Domestic Violence in the Lives of Women Receiving Welfare

Mental Health, Substance Dependence, and Economic Well-Being

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Using data from a random sample of women from the welfare caseload in an urban Michigan county, the authors investigate the prevalence of domestic violence and its association with mental health, health, and economic well-being. Nearly a quarter of the women experienced physical partner violence in the past 12 months, and almost two thirds in their lifetimes. Recent victims had significantly higher rates of five psychiatric disorders (depression, generalized anxiety disorder, post-traumatic stress disorder, drug dependence, and alcohol dependence) and health problems than women who never experienced domestic violence. Recent partner violence was also associated with greater material hardship. Analyses did not indicate any significant association between domestic violence, past or present, and employment.

Although domestic violence is clearly a problem for women of all socioeconomic groups (Plichta, 1996; Straus & Gelles, 1990; Tjaden & Thoennes, 2000), attention must be given to low-income women who suffer from domestic violence victimization. A number of studies (Allard, Albeda, Colten, & Cosenza, 1997; Browne & Bassuk, 1997; Lloyd & Taluc, 1999) have documented the high

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prevalence of domestic violence in the lives of women on welfare. Focusing on lifetime physical abuse by a male partner in welfare samples, prevalence rates range from 28% to 63% with most estimates converging in the 40% to 60% range. Current or recent domestic violence rates for welfare recipients range from 8.5% to 41.4% (see Tolman, 1999). These high prevalence rates support concern that domestic violence may be an important barrier to welfare recipients' ability to obtain and maintain employment because abusers may actively interfere with their partners' attempts to work (Allard et al., 1997; Lloyd & Taluc, 1999; Raphael, 1995).

Domestic violence may also be an indirect barrier to job search and job maintenance by increasing the risk of health problems and psychiatric disorders that could interfere with these activities. A number of studies have documented the impact of abusive behavior on the physical and psychological well-being of women (Campbell & Lewandowski, 1997; Plichta, 1996). In a national study of women's health among a random sample of women aged 18 to 64, women who experienced violence were more likely to report having a diagnosis of a depressive or anxiety disorder from a physician in the past 5 years than nonabused women (Plichta, 1996). Women in this sample who were physically abused by their spouse or partner in the past year were also more likely to have a high level of current depressive symptoms (74% compared to 34.2% of nonabused women). Abused women were nearly twice as likely as nonabused women to rate their health as fair or poor and more likely to report physical symptoms of health problems.

In addition to creating barriers to work and diminishing women's physical and psychological well-being, domestic violence may also increase the risk of material hardships, such as homelessness, food insufficiency, and other economic problems. Women who are victims of domestic violence often have to decide between staying with an abusive partner and leaving sufficient shelter and food. Homelessness has been linked to domestic violence in a number of studies (Browne & Bassuk, 1997; Metraux & Culhane, 1999; Toro, Bellavia, Daeschler, & Owens, 1995). Poor women with children who are the victims of domestic violence may rely on public assistance programs as a safety net from homelessness and hunger when fleeing violent partners.

RESEARCH QUESTIONS

In this study, we examine the prevalence of domestic violence in a random sample of welfare recipients, and the association of domestic violence with mental health, health, and economic well-being of women on a welfare caseload. We hypothesize that domestic violence victims will have poorer mental health, physical health, and economic outcomes. Specifically, we predict that domestic violence victims will have higher levels of mental health and substance abuse disorders, poorer perceived health, higher levels of physical health impairment, and higher rates of material hardships (such as eviction, utility shut-off, homelessness, and food insufficiency). Furthermore, we hypothesize that domestic violence victims will be less likely to be employed and more likely to continue to receive cash assistance.

METHOD

STUDY OVERVIEW

We report data from the first wave of the Women's Employment Study (WES), a three-wave survey of welfare recipients in an urban Michigan county. The WES collects detailed information on recipients' experiences with domestic violence, mental health and physical well-being, and employment and welfare status. In the fall of 1997, we conducted face-to-face interviews with a random sample of 753 women who were welfare recipients in February 1997. Michigan's Family Independence Agency, which administers the state's TANF program, provided names and addresses of all single-parent cases.

