers. They may witness violence directly or indirectly; they may well be abused themselves. They are at serious risk for

- developmental delays
- symptoms of post traumatic stress disorder
- irreversible psychological damage
- internalizing an acceptance of violence as a means of stress management and conflict resolution
- replicating the violence they witnessed as children in their adult relationships and parenting experiences

And, because Massachusetts lacks a cohesive set of policies to respond to children exposed to domestic violence, these risks are being realized every day in our homes, schools, clinics, courts, jails, and streets.

Experts, including clinicians in the fields of child welfare and domestic violence, who have considered what should be done to alter this course are in agreement on one general principle: the creation of integrated community networks

offers our best opportunity to break this cycle of violence. Integrated community networks are marked by four key components

- they have the capacity and willingness to identify domestic violence as a primary cause of a child's distress
- they make safety for the child and adult victims of violence a first priority
- they offer a full range of intervention services
- they commit to education and training in domestic violence prevention and non-violent conflict resolution

Early identification, the first component of integrated community networks, takes place in health care facilities, social service agencies, and schools, and is a critical starting point. Safety, as a primary need of both the child and adult victims of family violence, is an equally important component of integrated networks.

Safety includes understanding the various and subtle ways in which true safety may be unavailable under our current *ad hoc* response system. Intervention, in the form of in-depth assessment and comprehensive treatment services, is crucial if children are to recover from the deep trauma that exposure to domestic violence can cause. Intervention services should be delivered by skilled, community based providers who collaborate across agency lines. On-going training and education for professionals as well as educational programs in non-violence and conflict resolution for children is the fourth key component of integrated community networks and an essential aspect of domestic violence prevention.

Within each of these key components a number of concrete steps can be taken to bring Massachusetts closer to meeting the needs of children exposed to domestic violence.

- To increase our ability to identify the children of domestic violence, we should:

- 1) Encourage the universal implementation in all medical care facilities of the Commonwealth, including all school based clinics and medical facilities, of protocols for exploring violence issues with all health care consumers;
- 2) Support the development and offering of continuing educational programs in domestic violence and its effect on children for all currently licensed social work, child welfare, and health professionals (especially those in emergency medicine, obstetrics and gynecology, family practice, pediatrics, psychiatry, internal medicine, and mental health); those who work with children in child care centers, public schools, and after-school programs; and for clergy, prosecutors, and victim witness advocates;
- 3) Authorize and fund the Department of Education to develop seminars on domestic violence for educators as well as a resource guide and protocol that will enable school personnel to make appropriate referrals to victims' services; and
- 4) Insure that the Department of Education addresses the safety needs of the children of domestic violence by, first, undertaking a review of all present and impending policies and regulations to determine whether and how these might be amended to more fully meet these safety needs and, second, adjusting these regulations and policies wherever necessary.

- To more fully insure the safety of the children of domestic violence we should:

- 1) Improve the capacity of battered women's programs to serve children through targeted funding initiatives that will enable the

programs to offer direct services to more children in and out of shelter than they are presently able to serve and provide children's services staff with appropriate training;

- 2) Improve the ability of the Department of Social Services to meet its statutory mandate to protect children by increasing funding for its Domestic Violence Unit as well as increased funding for its network of community-based children's services (including individual and group support services, services for teens and services for perpetrators of violence);
- 3) Insure that the Transitional Aid To Families With Dependent Children (TAFDC) Program advances the safety needs of the children of domestic violence by, first, undertaking a review of all present and impending policies and regulations to determine whether and how these might be amended to more fully meet these safety needs and, second, adjusting these regulations and policies wherever necessary;
- 4) Insure that regulations and policies of the Executive Office of Communities and Development and the Commonwealth's public housing authorities advance the safety needs of the children of domestic violence by, first, undertaking a review of all policies and regulations to determine whether and how these might be amended to more fully meet these safety needs, second, adjusting these regulations and policies wherever necessary, and, finally, increasing options for obtaining safe housing including transition to independent living arrangements;
- 5) Enact legislation providing that the interests of children who have been exposed to serious and chronic abuse are best served by a rebuttable presumption against an award of custody or unsupervised visitation to the perpetrator and by ordering visitation only if adequate provision for the safety of the children and abused parent can be made;
- 6) Provide adequate funding to insure the availability of visitation center services throughout the Commonwealth;
- 7) Facilitate strong and consistent enforcement of all civil and criminal statutes applicable to perpetrators of domestic violence and supporting the continuing education of all components of the law

enforcement community, especially with regard to the special needs of children;

- 8) Appropriate funds sufficient to make SAFEPLAN Massachusetts advocates available in all district and family and probate courts to assist battered women seeking protection from abuse to not only obtain protective orders but also access the full array of legal and social services available to them and their children;
 - 9) Promote collaboration among courts, law enforcement agencies, batterer's intervention programs, and social service systems providing assistance and treatment to battered women and their children;
 - 10) Increase targeted funding initiatives for legal services for battered women in order to improve their ability to insure that they and their children receive the full range of legal protections available to them; and
 - 11) Authorize the Department of Education to undertake a study of options available to Massachusetts for developing protocols that ensure the safety of children in the school setting and for protecting their school records from batterers.
- To facilitate swift and skillful intervention and treatment for children

harmed by exposure to domestic violence we should:

- 1) Fund the Department of Social Services to provide multi-disciplinary assessment and a full range of treatment services for children affected by domestic violence;
- 2) Take steps to insure that current reimbursement systems do not prohibit the provision of the full range of psychological services needed to effectively treat children found to be harmed by exposure to domestic violence; and
- 3) Fund community-based pilot projects (as described in this paper) that, working in collaboration with battered women's service programs, the Department of Social Services, schools and other

providers, can deliver comprehensive intervention services to children.

- To increase our chances for breaking the cycle of domestic violence

through education and training, we should:

- 1) Encourage professional training (especially collaborative and interdisciplinary training initiatives) and on-going professional education in domestic violence and its impact on children;
- 2) Support the piloting and expansion of effective anti-violence programs that promote collaboration among parents, schools, community and law enforcement officials in community based settings throughout the Commonwealth. These programs should include the issues of domestic violence and its effect of children as well as parent training and teen dating violence prevention;
- 3) Introduce anti-violence and conflict resolution programming that is found to be effective in pre-school and elementary schools throughout the Commonwealth, expand successful middle and high school programs, and develop strategies that encourage media participation in the effort to decrease children's exposure to violence;
- 4) Support pilot job training and education, and economic development programs that integrate domestic violence issues (especially those that deal with the impact of domestic violence on children) into their curricula;
- 5) Fund the Department of Public Health to undertake a project aimed at evaluating existing and newly created school and community based violence prevention programs and to develop a manual for the development of model programs; and
- 6) Encourage the development of parenting skills programs for the parents of those children who have been exposed to domestic violence.

