

**Evaluation of  
Clinical Services for Children  
Affected by Domestic Violence:**

**Lessons Learned and To Be Learned**

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## Introduction

In June 2001, The Domestic Violence Unit of the Massachusetts Department of Social Services enlisted Northnode, Inc. and nine DSS-funded Massachusetts agencies that provide clinical services to children affected by adult domestic violence to work together to evaluate the impact of group services for children.<sup>1/</sup> Working collaboratively, and with key assistance from the University of Massachusetts Medical School,<sup>2/</sup> the group undertook the following activities:

- Selected particular outcomes that all participating agencies agreed were desirable and achievable in their work with children who witness domestic violence;
- Developed a curriculum for a 12-week therapeutic group for children between the ages of eight and 12, which addressed all of the chosen outcomes;
- Developed an array of instruments that would test the extent to which children who participated in the group actually achieved the sought-after benefits; and
- Worked together to explore clinical and programmatic issues that arose as agencies provided the group services to children and strove to also engage adult caretakers<sup>3/</sup> in the process of therapeutic intervention.

As a result of these efforts, statistically significant improvements were found in all of the outcome measures used, in caretakers' perceptions of their children's achievement of behavioral goals, and in group facilitators' ratings of children's improvement in the five skill areas emphasized in the curriculum. Caretakers described the groups as valuable in assisting the children in feeling less isolated and fearful as a result of their exposure to family violence.

This paper briefly describes the outcomes chosen, the development of the curriculum, the instruments used to evaluate the impact of the groups, and the data collected. It sets out lessons learned from the project as well as lessons still to be learned from ongoing work with children affected by domestic violence.

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<sup>1/</sup> The nine participating agencies are: Berkshire County Kids' Place; Brockton Family and Community Resources; Caritas Holy Family Hospital, Family Safety Project; COVE Project of Women's Crisis Center of Greater Newburyport; HarborCOV and Massachusetts General Hospital; South Shore Women's Center; The Family Center and The Guidance Center; the Worcester Youth Guidance Center; and the YWCA of Western Massachusetts.

<sup>2/</sup> Carole Upshur, EdD, of the Department of Family Medicine and Graduate School of Biomedical Sciences, worked with project participants to develop evaluation instruments and conducted the analysis of data provided by group facilitators.

<sup>3/</sup> We use the term "adult caretaker" or "caretaker" throughout this report to refer to the non-offending caretaker of the children who participated in groups. Most often, though not always, this was the mother.

## Background

A fair amount has been learned about the impact of adult domestic violence on children. We know, for example, that thousands of Massachusetts children are affected by adult domestic violence each year.<sup>4/</sup> We know that whether they witness violence directly or indirectly, and whether they are also abused or "only" witness the violence, children who are exposed to adult domestic violence 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, and replicating the violence they witnessed as children in their adult relationships and parenting experiences."<sup>5/</sup> We also know that for clinical intervention to be truly effective, it must be "integrated into an overall community response by mental health, social service, and legal professionals that does not silently condone violence against women and children."<sup>6/</sup>

Despite this knowledge, children affected by adult domestic violence have historically met a fragmented system of services, a system too often marked by domestic violence service providers who lack the capacity to provide skilled clinical assessment and intervention services for children and by mental health providers who do not appreciate the extent to which family violence pervades the lives of their adult clients and do not fully understand the impact of domestic violence on children.

In 1999, in an effort to begin to systemically address these problems, the Massachusetts Department of Social Services (DSS) issued a Request for Responses (RFR) seeking proposals from agencies interested in working with DSS to expand the Commonwealth's capacity to respond more effectively to the children of domestic violence. In addition to recognizing the serious risk factors facing children who are exposed to domestic violence, the RFR observed that "intervention for children who live with domestic violence must be embedded in a continuum of services geared toward the family and geared toward supporting the efforts of the non-abusing parent to establish a safe environment for herself and her children. Effective mental health services for children are also connected to a wide array of community services and build on community strengths and resources."<sup>7/</sup>

Nine agencies in various parts of Massachusetts received funding under the RFR and began to develop and deliver a range of services for children. DSS then turned to the issue of evaluation, seeking to better understand the impact of clinical interventions with

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<sup>4/</sup> An analysis of civil restraining orders issued in one year in Massachusetts found that approximately 43,000 children had been exposed to domestic violence. See 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.