The sample included single mothers between the ages of 18 and 54 who were residents of the selected county, had a racial identity of either White or Black, and were United States citizens. Because noncitizens and other ethnic/racial groups comprised a small proportion of the overall caseload, there was an insufficient sample size to examine these groups in detail. With these exceptions, the WES sample can be characterized as a simple random sample, systematically selected with equal probability from an ordered list of eligible women.

In the first wave, we collected data on physical health, mental health, partner violence, demographic characteristics, income, health insurance, current/most recent job, current welfare status, and work and welfare histories. The response rate was 86.2% (753/874). The sample is representative of the population and has been verified on the bases of race, age, months on welfare, number of people on caseload, employment codes, and monthly reported income. The comparison of sample distributions to population distributions produced no differences that warranted corrective weights in analysis (Danziger et al., 2000).

STUDY PARTICIPANTS

Fifty-seven percent of participants were Black and 43% were non-Hispanic White. The sample was limited to recipients between the ages of 18 and 54, with 28% younger than 25, 46% between the ages of 25 and 34, and 26% who were 35 or older. In terms of urban and rural residence, 86% of the women lived in urban census tracts in the county. Nearly one quarter (24%) of the participants were currently living with a spouse or partner, and 66% were the primary caregiver for at least one child between the ages of 0 and 5 (for further discussion of the sample, see Danziger et al., 2000).

MEASURES

Domestic Violence

Domestic violence was assessed with a modified version of the Conflict Tactics Scale (CTS; Straus, 1979). We augmented the CTS by adding items that asked about additional physical and non-physical forms of abusive behavior. These domestic violence items were used to create 12-month and lifetime prevalence measures. The scales include a five-item threat scale (12-month alpha = .71, lifetime alpha = .79), an eight-item direct physical violence scale (12-month alpha = .83, lifetime alpha = .89), a six-item severe physical violence scale, which includes the same variables as the physical violence scale without two items sometimes considered not severe (slapped, kicked, or bit you, and pushed, grabbed, and shoved) (12-month alpha = .81, lifetime alpha = .86), and a two-item interference with work scale (12-month alpha = .61, lifetime alpha = .67). We report the prevalence of each type of domestic

violence subscale for our sample, but our bivariate and multivariate analyses defined domestic violence as the presence of severe physical abuse only. (See Table 1 for list of items in each index.)

Health

Health status was assessed by sections of the SF-36 Health Survey (Ware & Sherbourne, 1992), which measures health dimensions, including physical and social functioning, mental well-being, and self-perceived general health status. We use two indicators of health problems in the analyses presented here: self-perceived health status of fair or poor, and age-adjusted physical limitations as measured by the SF-36 physical limitation subscale, which is defined as the bottom quartile in national norms for women for that scale. Women who had both a physical limitation and rated their health as poor or fair were coded as having a health problem in our logistic regression analyses.

Mental Health

Mental health and substance dependence were measured using diagnostic screening batteries developed from the University of Michigan Composite International Diagnostic Interview (UM-CIDI; Wittchen & Kessler, 1994). The screening scales assess *DSM-III-R* disorders. We used short-form scales to assess depression, generalized anxiety disorder, and alcohol and drug dependence in the past 12 months. We measured post-traumatic stress disorder (PTSD) over the lifetime of the participant using the full UM-CIDI measure. We also determined which women with lifetime PTSD had reactions persisting into the past 12 months resulting from their most upsetting traumatic event.

Material Deprivation

Participants answered questions with regard to a number of indicators of material deprivation. We asked if each of the following had occurred within the past 12 months: experienced homelessness, had gas or electricity shut off, and/or faced eviction. We also asked about the amount of food the family had to eat and, following Alaimo, Briefel, Frongillo, and Olson (1998), classified participants as food insufficient if they reported that they "sometimes" or "often" did not have enough to eat.

Employment and Welfare Status

We defined a participant as employed if she was working at least 20 hours per week (as required for a welfare recipient to be in compliance with Michigan's welfare rules at the time of the study). Welfare status is a dichotomous variable, defined by the participant's self-report that she was currently receiving cash assistance from Michigan's Family Independence Agency.