Creating integrated networks of the kind recommended in this report is groundbreaking work and there are few models. The development of one or more

pilot projects in carefully selected communities should be considered, therefore, to provide manageable opportunities to test the community-building strategies necessary for successful networking.

Building an infrastructure of community-based and integrated networks deliberately and strategically in cities, towns and neighborhoods across Massachusetts is our best hope for long lasting intervention on behalf of the children of domestic violence. As three of the experts to whom we have turned in the writing of this paper concluded:

A sober look at our world reveals ... all too many children struggling to move forward, but [who] are being diverted, or even blocked by the adults who surround them.... Abused women and front-line staff in shelters have spoken out for over a quarter century about violence in the lives of women and children. Gradually, social scientists have 'validated' these observations with increasing evidence that witnessing violence is neither a benign nor passive event. Violence and the misuse of power and control may gradually traumatize even the most resilient of hearts and minds among our children....[It is] our strong belief that stopping violence and healing from its effects are possible only through a coordinated, multi-system response.²

Introduction

The injury, physical as well as psychological, suffered by adult women who are beaten by their partners has been well documented. For every battered woman who is also a mother, there are children who suffer deep and enduring harm as a result of witnessing the abuse of their mothers, often by their fathers. Massachusetts has made significant strides in responding to what has been fairly called a "state of emergency" with regard to domestic violence. The expansion of services that has resulted has not, however, been undertaken in a coordinated manner. Moreover, very little has been done on a state-wide basis to directly address the needs of the children of domestic violence.

The lack of a cohesive set of policies leaves the children of domestic violence at great risk for

- being seriously abused themselves
- developmental delays
- irreversible psychological damage
- emulating in their own adult relationships, the violence to which they have been exposed as children

On the other hand, if policies aimed at minimizing these risks are formulated and implemented in a thoughtful and coordinated manner, we can begin to bring a strong measure of recovery and protection to the children of domestic violence.

In December, 1994, the Governor's Domestic Violence Commission authorized its Transition Subcommittee to collect and analyze the existing research on the impact of childhood exposure to domestic violence; develop a set of recommendations for public policies aimed at protecting the children of domestic violence; and submit those recommendations to the full Commission for its input, endorsement, and implementation.

The Transition Subcommittee assembled a Working Group of experts in the fields of domestic violence and child welfare to prepare this report. The members of the Working Group are listed in the Appendix.

The authors marshaled the clinical evidence of both short and long term damage caused by childhood exposure to domestic violence to determine points of expert agreement, areas of controversy, and places where additional research is needed. Concentrating on areas of general expert agreement, the authors studied the literature for emergent policy initiatives that would, if adopted, constitute an effective response to children already harmed by exposure to domestic violence, empower battered mothers to better care for their children, and also prevent additional injury to the children of abused or at-risk women.

A draft of the research was distributed to a circle of readers expert in the fields of child welfare, domestic violence, law enforcement, public health, social and welfare policy, and education. Most of their comments were incorporated into this draft of the report and their names appear in the Appendix.

In March, 1996, after several presentations and discussions, the full Commission endorsed the recommendations of the Children's Working Group and adopted this report.

Studies of the impact of domestic violence on its adult victims and on children have historically followed distinct paths with the latter being a relatively new area of concern and interest. One result of this history is that the needs and interests of adult victims of violence have often been viewed as distinct from and sometimes even in conflict with the needs of the children of domestic violence. Although conflict may arise as a battered woman struggles to sort through the complex, powerful, and oftentimes contradictory messages she has internalized about herself and her role as a mother, research shows that the interests of battered mothers and their children are intricately interwoven.³ Indeed, the best way to protect most children is to support mothers in their efforts to protect themselves. Public policy should be informed by this understanding and it can do so without jeopardizing our ability to intervene effectively on behalf of children.

This report has two parts. The first part summarizes the clinical literature on the impact on children of exposure to domestic violence. The second contains a series of policy initiatives and concrete recommendations for action that emerge from the clinical findings and that are offered as a blueprint for developing a comprehensive response to the children of domestic violence.

Implementing these recommendations will take time. Some of them are capable of implementation at little or no expense while others will be costly. It is our belief, however, that the expenditure of funds aimed at responding to the children of domestic violence is powerfully cost-effective. By fully implementing these recommendations, Massachusetts will have taken strong first steps toward saving countless lives as well as dollars.

Part I

Childhood At Risk: The Impact of Domestic Violence on Children

[C]hildren...who do not see their mothers abused, but who hear her screams and crying, the abuser's threats, sounds of the impact of fists hitting flesh, glass breaking, wood splintering, or cursing and degrading language, do witness the abuse. Events can be 'witnessed' in many ways, not just by sight. Children also witness the consequences of the abuse after the abuse has actually occurred...They may observe blood, bruises, torn clothes, broken glass, ...their mother's tears...They witness the tension in the house, the apprehension of their mother when the abuser enters the room....⁴

If we are to respond comprehensively to children exposed to the battering of their mothers we need to understand what it really means to be a child caught in the crossfire of domestic violence.

Violence among family members occurs at an alarming rate. Conservative estimates are that between 25 and 30 percent of American women are beaten at least once during the course of intimate relationships.⁵ The estimated number of children at risk of exposure to family violence varies from a low of 3.3 million children⁶ to a high of ten million.⁷ Even at the low end of the scale, the data are staggering.