<sup>5/</sup> *The Children of Domestic Violence, A Report of the Governor's Commission on Domestic Violence of the Commonwealth of Massachusetts*. 1997, p. 1.

<sup>6/</sup> 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, p. 475.

<sup>7/</sup> *Clinical Services for Children Affected by Domestic Violence*. 1999, RFR File Number DSS-M9913, p. 4.

children and, through that understanding, to improve the Commonwealth's overall response to children affected by adult domestic violence.

To these ends, the project commenced with a review of the literature evaluating various forms of intervention and treatment with children. Although the literature review revealed precious little material evaluating specific treatment methodologies,<sup>8/</sup> it did provide clues about how Massachusetts providers could think about evaluation and also signaled an opportunity for Massachusetts to make a significant contribution to the general knowledge base in this field.

Taking up the challenge and working collaboratively, we developed a mission statement to guide our work, engaged in a process through which we agreed to develop and then evaluate a therapeutic group service for children between the ages of eight and 12, decided to evaluate the impact of this service from multiple perspectives, and most importantly, agreed that evaluation requirements would never take precedence over the provision of high quality services to adults or to children affected by domestic violence.

## Developing the Evaluation Methodology

### 1. Choosing Outcomes and Target Population

The process of choosing outcomes involved finding shared goals among nine distinct agencies and coming to agreement that, for purposes of this study, all participating agencies would undertake to provide a common set of services using agreed upon methodologies and instruments. The group explored a number of desirable outcomes, settling on ones that were of substantial clinical interest, that had the potential for bringing real help to children affected by domestic violence, that were capable of being measured, and that could be sought after by all participants using fairly uniform methods of therapeutic group intervention.

Applying these criteria, agency participants decided to focus on the following five outcomes: increased pro-social behavior, increased ability to identify/express feelings, increased conflict resolution skills, increased recognition of and decreased tolerance for abuse, and increased safety planning skills. The group also decided to evaluate the ability of group services to achieve these outcomes by developing and offering a twelve-week therapeutic group for children between the ages of eight and 12.

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<sup>8/</sup> At the time the project began, there were five published studies that evaluated specific therapeutic interventions with children who had been exposed to adult domestic violence.

## 2. Developing a Curriculum

A curriculum for the group was developed collaboratively, building on materials provided by several of the participating agencies as well as materials from *Group Treatment for Children Who Witness Woman Abuse, A Manual for Practitioners*, developed by (and used with the permission of) the Children's Aid Society of London and Middlesex, Ontario, Canada.<sup>9/</sup>

The course covered subjects such as feelings, defining abuse, safety planning, substance abuse, sexual abuse, and conflict resolution. It included the use of a video entitled, *It's Not Always Happy in My House*. Participating agencies agreed to adhere to the contents of the curriculum (especially those parts that focused on the outcomes designated for evaluation) and also had freedom to introduce variations that made the course more effective for the particular group of children participating. In this way, an effort was made to meet the need for substantial uniformity in the delivery of group services and also accommodate the desire of agency participants for flexibility in using the curriculum.