Demographic Variables

We examined demographic characteristics known to be associated with increased risk for poor mental health, health, and economic outcomes among women. These include age (Turner & Lloyd, 1999), race (Black or White; Geronimus, 1999; Ng-Mak, Dohrenwend, Abraido-Lanza, & Turner, 1999), having less than a high school degree or equivalent GED (Ross & Mirowsky, 1999), preschool children younger than 5 years in the home (Hofferth, 1999), and whether or not the participant was living with a male partner (Brown & Moran, 1997; Muntaner, Eaton, Diala, Kessler, & Sorlie, 1998; Prigerson, Maciejewski, & Rosenheck, 1999). Poverty was measured using the official ratio of total family income to the federal poverty line for a given family size (Danziger & Gottschalk, 1995).

RESULTS

PREVALENCE OF VIOLENCE

Table 1 lists the prevalence of each type of abuse and the summary subscales. Using the more stringent definition of severe abuse, about half the sample (51%) experienced severe abuse in their lifetime, with 14.9% having at least one of these events occur in the last year with a partner. Women in the sample also report direct interference by their partners with their ability to go to work and, once there, to perform their jobs without interference. For women currently experiencing severe violence, 48.2% reported direct work interference within the past year.

Table 2 compares the prevalence of physical and severe abuse in our study with other welfare samples as well as national studies. Our findings are consistent with the prevalence found in other

TABLE 1
Prevalence of Abusive Behaviors by Partner (in percentages)

	Lifetime	*12 Month*
Threats		
Threatened to take your children away	27.5	11.7
Threatened to turn you into Child Protective Services	12.1	5.3
Threatened to hit you with a fist	55.0	15.0
Threatened to harm or harmed your family and friends	20.7	6.6
Threw anything at you that could hurt you	31.5	7.8
Any threats	61.4	24.0
Physical violence		
Slapped, kicked, or bit you	34.0	8.8
Pushed, grabbed, or shoved you	55.4	20.1
Severe physical violence		
Hit you with his fist	31.3	7.8
Hit you with an object that could hurt you	25.4	5.8
Beat you	28.6	5.4
Choked you	31.5	6.4
Threatened to or used a weapon	25.8	7.0
Forced you into any sexual activity against your will	19.3	2.1
Any physical violence	62.8	23.2
Any severe physical violence	51.0	14.9
Work interference		
Stayed home from work or school because of something partner did	23.2	5.6
Harassed you at work, training, or school or interfered with attempts to go to work, training, or school	22.8	7.3
Any work interference	31.9	9.8

welfare studies, but the prevalence of domestic violence in our sample is considerably higher than national norms—two to three times the prevalence of national samples.

DOMESTIC VIOLENCE AND MENTAL HEALTH

Compared to national norms for women (Kessler et al., 1994), our sample had two to three times the prevalence for three of the diagnoses included in the study: depression, generalized anxiety disorder, and lifetime PTSD. Rates of drug dependence were somewhat higher and alcohol dependence lower than the national norms (see Table 2).

In Table 3, we examine the relationship between domestic violence and mental health and divide the sample into three groups: (a) women who experienced severe violence in the past 12

TABLE 2
National Comparisons of Prevalence of Domestic Violence and Mental Health

	WES	*Welfare*	*National*
Domestic violence			
Physical abuse—12 months	23.2	14.6-24.0[a]	7.8[b]
Physical abuse—lifetime	62.8	57.3-64.9	21.7[c]
Severe abuse—12 months	14.9	3.2[d]-3.4[e]	
Severe abuse—lifetime	51.0	33.8-61.0	
Mental health disorders[f]			
Major depression	25.4		12.9
Generalized anxiety disorder	7.3		4.3
Alcohol dependence	2.7		3.7
Drug dependence	3.3		1.9
PTSD—lifetime	29.5		10.4