Children in homes where domestic violence occurs are physically abused or neglected at a rate 15 times as high as the national average.⁸ Several studies, both locally and nationally, have found that in 60 to 75% of families where a woman is battered, children are battered as well.⁹ The most serious cases of child abuse resulting in emergency room treatment are often “extensions of the battering rampages launched against the child's mother, with 70% of the serious injuries to children and 89% of the fatal injuries inflicted by men.”¹⁰

Studies have shown that despite mothers' efforts to shield their children from violence, 68 to 87% of incidents of partner abuse are, in fact, witnessed by children.¹¹ In what may be the first qualitative analysis of its kind in the nation, the Massachusetts Office of the Commissioner of Probation recently found that an estimated 43,000 Massachusetts children are exposed to reported acts of domestic violence each year.¹²

Domestic violence visits extraordinary material, physical and psychological devastation on its victims. Those forced to flee a dangerous home may be faced with homelessness and destitution.¹³ Those who must remain in their homes live with intense fear. When a battered woman separates from a violent partner, the batterer may purposefully sabotage his victim's ability to parent. Because domestic violence is characterized by a pattern of coercive behavior, a batterer may threaten to take custody of children as a way of continuing his control of the victim. Prolonged litigation over custody and visitation can have a deeply negative effect on children.¹⁴ Women whose immigration status is dependent upon a violent

partner, often struggle with the impossible choice of remaining in an unsafe environment and being forced to leave her home (and, perhaps the only known home of her citizen children) in the United States.¹⁵

Parent-child relationships, influenced by many factors, can be deeply impacted when a battered mother's physical and mental health are adversely affected by domestic violence.¹⁶ Researchers who have studied the children of domestic violence confirm what common sense suggests, namely, that our fears for their safety and well-being are completely realistic.¹⁷

Children exposed to the battering of their mothers suffer the same harm and display the same symptoms as children who are actually abused, including the symptoms of post traumatic stress disorder.¹⁸ And their terror is comparable to the experience of combat soldiers suffering the effects of prolonged exposure to war.¹⁹ For, like combat veterans suffering from post traumatic stress disorder, the children of domestic violence demonstrate remarkable distortions and disconnections between what they feel, how they behave, and what they can remember.²⁰ Such trauma damages their capacity to trust, leaves them hypervigilant,²¹ impairs their ability to manage tension, frustration, and transition, and adversely impacts their school work and social relationships.²² If left untreated, trauma of this type is likely to thread its way into adulthood appearing as emotional instability, the formation of inadequate or volatile relationships, lagging work productivity, substance abuse and inconsistent, if not abusive, parenting styles.²³

The severity of a particular child's reaction to family violence is often related to his or her age, proximity to the violent event, the victim's relationship with the

child, and the presence of a parent or caretaker to mediate the intensity of the violence.²⁴

During their early years, children naturally turn to their parents as their most immediate source of stability and protection. When these same adults are the perpetrators or the emotionally distraught casualties of violence, the child's need for safety and stability is shattered.²⁵ Very young children who have witnessed violence bear the additional burden of being least able to communicate their fears and reactions in words.²⁶ Among preschoolers exposed to domestic violence, trauma symptoms frequently observed by clinicians include regression to earlier stages of functioning, insomnia, sleepwalking, nightmares and bed-wetting, headaches, stomach aches, diarrhea, ulcers, and asthma.²⁷

Exposure to family violence may lead to significant emotional difficulties such as feelings of shame, embarrassment, guilt, fear, and anxiety that are played out with sometimes devastating consequences in children's relationships.²⁸ Adolescence may be marked by the beginning of violence in peer and dating relationships. For girls, witnessing their mothers being battered during early adolescence may result in their belief that threats and violence are the norm in relationships,²⁹ and for boys, it may result in the belief that violence is an appropriate way to resolve conflicts.³⁰ Children in this age group who witness violence against their mothers often have difficulties in school, including poor

academic performance, school phobia, and difficulties in concentration.³¹ They have an increased tendency to fight with peers, rebel against instruction and authority, and exhibit an unwillingness to do school work.³² Many suffer low self-esteem, sadness, depression, poor impulse control, and feelings of powerlessness.³³

A New York state study, found that children from families where violence was present were five times as likely to be delinquent as those from the general population and 24 times more likely to have committed rape, and 50% more likely to have committed assault.³⁴

Between 60% and 75% of men seen in batterer's intervention programs report witnessing their fathers beat their mothers or being physically abused themselves when they were children.³⁵ In fact, the majority of studies of abusive men find that a high percentage come from homes in which there was abuse either of a spouse, a child, or both.³⁶ Findings such as these are consistent with studies of homicides occurring between partners, which indicate that the majority of men involved in those relationships also witnessed abuse and/or were abused as children.³⁷

Many assume that once a battered woman takes steps to protect herself and her children from further harm, the cycle of violence is stopped and its impact reversed. Too often this is not the case. In fact, obtaining protective court orders is only a first step toward protecting children. Children (along with their mothers) are at continuing or increased risk of being battered when a mother has begun to take

steps to end a violent relationship.³⁸ Unwilling to accept these changes, a batterer may attempt to continue the relationship and, failing, may re-direct his fury toward the children. Parental kidnapping is one of the more serious manifestations of batterers' refusal to be stopped, yet the vulnerability of children to abduction is not widely recognized or accounted for by courts in the course of making custody and visitation orders.³⁹

The long term implications for society of childhood exposure to domestic violence are staggering. Just as they learn from all life experiences, children learn from exposure to violence in their homes. Specifically, the children of domestic violence learn that

- violence is an appropriate form of conflict resolution
- violence has a place within the family interaction
- if violence is reported to others in the community, including mental health and criminal justice professionals, there are few, if any, consequences
- sexism, as defined by an inequality of power and decision-making roles within the family, is to be encouraged
- violence is an appropriate means of stress management⁴⁰

Unless steps are taken to protect children from the devastating harm that is often caused by violence against their mothers, far too many children will live out these life lessons in their adult relationships and in their relationships with their own children.⁴¹ The price for society, as we have already begun to see, is calamitous.

Part II

Integrated Community Networks: A Comprehensive Response to the Children of Domestic Violence

Fully grasping the implications of the data summarized here or the profound damage that domestic violence can cause children is not easy; after all, the statistics and clinical observations cited in Part I of this report reflect the pain of real children caught in the crossfire of violence, aimed at their mothers, that they are powerless to stop. Yet, if it is to be effective, our response to the children of domestic violence must honor the depth of trauma and complexity of needs that the experts have described.