## 3. Evaluation Instruments

In order to meet our commitment developing and implementing the evaluation in ways that would generate real confidence in the findings, it was agreed that the effect of the group services would be evaluated from multiple perspectives: those of the children who participated, the caretakers of participating children, and the group facilitators. To this end, we used a standardized instrument, the Pediatric Symptom Checklist (used as a pre and post test) to provide a general view of whether and how the emotional condition of children changed from the beginning of the group experience to its conclusion. We also developed the following instruments to provide additional perspectives on how children responded to the course:

- A demographic questionnaire to capture information about the children and families participating in the study;
- A children's questionnaire (used as a pre and post test) to determine whether and to what extent children learned the key lessons that the course intended to teach;
- A facilitator's evaluation of children's participation (used as a pre and post test) to document changes in children's behavior as group participants;
- A goal attainment scaling instrument in which caretakers were invited to articulate specific goals for the children, which they then reviewed at the close of the course to determine whether and to what extent the goals they had for the children had been met; and

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<sup>9/</sup>Participants from Brockton Family and Community Resources, Caritas Holy Family Hospital, and The Guidance Center contributed materials to the curriculum which was developed by Northnode and participants from Massachusetts General Hospital, The Guidance Center, and the Worcester Youth Guidance Center.

- A general course evaluation completed by the caretakers at the conclusion of the course.

The decision to undertake this kind of multi-tiered evaluation meant that a significant amount of time would have to be dedicated to administration of study instruments. Despite the burdens created by this approach, agency participants remained true to their commitment to a high quality evaluation and the results, as summarized below, demonstrate the value of this effort.

## Evaluation Results

As noted in the introduction to this report, children who participated in the study demonstrated statistically significant improvement in all of the outcome measures used. These improvements were confirmed independently by caretakers' ratings of the children's psychiatric symptoms (using the Pediatric Symptom Checklist) and by group facilitators' ratings of children's changes in the areas emphasized in the curriculum. Caretakers generally found the groups to be valuable in assisting the children in feeling less isolated and fearful.

### 1. Description of the Participants

Data were included for 75 children from nine different programs.<sup>10/</sup> Caretakers' evaluations of the group experience were available for 39 caretakers. Characteristics of the children who participated were as follows:

- The average age of the children was 9.88 years.
- 79% of participants were White, 13.3% were Hispanic, and 7% were "Other."
- Children were almost evenly divided between boys and girls.
- 74% lived with their mother or mother and siblings; three lived in foster care; seven lived with grandparents; six lived with other relatives; and three lived in a shelter.
- 45% had been physically abused; 13% had been sexually abused.
- Four children currently lived with the batterer; 61% had been separated from the batterer for a year or less, while an additional 18% had been separated for 1-2 years.
- 59% of the children were receiving other types of services (including individual therapy, family therapy, after-school program participation, and psychiatric care with medication monitoring).

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<sup>10/</sup> In a number of instances, data were missing, resulting in outcome data being available on only 66 of the 75 participating children.

- 61% of the children had contact with the abusive individual: 30% by phone, 48% via unsupervised visits, and 14% via supervised visits.

## 2. Summary of Outcomes

Based on the children's pre and post tests and the facilitator's pre and post tests, there were highly significant and positive changes in all five outcomes. Children self-reported increased safety planning skills, learning about violence, and conflict resolution skills. Mothers rated the children's behavior as improved from the time they began group participation to the end of their group experience. Facilitators also recorded significant improvement in all areas for most of the children who participated.

In terms of the goals set by caretakers for their children, goals related to safety planning showed the greatest progress, followed closely by goals related to expressing feelings. Overall, 83.5% of goals set were met or exceeded for 47 children for whom both pre and post goal setting information was available.

A total of 44 caretakers, mostly mothers, rated the groups on how much information they were provided about the group and how helpful the group was. Slightly more than half (56%) reported they had enough information about the group, although 43% felt they did not have as much information as they would have liked. However, all who reported asking questions said they were satisfied with answers and the help they received learning about the group. Overall, caretakers rated the helpfulness of the group to their child very highly: 64% gave the highest helpfulness rating, while 32% rated the group a moderately helpful. Only 5% of the mothers who completed an evaluation of the group services characterized them as "not very helpful."

