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Life Constraints and Psychological Well-Being of Domestic Violence Shelter Graduates

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Psychosocial adjustment and life constraints of 81 domestic violence shelter graduates were examined via field interviews in the community, assessing women's current life status, satisfaction with core life domains, and violence experience, pre- and post-shelter. Psychometric scales for depression and trauma symptoms were also administered. Participants had received extensive services in either an emergency or a transitional living shelter. Although fairly satisfied across life domains, many had serious post-shelter financial hardships. Most importantly, they reported remarkably little post-shelter violence exposure, either within or outside of romantic relationships. Despite now living independently, 43% and 75% reported clinical levels of depression and trauma symptoms, respectively. In hierarchical stepwise regressions, depression was related to women's childhood sexual abuse, dissatisfaction with housing and their own parenting, and experience of financial difficulties conjoined with public assistance. Trauma symptoms were associated with childhood sexual abuse and post-shelter financial difficulties. The impaired psychosocial functioning and life difficulties of these predominantly successful domestic violence survivors highlights the need for specialized shelter intervention and continuity of care in the community.

KEY WORDS: domestic violence; women's shelters; depression; trauma.

A central community service for victims of domestic violence has been the provision of residential shelters for women and their children. Research on the post-shelter success of battered women has been sparse, and, while this client population is commonly thought to have a wide range of clinical and social service needs, relatively little is known about their psychosocial adjustment following shelter residence. The present study is a follow-up investigation of former shelter clients who had received extensive intervention services and were living independently in the community at the time of the research contact. As these women were program "graduates" of either an emergency (first-stage) or a transitional living (second-stage) shelter, they constitute a select group. However, knowledge gained from an assessment of their quality of life and psychological well-being has value for the comparative study of the post-shelter lives of battered women who receive more limited community support or who are less successful in completing shelter programs.

Existing research indicates that domestic violence is a social epidemic (e.g., Tjaden & Thoennes, 2000) with extensive physical and psychological effects for survivors (e.g., Browne, 1993; Campbell & Soeken, 1999; Houskamp & Foy, 1991; Jaffe *et al.*, 1986; Straus & Gelles, 1990). A standard and quite essential community response to domestic violence is the provision of shelters that enable battered women and their children to escape the violence and to have access to resources that will help them construct healthier, more adjusted lives.

Women trying to escape domestic violence and recover from its effects face numerous challenges, which can seem insurmountable in view of their limited resources (e.g., Lein *et al.*, 2001; Lloyd & Taluc, 1999; Strube & Barbour, 1983, 1984; Sullivan & Davidson, 1991; Sullivan *et al.*, 1994). Services provided by shelters and transitional living programs are indubitable

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humanitarian efforts, but little is known about the long-term impacts of such programs on the lives of the women served. While the design of the present study does not enable us to answer questions about program efficacy, we do seek to understand how program graduates have fared living independently.

Shelter Residence

There are over 1300 domestic violence shelters in the United States, according to the 1997 National Directory of Domestic Violence Programs (Saathoff & Stoffel, 1999), and over 500 shelters in Canada serve battered women and their children (Statistics Canada, 2000). In addition to providing protection and respite, shelters seek to increase women's knowledge of community resources and services and to provide counseling, training, and education (Cannon & Sparks, 1989). Shelters are typically designated as either "first-stage" or "second-stage" refuges (Tutty *et al.*, 1999). First-stage shelters are an emergency provision offering short-term (usually up to 11 weeks) refuge; second-stage shelters, to which some women transfer after residence in a first-stage shelter, are designed for longer-term stays of 6–12 months.