Integrated community networks, in which comprehensive services are available to the child and adult victims of violence at all entry points within a given community, offer the best opportunity we have for such a response.⁴² Integrated community networks are marked by conscious and close collaboration across agency and organizational lines so that victims of violence have access to all of the services they may need regardless of when and where they first present themselves for assistance. In addition, integrated community networks are tied to

state-wide systems so that victims of violence can access safety and related services in communities away from home when these are needed.⁴³

Consider this example: in the course of a child's visit to a community health center a primary care clinician (having made a routine inquiry) learns that the mother is being abused and her child exposed to domestic violence. In a community where an integrated response system is in place, the revelation of domestic violence results in

- immediate concern for and the offering of services aimed at meeting the family's need for safety
- a preliminary assessment of the extent of harm already suffered by the family including a preliminary determination of whether there is a need for more in-depth evaluation of symptoms of trauma
- the offering of a comprehensive set of services including those offered by the battered women's service system, legal assistance, medical and mental health services (if necessary), and any other social service that may be needed

The key feature of this system is that at the initial point of entry (here, the community health center), the child has all of the intervention options of her community available to her. Experts, particularly those who provide clinical intervention and treatment services to the children of domestic violence, agree that this feature is critical because it is built on the recognition that domestic violence has complex causes and effects and that its victims need comprehensive services that address as many of the causes and effects as possible.⁴⁴ Moreover, because they are holistic, integrated community networks are more likely to succeed in actually stopping the cycle of violence and placing a child on the path of recovery.⁴⁵

To appreciate the benefit of this approach, one need only compare it to our present system where services received by a child exposed to domestic violence depend upon such variables as when and where he enters the system and the level of community collaboration that may have been achieved by the agency to which he first turns for help. Under our present system, a child and his mother might receive emergency shelter services but no extended mental health care; legal assistance but no emergency shelter services; shelter and mental health services but no legal advocacy; or shelter services but no income support assistance. If it were true, as it often is, that all of these services are needed for a family to be able to take a firm stand against continued violence and begin to recover from its devastating impact, then the failure of any one or more of these services to be available could well result in a return to violence and ever deepening harm.

As they are developed, integrated community networks will differ from one community to another, reflecting the particular needs within communities as well as the extent to which communities have already begun the collaborative process that is required for the creation of these systems. No matter how they are organized, however, integrated systems contain the following essential components:

- the capacity and willingness, among all key providers to identify domestic violence as an underlying cause of a child's stress and dysfunction;
- the prioritizing of safety for both the child and adult victims of violence;
- full availability of comprehensive intervention services aimed at safety and recovery for the child and his or her family; and

- a community-wide commitment to ongoing education and training in domestic violence prevention and intervention for professionals who serve children and families along with education directed toward children and teenagers on non-violence.

A few words about each of these key components follow along with steps that can be taken to begin (and in some communities, advance) the development of integrated networks in communities throughout the Commonwealth. These recommendations are not meant to be exhaustive but are offered as a blueprint for beginning to respond in a full way to the children of domestic violence.

Identification

Experts agree that intervention at the earliest possible moment is the critical first step in responding holistically to the children of domestic violence. Professionals who work with children need to be able to identify domestic violence when it is the underlying problem in a child's life. If they can accurately identify exposure to domestic violence as a key factor in a child's distress, then they can intervene swiftly and appropriately.

To give but one example, battered women and their children present with multiple physical injuries in hospital emergency rooms, clinics, and personal physicians' offices.⁴⁶ Yet, they are often not identified as battered and, as a result, they fail to receive appropriate treatment for the causes of their injuries.⁴⁷ The

implementation of protocols in all medical care settings for interviewing women and children with the aim of identifying domestic violence as a factor underlying the presenting medical problem is likely to significantly increase the rate of identification of domestic violence.

Concrete steps that can be taken to enable communities to develop the capacity to identify the children of domestic violence as early as possible include:

- 1) Encouraging universal implementation in all medical care facilities of the Commonwealth, including all school based clinics and medical facilities, of protocols for exploring violence issues with all health care consumers;
- 2) Supporting the development and offering of continuing educational programs in domestic violence and its effect on children for all currently licensed social work, child welfare, and health professionals (especially those in emergency medicine, obstetrics and gynecology, family practice, pediatrics, psychiatry, internal medicine, and mental health); those who work with children in child care centers, public schools, and after-school programs; and for clergy, prosecutors, and victims witness advocates;
- 3) Authorizing and funding the Department of Education to develop seminars on domestic violence for educators as well as a resource guide and protocol that will enable school personnel to make appropriate referrals to victims' services; and
- 4) Insuring that the Department of Education addresses the safety needs of the children of domestic violence by, first, undertaking a review of all present and impending policies and regulations to determine whether and how these might be amended to more fully meet these safety needs and, second, adjusting these regulations and policies wherever necessary.

Safety

Having increased our capacity to identify domestic violence in a wider variety of system entry points, the next critical component of any integrated network is the ability to keep children safe from further harm. Experts agree that safety is an essential prerequisite to recovery for the children of domestic violence.⁴⁸ The Commonwealth has recognized the importance of safety and has already taken important steps aimed at protecting the children of domestic violence. These steps include appropriating funds for direct services to battered women and their children through the state-wide network of battered women's service programs,⁴⁹ and the creation of a Domestic Violence Unit within the Department of Social Services.⁵⁰

Safety, however, needs to be understood and addressed more comprehensively than it has been if the children of domestic violence are to have as many options open to them as possible. This means recognizing that in addition to emergency shelter, safety includes a network of safe homes, financial support to see women and children through the period following separation from the batterer (who is often the primary or sole financial provider within the family),⁵¹ emergency and transitional housing, and a judicial system that has explicitly prioritized safety both in law and practice.

Many battered women, for example, turn first to the courts for orders of protection that will make themselves and their children safe. Studies have shown that consistent and certain application of all criminal and civil statutes relevant to

domestic violence and child abuse can have a positive impact.⁵² In addition, children are increasingly caught in the cross fire of civil court proceedings, as batterers retaliate by initiating paternity, custody and/or visitation actions in the Commonwealth's probate and family courts. Creating integrated community-based networks includes recognizing our courts as important providers of safety services for the children of domestic violence. One important tool that courts need to adequately safeguard the children of domestic violence is express statutory authority for a rebuttable presumption that unsupervised custody or visitation with a perpetrator of domestic violence is not in the child's best interest.⁵³

Concrete steps that will increase safety options for the children of domestic violence in a comprehensive way include:

- 1) Improving the capacity of battered women's programs to serve children through targeted funding initiatives that will enable the programs to offer direct services to more children in and out of shelter than they are presently able to serve and provide children's services staff with appropriate training;
- 2) Improving the ability of the Department of Social Services to meet its statutory mandate to protect children by increasing funding for its Domestic Violence Unit as well as increased funding for its network of community-based children's services (including individual and group support services, services for teens and services for perpetrators of violence);
- 3) Insuring that the Transitional Aid To Families With Dependent Children (TAFDC) Program advances the safety needs of the children of domestic violence by, first, undertaking a review of all present and impending policies and regulations to determine whether and how these might be amended to more fully meet these safety needs and, second, adjusting these regulations and policies wherever necessary;