Caretakers also had a number of suggestions for making the group experience even more effective. These included the following:

- Providing more information from group facilitators about children's progress;
- Providing more details about the activities that children would be engaging in while in groups;
- Offering a concurrent opportunity for caretakers to meet and talk with one another about parenting and related issues (with child care provided for children not participating in the group); and
- Incorporating more active movement activities into the curriculum.

## Lessons Learned

This study clearly demonstrates the value of group services for children in this age group.<sup>11/</sup> In addition to seeing the ways in which group participation generated improvements in the five outcome areas on which the study focused, many other lessons were learned through this study, including those that follow:

- Structured groups such as the ones offered by the participating agencies contribute substantially to children's understanding of domestic violence, their ability to consider how to keep themselves safe, their ability to manage conflicts, and their improvement in social interactions (pro-social behavior).
- The creation of a safe group environment gave participating children a way and an opportunity to talk about things that they may not have been able to talk about in individual therapy or in other settings; by naming abuse, the group gave children a language for their experiences.<sup>12/</sup>
- Substantial engagement of the adult caretakers is a critical aspect of successful group experiences; steps that might be taken to enable caretakers to be more involved include the following: providing concurrent groups for caretakers that address the issues being covered in the children's groups; providing child care for siblings not participating in group services; coordinating services so that individual counseling or other peer support groups for adults are offered at the same time as groups for children; and exploring the development of facilitated groups that bring parents and children together to work on a range of parent-child issues that arise in families where domestic violence is present.
- More complete integration of clinical services for children with services for the adult survivors of domestic violence is an important aspect of improving the system's response to children affected by adult domestic violence; for domestic violence service agencies that do not have the capacity to provide in-house clinical services for children, the need to be more fully connected to clinical providers is as clear as the benefit that these specialized services can provide.
- There is a need to incorporate physical activity in therapeutic groups for children in this age group, as a way to deal with the sometimes intense energy that children bring to the group, and to encourage and model

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<sup>11/</sup> In making this statement, we acknowledge a significant limitation to our study, namely, the lack of control groups that might have enabled us to study outcomes for children who received different group services or other types of clinical interventions (such as individual therapy) or to compare the children in our study to those who received no services at all. Despite this limitation, we believe that the lessons learned are of real value to our own community of providers and to others who might be contemplating the development of clinical services for children affected by adult domestic violence.

<sup>12/</sup> Just as naming abuse has an empowering effect on adults who have been or are being battered, naming the abuse for children gave them a way to work with their experience that may not otherwise have been available to them.

appropriate physical interactions among children and between children and adults.

- There is also a need to develop strategies for helping children deal with the stress associated with exposure to adult domestic violence; in addition to body work, providers can work to better understand how free play and creativity might contribute to children's sense of well-being even as they struggle with the violence that surrounds them.
- A significant number of children are engaged in some kind of relationship with the perpetrators of abuse (who are often, although not always, their fathers). Acknowledging this fact and incorporating it appropriately into children's services is an important next step for this system of services. This could include the following: advocating for and providing training for judges who may issue orders for custody or visitation without full awareness of the impact of such orders on children; developing stronger relationships with court-based domestic violence advocates; offering and providing training for those who serve as guardians *ad litem* in custody and visitation cases involving children of domestic violence and for police who respond to calls related to domestic violence; and engaging providers of domestic violence, supervised visitation, and batterer intervention services in an exploration of how the differing approaches and philosophies of these systems might be harmonized to assure safe and appropriate relationships between the children of domestic violence and their fathers.
- Given the large number of children who were receiving other services while they participated in these groups, attention needs to be paid to the quality of the connections among service providers and to the education of other service providers about the effects of adult domestic violence on children. Training for (and, perhaps, formal case consultation with) children's advocates in domestic violence service agencies and for providers in the larger mental health services systems would be important places to begin.