Service provision, service utilization, reunification with an abusive partner, and residents' psychological well-being have been the main issues addressed by published research on shelter life and post-shelter living. Evaluations of shelter service provision and residents' needs (e.g., Cannon & Sparks, 1989; Tutty *et al.*, 1999) have indicated that, while women tend to be satisfied with services received, they face multiple obstacles to living violence-free and independently.[3]

Post-Shelter Violence Experience

The proportion of women who return to their abusers post-shelter has been found to be approximately 50% (Giles-Sims, 1983; Snyder & Scheer, 1981).[4] Tan *et al.* (1995) reported that 10 weeks post-shelter, 46% of women experienced physical abuse, and 49% were exposed to psychological abuse. Those rates were relatively stable 6 months post-shelter: 44% physically abused and 56% psychologically abused. Fleury *et al.* (2000) reported 36% re-abuse by an ex-partner for those who had remained away from that partner 10 weeks post-shelter. Sullivan and Bybee (1999) found reduced re-exposure following an experimental post-shelter intervention. Intervention recipients experienced less violence over 2 years than those who received only a standard emergency shelter intervention. Also, Berk *et al.* (1986) have found that among women who utilize shelter services each effort made to obtain help reduced the number of new violent incidents that they experienced.

Life Constraints

Shelter residents have been found to have lower incomes, less education, and more children, as compared to domestic violence victims not residing in shelters but served by their programs (Gondolf & Fisher, 1988). As well, they have experienced more frequent and more severe abuse and have engaged in more help-seeking behaviors (Gondolf & Fisher, 1988). Battered women's success after shelter residence is often measured by the ability to live independently, which is inextricably linked to economic resources. Overcoming life constraints (e.g., securing affordable housing, transportation, and sufficient employment) is believed to be critical to successful escape from an abusive partner (Sullivan *et al.*, 1994) and to psychological health and adjustment following such a relationship (Mitchell & Hodson, 1983).

Financial Resources

There is a cyclical relationship between socioeconomic factors and violence victimization (Byrne *et al.*, 1999). Women are at increased risk for violence when their incomes are below the poverty level, and women who are assaulted are at increased risk for poverty and unemployment. Financial dependence upon an abuser and lack of resources in the community are entrapments in an abusive relationship (Sullivan *et al.*, 1994). Economic dependence and having nowhere else to go affect the decision to leave an abusive relationship and the decision to return (Aguirre, 1985; Strube & Barbour, 1984).[5]

Housing and Transportation

Housing clearly is an imperative for battered women (Lein *et al.*, 2001; Sullivan *et al.*, 1992). Some shelter

[3] Women are considered to be living independently if they do not reunify with their batterer post-shelter. Of course, living independently does not guarantee a lack of violence, but it is vital to a woman's ability to break damaging bonds she has with her abuser.

[4] Re-victimization is not tantamount to re-unification, but it is reasonable to infer that greater post-shelter victimization occurs under these circumstances.

[5] Because of financial constraints and scarcity of affordable housing, many battered women turn to public housing, which may be very difficult to find in their community. In the county where the present study was conducted, the median house price was $286,585 and the median monthly rent was $939 (U.S. Census Bureau, 2000).

graduates may move-in with friends or relatives, but others, whether out of necessity or desire, seek to live independently. Only a few studies (Jouriles *et al.*, 1998; Lein *et al.*, 2001; Sullivan & Davidson, 1991; Sullivan *et al.*, 1992) have discussed transportation needs, yet means of transportation are often controlled by the abuser. When leaving the abusive relationship, the woman must find a means of commuting to work or school and doing errands. With limited economic resources, obtaining a car is extremely difficult; if the area has poor public transportation, she is essentially hobbled.

Psychological Well-Being: Life Satisfaction, Depression, and Trauma Symptomatology

Damage to a woman's psychological well-being is an insidious result of domestic violence victimization (Browne, 1993; Campbell & Soeken, 1999; Crowell & Burgess, 1996; Sullivan & Bybee, 1999). Her quality of life suffers, and she is prone to severe psychological adjustment difficulties, such as posttraumatic stress disorder and major depression (Cascardi *et al.*, 1995; Houskamp & Foy, 1991; Jaffe *et al.*, 1986; Schlee *et al.*, 1998). Violence exposure in her family history is also a crucial variable, as physical (Campbell *et al.*, 1997) and sexual abuse (Beitchman *et al.*, 1992; Rodriguez *et al.*, 1996; Zlotnick *et al.*, 2001) as a child have been found to be related to adult depression, trauma, and re-victimization. New hardships and continuing adversity can exacerbate distress, which in turn increases the likelihood of further adversities and inability to overcome obstacles. Importantly, battered women's mental and physical health can improve upon the cessation of the violence (Campbell & Soeken, 1999).