- 4) Insuring that regulations and policies of the Executive Office of Communities and Development and the Commonwealth's public housing authorities advance the safety needs of the children of domestic violence by, first, undertaking a review of all policies and regulations to determine whether and how these might be amended to more fully meet these safety needs, second, adjusting these regulations and policies wherever necessary, and, finally, increasing options for obtaining safe housing including transition to independent living arrangements;
- 5) Enacting legislation providing that the interests of children who have been exposed to serious and chronic abuse are best served by a rebuttable presumption against an award of custody or unsupervised visitation to the perpetrator and by ordering visitation only if adequate provision for the safety of the children and abused parent can be made;
- 6) Providing adequate funding to insure the availability of visitation center services throughout the Commonwealth;
- 7) Facilitating strong and consistent enforcement of all civil and criminal statutes applicable to perpetrators of domestic violence and supporting the continuing education of all components of the law enforcement community, especially with regard to the special needs of children;
- 8) Appropriating funds sufficient to make SAFEPLAN Massachusetts advocates available in all district and family and probate courts to assist battered women seeking protection from abuse to not only obtain protective orders but also access the full array of legal and social services available to them and their children;
- 9) Promoting collaboration among courts, law enforcement agencies, batterer's intervention programs, and social service systems providing assistance and treatment to battered women and their children;
- 10) Increasing targeted funding initiatives for legal services for battered women in order to improve their ability to insure that they and their children receive the full range of legal protections available to them; and
- 11) Authorizing the Department of Education to undertake a study of options available to Massachusetts for developing protocols that

ensure the safety of children in the school setting and for protecting their school records from batterers.

Intervention

From the perspective of clinical experts who work with the children of domestic violence, comprehensive intervention proceeds through several steps. The first of these is assessment which includes an evaluation of the harm already suffered by a child, the risk of additional harm, and the environment in which the child lives. Evaluating a child's environment is critical if the package of services to be developed and delivered is to be responsive to the specific needs of each child. This includes an assessment of the condition and needs of the child's parents, other family resources, and living circumstances. Assessing the needs of the mother is an integral part of intervening on behalf of children exposed to domestic violence. The best assessments take place at the site where the child first enters the service system, are collaborative in nature and are completed by a team of experts that includes battered women's service providers, mental health and medical care specialists and child welfare specialists.⁵⁴

Having fully assessed the child's circumstances, he or she should then be offered a full range of individualized services. Services can include individual

therapy and/or group counseling for the child and mother, parenting skills training, and advocacy services. Like the assessment, services are most likely to succeed when offered in a collaborative manner, calling on the particular skills of each service provider as needed. In addition, the provision of services should be driven by the needs of the family rather than by insurance and cost-containment policies.⁵⁵ For children residing in battered women's shelters, the services described here should be available on site or in close proximity to the child and mother. On leaving the shelter, further evaluation and planning should be undertaken (again collaboratively) so that plans for continuation of services in the home community can be arranged.

There are several concrete steps that can be taken to promote the development of comprehensive, community-based intervention services. These include:

- 1) Funding the Department of Social Services to provide multi-disciplinary assessment and a full range of treatment services for children affected by domestic violence;
- 2) Taking steps to insure that current reimbursement systems do not prohibit the provision of the full range of psychological services needed to effectively treat children found to be harmed by exposure to domestic violence; and
- 3) Funding community-based pilot projects (as described in this paper) that, working in collaboration with battered women's service programs, the Department of Social Services, schools and other providers, can deliver comprehensive intervention services to children.

Education and Training

The quality of services delivered by integrated community networks is closely tied to the skill of its providers and experience has taught that on-going training is a critical component of such systems. Without a commitment to training it will be impossible to sustain the delivery of high quality services in the long term and children will be at risk for losing the benefits that intervention might initially bestow.

And, although childhood exposure to domestic violence is a powerful indicator of potential adult problems associated with violence, it is also true that violence against women and children is often perpetrated by men who were not exposed to domestic violence as children. Increasingly, researchers who study and professionals who treat the children of domestic violence have advocated early childhood education in non-violence as a key “primary prevention” strategy to be undertaken and evaluated.⁵⁶ These programs do not focus exclusively on domestic violence, but rather include issues of intra-family violence in their curricula placing it in the broader context of developing and nurturing the willingness and desire to interact non-violently with all people.

Concrete steps that should be considered in the effort to educate both professionals and children include:

- 1) Encouraging professional training (especially collaborative and interdisciplinary training initiatives) and on-going professional education in domestic violence and its impact on children;

- 2) Supporting the piloting and expansion of effective anti-violence programs that promote collaboration among parents, schools, community and law enforcement officials in community based settings throughout the Commonwealth. These programs should include the issue of domestic violence and its effect of children as well as parent training and teen dating violence prevention;
- 3) Introducing anti-violence and conflict resolution programming that is found to be effective in pre-school and elementary schools throughout the Commonwealth, expand successful middle and high school programs, and develop strategies that encourage media participation in the effort to decrease children's exposure to violence;
- 4) Supporting pilot job training and education, and economic development programs that integrate domestic violence issues (especially those that deal with the impact of domestic violence on children) into their curricula;
- 5) Funding the Department of Public Health to undertake a project aimed at evaluating existing and newly created school and community based violence prevention programs and to develop a manual for the development of model programs; and
- 6) Encouraging the development of parenting skills programs for new parents and parents who those children have been exposed to domestic violence.

Needless to say, there are challenges associated with the creation of integrated community networks, including fully funding the critical components of such systems, overcoming traditional barriers to collaboration,⁵⁷ developing and supporting leadership within the systems to insure their development, growth and continuity, and insuring accountability of the various components of the system to one another and to consumers.

The process of developing integrated responses to domestic violence is at once groundbreaking and complex. Meeting the challenges set out above will take creativity and commitment. The funding of one or more pilot projects in carefully selected communities within the Commonwealth may present the best opportunity for developing successful integrated networks because they provide a manageable opportunity to test new and evolving community-building strategies while providing services to a targeted segment of the population.

Pilot project communities should be chosen on the basis of a careful assessment of the likelihood that they will succeed, with assistance, in integrating a wide array of services for victims of domestic violence. Assessing the potential for successful integration of response systems includes exploring a community's commitment to overcoming traditional barriers to collaboration, the extent to which a network of services for battered women and children already exists (including a domestic violence roundtable or similar structure), and the existence of organizations within the community that have demonstrated creative leadership in bringing family violence and related providers together. Each pilot project should include a comprehensive research and evaluation component so that we can discover what works and what does not. Successful pilot communities would serve as models for other parts of the Commonwealth and, in this way, Massachusetts can build toward a statewide integrated response system for the children of domestic violence.