NOTE: WES = Women's Employment Study; PTSD = post-traumatic stress disorder
a. For full review and citations of welfare prevalence data see Raphael and Tolman, 1997.
b. Straus and Gelles, 1986.
c. Tjaden and Thoennes, 2000
d. Plichta, 1996.
e. Straus and Gelles, 1986.
f. Comparisons are with women in the National Comorbidity Survey (Kessler et al., 1994). All comparisons are for 12-month diagnoses, with the exception of PTSD, which compares lifetime prevalence.

months (Recent, n = 112, 14.9%); (b) women who experienced severe violence at some point in their lives but not in the past 12 months (Past, n = 272, 36.1%); and (c) women who never experienced severe violence (Never, n = 369, 49%). Women who experienced domestic violence in the past 12 months had nearly three times as many mental health disorders as their nonabused counterparts and were generally one and a half to two times more likely to have a mental health disorder than the past-victim group (see Table 3).

We also examined the service utilization and service needs of domestic violence victims. Recent victims were twice as likely to have received treatment for mental health problems (19.6%) than the past victims (13.6%) and the never-victimized group (10.0%), and twice as likely (26.8% vs. 13.6%) to report currently needing treatment than their counterparts who had experienced violence in their lifetime but not in the past 12 months. They were more than three times as likely than the never-victimized group (26.8% vs. 8.7%) to identify a current need for mental health treatment.

We conducted hierarchical logistic regression analyses to determine if domestic violence was significantly associated with mental health and substance disorders when accounting for demo-

TABLE 3
Domestic Violence and Mental Health, Physical Health, and Economic Outcomes (in percentages)

	Recent (R) Severe Violence (n = *112)*	*Past (P) Severe Violence* (n = *272)*	*Never (N) Severe Violence* (n = *369)*	χ^2 *Test*		
Mental health and substance dependence						
Depression	44.6	31.3	15.2	R > N***	R > P*	P > N***
GAD	13.4	9.2	4.1	R > N***		P > N**
PTSD—12 months	38.4	17.6	5.1	R > N***	R > P***	P > N***
PTSD—lifetime	53.6	40.8	13.8	R > N***	R > P*	P > N***
Drug dependence	6.3	4.0	1.9	R > N*		
Alcohol dependence	8.0	2.6	1.1	R > N***	R > P*	
Any mental health disorder	58.9	42.6	20.3	R > N***	R > P**	P > N***
Any disorder	60.7	43.8	20.9	R > N***	R > P**	P > N***
Any substance disorder	11.6	5.9	2.4	R > N***		P > N*
More than one disorder	36.6	15.8	5.1	R > N***	R > P***	P > N***
Health						
Age-specific physical limitation	55.4	48.2	41.2	R > N**		
Fair or poor health	35.7	30.9	19.5	R > N***		P > N**
Health barrier	24.1	23.2	15.2	R > N*		P > N*
Economic						
Eviction	16.1	8.8	6.8	R > N**	R > P*	
Food insufficiency	35.7	26.5	19.8	R > N***		P > N*
Homeless	14.3	7.7	4.1	R > N***	R > P*	P > N*
Utility shut off	15.2	8.5	8.4	R > N*		
Any hardship	54.5	42.3	32.5	R > N***	R > P*	P > N*
Employed more than 20 hours	55.4	60.4	56.4			
Cash assistance in past month	76.8	69.9	72.3			

NOTE: PTSD = post-traumatic stress disorder.
* $p < .05$. ** $p < .01$. *** $p < .001$.

TABLE 4
Effects of Demographic and Domestic Violence Variables on Mental Health Disorder

	I		*II*	
	B	*Exp (B)(CI)*	*B*	*Exp (B)(CI)*
Black	–.32	.73 (.53, 1.00)*	–.10	.91 (.64, 1.28)
Cohabiting	–.31	.73 (.49, 1.08)	–.17	.84 (.56, 1.26)
Preschool child	–.07	.94 (.64, 1.38)	–.08	.92 (.62, 1.38)
Less than high school	.14	1.15 (.82, 1.61)	.11	1.12 (.79, 1.59)
Income-to-needs ratio	–.11	.90 (.67, 1.20)	–.14	.87 (.64, 1.18)
Age	.02	1.02 (.99, 1.04)	.02	1.02 (.99, 1.04)
Recent domestic violence			1.71	5.54 (3.48, 8.82)****
Past domestic violence			1.05	2.87 (2.00, 4.12)****
Constant	–.73		–1.44	

NOTE: N = 741. For Model 1, χ^2 = 7.6; df = 7; Nagelkerke R^2 = .01. For Model 2, χ^2 = 68.1***; df = 9; Nagelkerke R^2 = .12.
* $p < .10$. *** $p < .01$. **** $p < .001$.