Life Satisfaction

After shelter exit, women's perceived quality of life appears to improve over time, with greater gains made by those who receive post-shelter intervention (Sullivan & Bybee, 1999). This is plausibly due to reduced victimization and gains in social support, resources, and psychological functioning. However, life domain satisfaction among domestic violence survivors merits further examination. Goal attainment (e.g., employment) may not reflect satisfaction with finances (wages and supplements), and neither may be indicative of psychological well-being. Compromises in employment satisfaction may also be a function of the pursuit of alternative goals, such as education and childcare.

Depression

Women abused by their partners suffer from moderate to high levels of depression (Campbell & Soeken, 1999; Cascardi & O'Leary, 1992; Sullivan & Bybee, 1999; Sullivan *et al.*, 1994). Greater abuse severity has been linked to higher depression levels (Cascardi & O'Leary, 1992; Mitchell & Hodson, 1983; Orava *et al.*, 1996); and greater personal resources have been associated with decreased depression (Mitchell & Hodson, 1983). In the absence of re-abuse, depression appears to decline over time (Campbell *et al.*, 1995) and decreases substantially with intervention (Sullivan & Bybee, 1999).

Trauma

Women exposed to domestic violence report high posttraumatic stress disorder (PTSD) symptoms, including intrusive thoughts, ruminations, and avoidance (Houskamp & Foy, 1991; Kemp *et al.*, 1995; Saunders, 1994), more so than nonabused maritally discordant women and community controls (Cascardi *et al.*, 1995). Studies of battered women have found that 45% (Houskamp & Foy, 1991) to 62% (Saunders, 1994) meet PTSD criteria. Severity of abuse and PTSD are positively associated; higher trauma symptoms occur for those who have suffered more severe violence (Houskamp & Foy, 1991; Kemp *et al.*, 1995).

Study Objectives

The present study assessed the psychosocial functioning of the adult female clients of an emergency shelter and a second-stage shelter who had "graduated" the shelter programs and had been living in the community for at least 6 months. The emergency shelter subgroup had an approximately 2-month stay in a high quality apartment structure with shared residential quarters in a middle-class neighborhood. The second-stage shelter subgroup had received a 1-year extended stay in a transitional housing program comprised of private apartments in an adjacent city. Study participants had experienced serious physical and psychological abuse in the intimate relationship that instigated their shelter stay, and many of the women had histories of abuse in their family of origin. During their shelter stays, residents were provided with a variety of counseling and social work services to facilitate their subsequent adjustment.

The assocations between abuse exposure (partner and childhood) and depression, trauma and life constraints were examined, taking into account quality-of-life factors,

such as financial resources. Childhood and partner abuse were expected to affect depression and trauma symptoms in accord with dose-response findings cited above–i.e., trauma symptoms and depression were expected to vary with the amount of directly experienced abuse (physical abuse, sexual abuse, or threats to kill) with the proximate partner, to which family of origin abuse would add.

We had no expectations for differences in current functioning between the two shelter subgroups. While the second-stage shelter provided more extensive intervention, residency was a function of clients' continuing needs. Participants from the emergency shelter received a shorter intervention, but they were able to live independently soon after shelter exit and perhaps had comparatively greater psychological and social resources at hand. Barring significant differences on key variables between shelter groups, we sought to combine them for analyses.