Conclusion

Emerging research confirms what common sense tells us: continuing exposure to the battering of one's mother is deeply traumatizing to many children. Without a coordinated and integrated response, the children of domestic violence are at unacceptable risk for individual and relational difficulty marked by interpersonal violence. We cannot afford to continue our presently fragmented approach to this escalating problem.

The recommendations contained in this report are meant to serve as a blueprint and a beginning. Task-oriented Work Groups whose efforts are coordinated by the Children's Working Group might be created to focus on each of the four key components of successful integrated community networks and, in this way, provide the Commission and appropriate branches of government with assistance in implementing the recommendations. The Children's Working Group might also be authorized to develop and present specific recommendations for choosing and funding pilot project sites.

However we decide to proceed, it is clear that with a commitment to develop integrated, community-based response systems, the cycle of violence will be broken for many children. The degree of success we achieve will be determined by the depth of commitment and staying power that we are able to bring to the

work. Finally, however, each child of domestic violence identified quickly and skillfully, each child brought to safety, each child assessed and offered a full range of healing services, and each child exposed not to battering but to non-violent models of human interaction and conflict resolution will be the best mark of our progress.

Endnotes

- ¹ Herman, J. L. (1992). *Trauma and Recovery*. New York: Basic Books (hereafter, *Trauma and Recovery*), p. 96.
- ² Peled, E., Jaffe, P. G., and Edleson, K. L., eds. (1995). *Ending The Cycle of Violence - Community Responses to the Children of Battered Women*. Thousand Oaks, CA: Sage), pp. 284, 285 (hereafter, *Ending The Cycle*).
- ³ As one team of researchers recently wrote: "Our study suggests that there is a high correlation between marital discord and aggression towards the child, compounding family instability and adding to the likelihood of adjustment problems. Children are caught in the crossfire of marital combat. They are used for purposes of retaliation and control in adult relationships. We believe that without ending violence between sexual partners, children will continue to be victims of systemic family aggression." McCloskey, L. A., Figueredo, J. A., and Koss, M. P. (1995). *The Effects of Systemic Family Violence on Children's Mental Health*. *Child Development*, Vol. 66, pp. 1239 - 1261. See also, McKay, M. M. (1994). *The Link Between Domestic Violence and Child Abuse: Assessment and Treatment Considerations*. *Child Welfare*, Vol. 73, No. 1, pp. 29 - 39; Stark, E. and Flitcraft, A. H. (1988). *Women and Children at Risk: A Feminist Perspective on Child Abuse*, in *International Journal of Health Services*, Vol. 18, No. 1, pp. 97 - 118; *Ending the Cycle*, pp. 97 - 105.
- ⁴ National Center on Women and Family Law. (1994). *The Effects of Woman Abuse on Children: Psychological and Legal Authority*, pp. 5 - 6 (emphasis added).
- ⁵ Pagelow, M. D. (1984). *Family Violence*. New York: Praeger, pp. 45 - 46, (hereafter, *Family Violence*).
- ⁶ Carlson, B. E. (1984). *Children's Observations of Interpersonal Violence*, in Roberts, A. R., (ed.) *Battered Women and their Families*. New York: Springer, pp. 147 - 167. See also Jaffe, P. G., Wolfe, D. A., and Wilson, S. K. (1990). *Children of Battered Women*. Newbury Park, CA: Sage Publications, p. 18 (hereafter, *Children of Battered Women*).
- ⁷ Straus, M. A. (1991). *Children as Witness to Marital Violence: A Risk Factor for Lifelong Problems Among Nationally Representative Sample of American Men and Women*. Paper presented at the Ross Roundtable on Children and Violence, Washington, DC.
- ⁸ *Women and Violence: Hearings before the US Senate Judiciary Committee, August 29, 1990 and December 11, 1990*. Senate Hearing 101-939, pt. 2, p. 142 (hereafter, *Women and Violence*. Ford, S. (1991). *Domestic Violence: The Great American Spectator Sport*. Oklahoma Coalition on Domestic Violence and Sexual Assault, p. 3.
- ⁹ Walker, L., Thyfault, R., and Browne, A. (1982). *Beyond the Juror's Ken: Battered Women*. *Vermont Law Review*, Vol. 7, No. 1 at p.11 (hereafter, *Beyond the Juror's Ken*); Strauss, M.A., Gelles, R. J. and Steinmetz, S. (1980). *Behind Closed Doors*. New York: Anchor Books (hereafter, *Behind Closed Doors*); Bowker, L. H.(1988). *On the Relationship*

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- Between Wife Beating and Child Abuse*, in Yllo, K. and Bograd, M., eds. *Feminist Perspectives on Wife Abuse*. Newbury Park, CA: Sage Publications, p. 21; McKibben, L., DeVos, E., and Newburger, E. (1989). *Victimization of Mothers of Abused Children: A Controlled Study*. *Pediatrics*, Vol. 84, No. 3, pp. 531 - 535.
- 10 *Women and Violence*, p.142.
- 11 Walker, L. (1984). *The Battered Woman Syndrome*. New York: Springer Publishing Co., p. 59; *Children of Battered Women*, pp. 20 - 21.
- 12 Cochran, D., Brown, M., Adams, S., and Powell, A. (1995). *The Tragedies of Domestic Violence - A qualitative analysis of civil restraining orders in Massachusetts*. Report of the Office of the Commissioner of Probation of the Massachusetts Trial Court, p. 9 (hereafter, *Tragedies of Domestic Violence*).
- 13 Zorza, J. (1991). *Woman Battering: A Major Cause of Homelessness*. *Clearinghouse Review*, Vol. 25, No. 4, pp. 421 - 429; Bassuk, E. D. and Rosenberg, L. (1988). *Why Does Family Homelessness Occur? A Case-Control Study*. *American Journal of Public Health*. Vol. 78, pp. 783 - 788; Help For Abused Women and Children. (1995) *Where do I go from here? Housing Needs of Battered Women, Affordable Housing Survey Results*.
- 14 *Children of Battered Women*, pp. 107-108; Davidson, H. (1994) *The Impact of Domestic Violence on Children. Report of the President of the American Bar Association*, pp. 13-15.
- 15 Orloff, L. E., Jang, D., and Klein, C. F. (1995). *With No Place to Turn: Improving Legal Advocacy for Battered Immigrant Women*, in *Family Law Quarterly*, Vol. 29, No. 2.
- 16 Wolfe, D. A., Jaffe, P., Wilson, S. K., and Zak, L. (1985). *Children of Battered Women: The Relation of Child Behavior to Family Violence and Maternal Stress*. *Journal of Consulting and Clinical Psychology*, Vol. 53, No. 5, pp. 657 - 665 and studies cited (hereafter, *The Relation of Child Behavior to Family Violence*).
- 17 Kashani, J., Daniel, A. E., Dandoy, A. C., and Holcomb, W. R. (1992). *Family Violence: Impact on Children*. *Journal of the American Academy of Child Adolescence and Psychiatry*, Vol. 31, No. 2; pp. 181 - 182; Fantuzzo, J., DePaola, L., Lambert, L., and Martino, T. (1991). *Effects of Interparental Violence on the Psychological Adjustment and Competencies of Young Children*. *Journal of Consulting and Clinical Psychology*, Vol. 59, No. 2, pp. 258 - 265; Hershorn, M. and Rosenbaum, A. (1985). *Children of Marital Violence: A Closer Look at the Unintended Victims*, in *American Journal of Orthopsychiatry*, Vol. 55, No. 2, pp. 260 - 266; Hughes, H. M. (1988). *Psychological and Behavioral Correlates of Family Violence in Child Witnesses and Victims*, in *American Journal of Orthopsychiatry*, Vol. 58, No. 1, pp. 77 - 90; Hurley, D. J. and Jaffe, P. (1990). *Children's Observations of Violence: II. Clinical Implications for Children's Mental Health Professionals*, in *Canadian Journal of Psychiatry*, Vol. 35, No. 6, pp. 471 - 476 (hereafter, *Children's Observations*).
- 18 *Children of Battered Women*, pp. 71 - 73; *Ending The Cycle*, pp. 29 - 32 and 172 - 173.
- 19 Contrary to the popular mythology and media messages, "[t]here is no such thing as 'getting used to combat'... Each moment of combat imposes a strain so great that men will break down in direct relation to the intensity and duration of their exposure." Appel, J. W. and Beebe, G. W. (1946). *Preventive Psychiatry: An Epidemiological Approach*, *Journal of the American Medical Association* 131, p. 1470. During the first world war, combat