TABLE 5
Effects of Demographic and Domestic Violence Variables on Substance Dependence

	I		*II*	
	B	*Exp (B)(CI)*	*B*	*Exp (B)(CI)*
Black	–.25	.78 (.39, 1.56)	–.07	.93 (.46, 1.89)
Cohabiting	.11	1.12 (.51, 2.47)	.27	1.31 (.59, 2.93)
Preschool child	–.36	.70 (.31, 1.57)	–.42	.66 (.29, 1.49)
Less than high school	.53	1.70 (.86, 3.39)	.51	1.66 (.82, 3.36)
Income-to-needs ratio	–.06	.94 (.51, 1.76)	–.08	.92 (.48, 1.78)
Age	.01	1.01 (.96, 1.07)	.01	1.01 (.96, 1.07)
Recent domestic violence			1.71	5.54 (2.26, 13.58)****
Past domestic violence			.84	2.31 (.99, 5.40)*

NOTE: N = 741. For Model 1, χ^2 = 4.2; df = 7; Nagelkerke R^2 = .02. For Model 2, χ^2 = 18.9**; df = 9; Nagelkerke R^2 = .08.
* $p < .10$. ** $p < .05$. *** $p < .01$.**** $p < .001$.

graphic differences among the recent, past, and never-victimized groups. Recent domestic violence was significantly associated with having any disorder (see Table 4) and with having a substance disorder (see Table 5).

TABLE 6
Effects of Demographic and Domestic Violence Variables on Health Status

	I		*II*	
	B	*Exp (B)(CI)*	*B*	*Exp (B)(CI)*
Black	–.26	.77 (.52, 1.15)	–.18	.84 (.56, 1.26)
Cohabiting	.26	1.30 (.83, 2.05)	.31	1.36 (.86, 2.16)
Preschool child	–.02	.98 (.62, 1.56)	–.03	.97 (.61, 1.55)
Less than high school	.62	1.87 (1.25, 2.78)***	.61	1.84 (1.24, 2.75)***
Income-to-needs ratio	–.47	.63 (.42, .93)**	–.48	.62 (.42, .92)**
Age	.06	1.06 (1.03, 1.10)****	.06	1.06 (1.03, 1.10)****
Recent domestic violence			.64	1.90 (1.09, 3.30)**
Past domestic violence			.40	1.49 (.97, 2.28)*

NOTE: N = 741. For Model 1, χ^2 = 42.1****; df = 7; Nagelkerke R^2 = .09. For Model 2, χ^2 = 49.7****; df = 9; Nagelkerke R^2 = .10.
* $p < .10$. ** $p < .05$. *** $p < .01$. **** $p < .001$.

DOMESTIC VIOLENCE AND HEALTH

Women experiencing domestic violence in the past 12 months reported significantly higher percentages of health problems than women who never experienced domestic violence (Table 3). In contrast to most of the mental health diagnoses, past victims were not significantly different from recent victims in their experiences of health problems.

Hierarchical logistic regressions controlling for demographic differences demonstrated that recent domestic violence was associated with significantly increased risk of having a physical health problem (see Table 6).

MATERIAL DEPRIVATION

Recent domestic violence victims experienced considerably more material deprivation in the past year than those women who had never been abused (see Table 7). Recent victims were significantly more likely to have been homeless, faced eviction, had their utilities shut off, and to have experienced food insufficiency in the past year. Recent victims were also significantly more likely than past victims to have faced eviction, homelessness, and utility shut off. Past victims differed significantly from those who had never experienced severe abuse on food insufficiency and homelessness.