## Lessons to Be Learned: New Questions to Explore

Even as the study provided a strong affirmative answer to the question of whether group services are likely to have a positive impact on children in this age group, it generated a number of questions to be explored by this group of providers and others who may be interested in working with children affected by adult domestic violence. These include the following:

- How can we better understand the value of group services as compared to individual therapy for children in this age group? Although it is generally thought that group services are most appropriate for children in this age

group, many of the children who participated in the study also received individual counseling or therapy. It would be helpful to know more about how each type of service affects children so that we can better fashion individualized treatment plans for children who seek our services.

- Do the positive effects demonstrated in this study hold true when siblings participate in group services? While a number of siblings took part in the groups, the study did not specifically look at the interactions of siblings; nor did it compare changes demonstrated among sibling within groups.
- What are the specific effects of repeating these groups? In a number of instances, children requested (and were granted) permission to participate in a subsequent course. Group facilitators believe that such participation has the effect of amplifying the benefits achieved in earlier rounds of participation, but this was not (and has not) been documented.
- Are group services likely to be helpful for younger children, particularly children of pre-school age? Seeking effective interventions with children at the earliest ages possible, project participants have discussed (and some are exploring) the efficacy of group services for children between the ages of four and six.
- How might the benefits of these group services be enhanced by the provision of integrated and concurrent services for caretakers? As the caretakers' evaluations showed, there was a real interest in concurrent services. How each participating agency develops such services and how they might be evaluated are both topics for future exploration.
- Closely related to the question above is the question of how services to mothers might be enhanced by the concurrent and integrated provision of services to their children. We need to recognize that the positive outcomes achieved for children might not produce comparably positive outcomes for mothers.<sup>13/</sup> As we develop more fully integrated adult and child services, we will need take into account the complex relationships between battered women and their children and work to develop services that are effective for both.
- How can this set of services be of comparable use to children whose cultures and countries of origin have norms that are different than those currently operating in the United States? Most of the children who participated in our groups were white and all spoke English. It would be important to explore adaptations of the curriculum that specifically speak to the realities and norms of immigrant children who are strongly connected, by language and culture, to their countries of origin outside the United States.

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<sup>13/</sup> The evaluation of a pilot project of comprehensive services, including group and individual therapy and case management offered through a program for battered women in New Jersey, found among other things that "while there are reported changes in children's behavior, the mothers' reported levels of stress do not decline following treatment...[in part because] [p]arenting is continuing to take place in the context of highly elevated life stress." Jeffrey, L.R. 1999. *Evaluation of a Program of Comprehensive Treatment Services for Child Witnesses to Domestic Violence: Peace: A Learned Solution (PALS) Project*. Paper presented at the Fifth International Conference on Children Exposed to Family Violence, Vancouver, British Columbia.

- As the system works to more fully meet the needs of children affected by domestic violence, how can clinical and therapeutic approaches be harmonized with the historic grass roots approaches of traditional domestic violence service agencies?
- Given that so many children are in contact with the perpetrator of abuse, how can services for children affected by adult domestic violence acknowledge and address these ongoing relationships in ways that are at once protective of safety and effective for the children and their non-offending caretakers? Closer collaboration between domestic violence service agencies, children's supervised visitation centers, and batterer intervention programs (including jointly developed and implemented evaluation projects) may provide important insight into how to work most effectively with children who have on-going relationships with the perpetrators (most often their fathers).

## In Conclusion

Evaluation studies such as the one described here make an important contribution to what is known about how to respond most effectively to children who have been affected by domestic violence. The project itself, the lessons learned, and the questions that remain to be answered all contain valuable insights. Whether these are taken up by current providers who are working to improve on already excellent services, by other providers seeking concrete ideas on how to develop effective sets of services for children, or by government agencies seeking to expand the capacity of community-based providers to respond to adults and children who have experienced domestic violence, the statewide effort to continuously improve our response to children affected by domestic violence is sure to be enhanced.