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- soldiers “broke down” in unprecedented numbers, giving rise to fierce debates about the causes and treatment of “shell shock.” Their symptoms parallel those of women traumatized by abuse and of children traumatized by exposure to domestic violence. See *Trauma and Recovery*, pp. 7 - 32.
- 20 *Trauma and Recovery*, pp. 51 - 56.
- 21 *Trauma and Recovery*, p. 100; *Children of Battered Women*, p. 72.
- 22 *Children of Battered Women*, pp. 26 - 31; Straus, M. B., ed. (1990). *Abuse and Victimization across the Life Span*. Baltimore, MD: Johns Hopkins University Press, pp. 68 - 71 and studies cited (hereafter, *Abuse and Victimization*).
- 23 Dr. Herman summarizes the damage in this way: “.the personality, formed in an environment of coercive control is not well adapted to adult life. The survivor is left with fundamental problems in basic trust, autonomy, and initiative. She approaches the tasks of early adulthood ... burdened by major impairments in self-care, in cognition and memory, in identity, and in the capacity to form stable relationships. She is still a prisoner of her childhood.” *Trauma and Recovery*, p. 110.
- 24 Groves, B., Zuckerman, B., and Marans, S. (1993). *Silent Victims: Children Who Witness Violence*. *Journal of the American Medical Association*, Vol. 269, No. 2, p. 262 (hereafter, *Silent Victims*); Vissing Y. M., Straus, M. A., Gelles, R. J., and Harrop, J. W. (1991). *Verbal Aggression by Parents and Psychosocial Problems of Children*, in *Child Abuse and Neglect*. Vol. 15, No. 3, pp. 234-236; Hughes, H. M., Parkinson, D., and Vargo, M. (1989). *Witnessing Spouse Abuse and Experiencing Physical Abuse: A Double Whammy?* *Journal of Family Violence*, Vol. 4, No. 2.
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- 26 Although they may be unable to describe traumatizing events, young children may, nevertheless, show “evidence of traumatic memory in their behavior and their play.” *Trauma and Recovery*, p. 38.
- 27 *Children of Battered Women*, pp. 28 - 29. See also, Pagelow, M. D. (1982). *Children in Violent Families: Direct and Indirect Victims*, in Hill S. and Barnes, B. J., eds. *Young Children and Their Families*.
- 28 *Children of Battered Women*, p. 26.
- 29 *Children of Battered Women*, p. 27.
- 30 *Family Violence*, pp. 349 - 350.
- 31 Wolfe, D. A., Zak, L., Wilson, S. K., and Jaffe, P. (1986). *Child Witness to Violence Between Parents: Critical Issues in Behavioral and Social Adjustment*. *Journal of Abnormal Psychology*, Vol. 14, No. 1, pp. 101 - 102.
- 32 Roy, M. (1988). *Children In The Crossfire*. Deerfield Beach, Florida: Health Communications, Inc., pp. 65 - 67 (hereafter *Children In The Crossfire*); Goodman, G. S.