TABLE 7
Effects of Demographic and Domestic Violence Variables on Material Deprivation

	I		*II*	
	B	*Exp (B)(CI)*	*B*	*Exp (B)(CI)*
Black	.04	1.04 (.76, 1.43)	.17	1.18 (.85, 1.64)
Cohabiting	–.27	.76 (.52, 1.12)	–.19	.83 (.56, 1.22)
Preschool child	–.12	.88 (.60, 1.29)	–.14	.87 (.59, 1.28)
Less than high school	.54	1.71 (1.23, 2.36)***	.53	1.70 (1.22, 2.36)***
Income-to-needs ratio	–.23	.79 (.59, 1.06)	–.25	.78 (.58, 1.05)*
Age	.00	1.00 (.98, 1.03)	–.00	1.00 (.97, 1.02)
Recent domestic violence			.99	2.69 (1.72, 4.21)****
Past domestic violence			.48	1.62 (1.15, 2.29)***

NOTE: N = 741. For Model 1, χ^2 = 18.9***; df = 7; Nagelkerke R^2 = .03. For Model 2, χ^2 = 39.2****; df = 9; Nagelkerke R^2 = .07.
* $p < .10$. *** $p < .01$. **** $p < .001$.

Logistic regression with the dependent variable of any material hardship revealed that both recent and past domestic violence were associated with increased risk of material hardship when controlling for demographic variables. Not graduating high school was also associated with increased risk of material hardship.

EMPLOYMENT AND WELFARE STATUS

Bivariate analyses did not show significant differences on employment and welfare status among those women who had experienced domestic violence, either past or recent, and those who had never experienced violence. Given the lack of bivariate results, we do not report here multivariate analyses of employment or welfare status, which also did not show a significant association of domestic violence with employment or welfare status.

DISCUSSION

Our results converge with previous studies in demonstrating a high prevalence of lifetime and recent domestic violence among

welfare recipients. Participants experienced a wide range of abusive behavior at the hands of intimate partners. The prevalence of domestic violence in this sample was considerably higher than in nationally representative samples of women. Of women who experienced recent abuse, a high percentage reported direct work interference by their partners, substantiating concerns that domestic violence may deter participation in work.

Clearly, recent victims appear to be most at risk for health and mental health problems, but our data provide some tentative evidence for persistence of these problems for women who have experienced abuse prior to the past year. Age was also a significant predictor of health problems, consistent with the literature. Those women living in greater poverty and who had less than a high school education were also more likely to have health problems.

There are several possible explanations for the higher levels of mental and physical health problems for recent victims. The most compelling explanation is that these problems represent the traumatic effects of violence on well-being. The finding that former victims had fewer mental health diagnoses than recent victims supports the interpretation that traumatic mental health effects diminish with time if women are not reabused. This is consistent with previous studies that have found a stronger relationship between frequency and severity of current physical abuse than prior history of mental illness (Campbell, Kub, Belknap, & Templin, 1997; Campbell, Kub, & Rose, 1996; Cascardi & O'Leary, 1992).

Given that physical and mental health problems are barriers to employment, we would expect that these problems would complicate women's attempts to achieve economic self-sufficiency. However, our cross-sectional data do not indicate any significant association between domestic violence, past or present, and working 20 hours or more per week. This finding is consistent with the cross-sectional results of two other studies (Browne, Salomon, & Bassuk, 1999; Lloyd & Taluc, 1999). However, Browne and colleagues (1999) do find that domestic violence victims are less likely to maintain stability of employment over time. Previous work (Salomon, Bassuk, & Brooks, 1996) demonstrated that domestic violence recipients were more likely to be welfare cyclers and to have received more total benefits than nonrecipients did. In

subsequent waves of this study, we will be able to examine the impact of domestic violence on job stability.

IMPLICATIONS FOR POLICY AND PRACTICE

During the ratification of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), the concern about the prevalence of domestic violence among welfare recipients led to the adoption of the Wellstone/Murray amendment, known as the Family Violence Option (FVO) [Section 402(a)(B)(7)] of Title 1, Temporary Assistance to Needy Families (TANF). In theory, the FVO gives states the option to screen welfare recipients for domestic violence and refer women with assaultive partners to specialized services. When deemed necessary, battered women can be granted temporary exemptions from welfare program requirements and time limits to obtain the services and assistance they need.

Our findings with regard to the work interference encountered by participants experiencing partner abuse suggest two implications for FVO implementation. First, some women may need temporary waivers of work requirements if they face significant direct interference by partners. Second, welfare-to-work programs may need to consider special safety procedures to protect women attending programs. These programs may also better serve women if safety concerns are addressed in job placement.

Our findings that battered women work at about the same rate as nonvictims, however, should quell concerns that adoption of the FVO would lead to a high number of exemptions. The possibility of longer-term effects, as Browne et al. (1999) found, however, remains a concern. The disruption of stable employment due to domestic violence may warrant that victims need access to benefits for longer periods of time than currently allotted by federal time limits.

Our material deprivation results illustrate the high degree of economic distress that battered women experience and support the use of cash assistance as a response to domestic violence. Some battered women flee abusive partners to protect themselves and their children from further abuse, leaving them vulnerable to increased material deprivation. Our results indicate that recent victims are most likely to experience such deprivation. The need

for a safety net from material deprivation while trying to escape or cope with domestic violence would be threatened without flexible enforcement of time limits for domestic violence victims. The final Federal regulations for the FVO make it clear that time limits can be extended if there is a continued need for assistance due to current or past domestic violence or risk of further violence (45 C.F.R. §260.59[a][2][I]). The preamble of the regulations encourages states to assure victims that they will be able to return for assistance if the need recurs. Because domestic violence may occur or recur after time limits are exhausted, battered women will be at greater risk of material deprivation without proper implementation of the FVO. States should consider not only extending time limits for receipt of benefits beyond 60 months for battered women but also restarting benefits when abuse occurs after benefits are exhausted.

Our analysis supports the need for making distinctions among welfare recipients in terms of their domestic violence histories and their specific needs. Whereas many of the women experiencing domestic violence have mental and/or physical health concerns, many do not. Consistent with Lyon (1997), we found that domestic violence survivors exhibit remarkable resiliency and continue to seek and achieve employment despite present and past abuse. To address this diversity of need, differential service plans are necessary. To the extent that safe, confidential, and comprehensive assessment can occur within welfare departments, differential service plans can be adopted. However, as discussed previously, effective screening, assessment, and referral will not be likely to occur without substantial training of welfare workers. A number of states have begun this process. Michigan, for example, recently completed the first phase of such training for welfare caseworkers (Saunders, Holter, Pahl, & Tolman, 1999). The availability of confidential and independent advocacy also is critical, given the potential for conflicts of interest between a battered woman's safety goals and the goals of welfare departments to transition women from welfare to work (Davies, 1996).

Nevertheless, screening and assessment will not be useful, however well done, if there is a lack of availability of resources and services to meet the assessed needs. Our results indicate that specialized domestic violence interventions, mental health services, and medical care that recognize the acute and long-term

traumatic effects of domestic violence are key resources that must be accessible to welfare recipients. These resources will be needed for some women even after they return to the work force. Because some women will lose Medicaid benefits because of employment and will work in jobs that do not offer medical benefits, access to health and mental health care may be limited for those who are successful in moving off welfare into stable employment.

Our results highlight the complexity of needs of battered women and the probability that services in many areas are necessary to support effective efforts at self-sufficiency. Service needs include access to domestic violence programs, specialized welfare-to-work programs that address women's safety in the program and the workplace, domestic violence training for welfare caseworkers, and access to health and mental health services for women survivors.

We must also go beyond the implications for FVO implementation by noting the severe impact domestic violence can have on a woman's well-being and that these effects may persist even after she has left a violent partner or the violence has stopped. We must not define our concern narrowly in terms of whether domestic violence survivors work or not, or only in terms of whether they have minimal economic resources to support themselves and their families. Rather, we must attend to the quality of their lives and recognize the ongoing burden survivors face. Resources and services that promote healing and well-being must be available long after a transition off of the welfare rolls.

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