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- and Rosenberg, M. S. (1987). *The Child Witness to Family Violence: Clinical and Legal Considerations*, in Domestic Violence on Trial: Psychological and Legal Dimensions of Family Violence. Sonkin, D. J., ed. New York: Springer, p.100.
- 33 Fagan, J, Stewart, D., and Hansen, K. (1983). *Violent Men or Violent Husbands*, in Finkelhor, D., Gelles, R., Hotaling, G., and Straus, M., eds. *The Dark Side of Families*. Beverly Hills, CA: Sage Publications), pp. 49 - 68; Hilberman, E. and Munson, K. (1978). *Sixty Battered Women*. *Victimology*, Vol. 2, No. 3/4, pp. 460 - 471.
- 34 Alfaro, J (1978) *Report on the Relationship Between Child Abuse and Neglect and Later Socially Deviant Behavior*. New York State Assembly Committee in Child Abuse. Albany, NY. Cited in Guarino, S. (1985). *Delinquent Youth and Family Violence: A Study of Abuse and Neglect in Homes of Serious Juvenile Offenders*. Boston Department of Youth Services, Commonwealth of Massachusetts Publication No. 14,020-200-74-2-86-CVC.
- 35 *Children of Battered Women*, pp. 22 - 25.
- 36 *Children of Battered Women*, pp. 59 - 60; *Family Violence*, pp. 250 - 251.
- 37 *Beyond the Juror's Ken*, p 10.
- 38 Hart, B. (1993). *Children of Domestic Violence*, in *Courts and Communities: Confronting Violence in the Family*, A Conference of the Family Violence, a Project of the National Council of Juvenile and Family Court Judges; *Beyond the Juror's Ken*, p. 12.
- 39 Finkelhor, D. et al. (1990). *Missing, Abducted, Runaway and Thrown Away Children in America*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention: Greif, and Heger. (1992); Girdner, L. K., and Hoff, P. (1994). *Obstacles to the Recovery and Return of Parentally Abducted Children, Research Summary*. US Department of Justice, Office of Juvenile Justice and Delinquency Prevention, pp. 9 - 10.
- 40 Wilson, S. K., Cameron, S., Jaffe, P., and Wolfe, D. (1989). *Children Exposed to Wife Abuse: An Intervention Model*, in *Social Casework: The Journal of Contemporary Social Work*, p. 180; *Children of Battered Women*, p. 52.
- 41 Theories of “intergenerational transmission of abuse” are generally supported by survey and research data. *Abuse and Victimization Across The Life Span*, pp. 3 and 217; *Children of Battered Women*, pp. 59 - 60.
- 42 As used here, the term “community,” may mean a county, a city, a grouping of cities or towns, or a neighborhood. For one example of an experiment in creating an integrated network in the “community” of a local hospital, see Groves, B. (1994). *Focus: Managing Care for Victims of Violence. The Child Witness to Violence Project*. Discharge and Planning Update, pp. 14 - 17.
- 43 Battered women and their children in need of emergency shelter often feel that they need to leave home communities to obtain a real measure of safety. For this reason, they are typically not sheltered in the communities in which they (and the batterers) reside. Recently implemented technological strides within the battered women’s service community have made it possible for women to quickly access emergency shelter on a state-wide basis. This is a first important step toward an integrated system of responses that we have already taken in Massachusetts.

44 *Children of Battered Women*, pp. 95 - 118; *Silent Victims*, p. 264; Gruznski, R. J., Brink, J., C., and Edleson, J. L. (1988). *Support and Education Groups for Children of Battered Women*, in *Child Welfare*, Vol. 67, No. 5, p. 443.

45 “Fundamentally, the clinical intervention must be integrated into an overall community response by mental health, social service and legal professionals that does not condone violence against women and children.” *Children’s Observations of Violence*, p.475.

46 *Abuse and Victimization Across The Life Span*, pp. 209 - 210.

47 Emergency room staff identify battering in only a small percentage of the total cases that are subsequently found to involve battered women. Loring, M. T. and Smith, R. W. (1994). *Health Care Barriers and Interventions for Battered Women*, in *Public Health Reports*, Vol. 109, No. 3, at pp. 328 - 338; Klongbeil, K. S. and Boyd, V. D. (1984). *Emergency Room Intervention: Detection, Assessment, and Treatment*, in Roberts, A. R., ed., *Battered Women and Their Families*, New York: Springer, pp. 5 - 32; Flitcraft, A. (1993). *Physicians And Domestic Violence: Challenges for Prevention*, in *Health Affairs*, Vol. 12, No. 4, pp. 154 - 161; Salabar, P. (1993). *Improving Emergency Department Response to Victims of Domestic Violence*. *Western Journal of Medicine*, Vol. 159, No. 5, pp. 559 - 560.

48 *Abuse and Victimization Across the Life Span*, pp. 99 - 100; *Children of Battered Women*, pp.83 - 84.

49 It should be noted that even with significantly increased funding during the early 1990’s battered women’s service programs have only a limited ability to shelter children and women. In addition, many battered women decide that they and their children cannot bear the upheaval caused by escape to a shelter. These are legitimate concerns for although battered women’s programs offer an array of services for shelter residents, moving to a shelter is not without negative consequences for children. *Children of Battered Women*, pp. 36 - 37; *Children In The Crossfire*, pp. 88 - 92.

50 The Domestic Violence Unit was created within the Department of Social Services (DSS) in 1993 to enable the Department to respond more effectively to the children of domestic violence who, according to DSS data, account for nearly 70% of all neglected and abused children who come to the attention of DSS.

51 Research indicates that there is a direct relationship between a battered woman’s economic options and her ability to separate from the batterer. See *Abuse and Victimization Across The Life Span*, p. 164.

52 *Attorney General’s Task Force on Family Violence* (1994) Final Report. Washington, DC: United States Government Printing Office; Goolkasian, G. A. (1986). *The Judicial System and Domestic Violence - An Expanding Role*. *Response*, Vol. 9, No. 4, pp. 2 - 7.

53 An increasing number of advocates, clinicians, and judicial organizations support the concept of a rebuttable presumption of the kind suggested here. See, for example, Section 401 of *Family Violence: A Model State Code* (1994). National Council of Juvenile and Family Court Judges, p.33.

54 Comprehensive assessment of the sort recommended here has two parts, the first aimed at determining severity of harm and the second aimed at providing specialized evaluation

of children who appear to be severely damaged by exposure to domestic violence. Clinicians conducting the preliminary assessment need to be educated about domestic violence, child development and post traumatic stress disorder so that they can initially assess the severity of the child's exposure to family violence. Where preliminary assessment shows severe harm, a more specialized evaluation is needed which is conducted by clinicians skilled in the assessment of risk along a continuum, in the treatment of trauma, and in forensic issues.

55 Clinicians have expressed concern that managed care initiatives contain financial incentives that result in cutting services at the expense of quality. This possibility needs to be addressed so that strategies can be developed to insure that the children of domestic violence receive adequate treatment services. For an informative series on the Massachusetts managed care system see Fendell, S. (1994). *Mental Health Managed Care: MHMA Report Card Mixed - Conflict Between Profits and Consumers*. Advisor, Notes From The Mental Health Legal Advisors Committee, No. 40; Fendell, S. (1995). *Managed Care Initiative Expands: Impact Continues to be Felt*. Advisor, Notes From The Mental Health Legal Advisors Committee, No. 42; and Fendell, S. (1995). *Mental Health Managed Care: Expansion to DMH Acute Care and Medicaid Update*. Advisor, Notes From The Mental Health Legal Advisors Committee, No. 43.

56 *Abuse and Victimization Across the Life Span*, pp. 26 - 27, 217; *Children of Battered Women*, pp. 90 - 91; *Ending The Cycle*, pp. 207 - 254.

57 See, for example, Schechter, S. and Edleson, J. L. (1995). *In the Best Interest of Women and Children: A Call for Collaboration Between Child Welfare and Domestic Violence Constituencies* in The Prevention Report, Iowa City, Iowa: National Resource Center for Family Centered Practice.