METHOD

Community Agency and Sample Selection

The study was conducted in conjunction with a nonprofit agency in southern California that provides domestic violence services for battered women and their children.[6] Clients come to its emergency shelter generally through a crisis hotline phone call or some other social service referral. The emergency shelter provides immediate housing and support services for up to 45 days. During their stay, women are assisted with housing, employment, educational, financial, and legal issues, and there is an on-site program for children. The second-stage facility offers low-cost housing and support services for up to 1 year, following an emergency shelter stay–not necessarily from the same agency. Vocational and life skills training, internships, and continued counseling are also offered at this site.

Participants

Women were eligible for study participation if they had "graduated"[7] one of the two residential programs and had been living in the community for at least 6 months. Eighty-one women (37 from the emergency shelter and 44 from the second-stage shelter) meeting these requirements comprised the study sample. Locating them post-shelter presented much difficulty, as we learned in pilot research, finding that clients often exited to temporary residences and that contact information provided at shelter exit was not operational months later. Our recruitment efforts used emergency contact information in shelter files, directory assistance, shelter staff contacts, and relays of information about the study among past shelter clients.

Of those eligible to participate (i.e., shelter graduates, living in the community for 6 months), we were able to contact 47% (39% for the emergency shelter; 61% for the second-stage shelter), although we had contact information on only 73%. Of those we were able to contact, 85% agreed to participate and scheduled an interview. Of those who agreed to participate, 15 women (10 from the emergency shelter and 5 from the second-stage shelter) canceled or failed to arrive at the appointment, and efforts to reschedule with them were unsuccessful. Interviews obtained from three other women could not be used for procedural reasons described later.

We sought to contact all emergency shelter graduates between 1998 and 2000 ($N = 156$) and secured completed participation on 24% of them. This subsample consisted of 37 women who had been out of the shelter an average of 18 months. At the time of shelter entry, their mean age was 38 years, and, on average, each had one child with her in the program. Seventy percent had college experience or technical training. Sixty percent were European/Caucasian and almost one-third were Hispanic.

Regarding the second-stage shelter, we sought to contact all graduates of the program's 5 years of service ($N = 92$) and secured completed participation on 48% of them. The subsample consisted of 44 women who had been out of the shelter an average of 38 months. At the time of shelter entry, their mean age was 39 years, and, on average, each woman had two children with her in the shelter. Fifty-seven percent had college experience or technical training at the time of entry. Half of the participants were of European/Caucasian descent, and 16% were Hispanic. Additional demographic information for both subsamples, along with comparative statistics, is displayed in Table I. Except for one participant, all were program graduates, including a few women who left the second-stage residential program sooner than the customary 1-year stay because they no longer needed its services.

Sample Representativeness

Case file data from the respective shelters were analyzed to ascertain sample representativeness. The

[6]We would like to extend our sincere thanks to Roe Piccoli, Lydia Pettis, Diane Sagen, Layla Abdul, Alisa Nealy, and the countless other shelter staff who assisted us with this project.

[7]Women were considered graduates of the emergency shelter program if they had participated in the program for at least 25 days and had left for positive reasons (e.g., found housing, employment). Second-stage shelter graduates included those women who had resided in the transitional housing program for at least 6 months and not been exited for rule-breaking.

Table I. Characteristics of Women at the Time of Shelter Entry

	Emergency shelter		Second-stage shelter	
	Clientele ($n = 304$)	Sample ($n = 37$)	Clientele ($n = 110$)	Sample ($n = 44$)
Average age (years)	33.3	37.8	31.9	38.8
Average no. of children with her	1.8	1.2	2.0	1.7
Educational background				
Not high school graduate (%)	22.5	16.2	19.8	9.0
High school graduate (%)	29.5	13.5	27.0	34.1
Some college/technical training (%)	35.5	62.2	40.5	47.7
College graduate (%)	12.7	8.1	12.6	9.1
Ethnic background				
African/Caribbean (%)	6.3	2.7	5.5	9.1
Asian/Pacific Islander (%)	4.3	2.7	8.2	9.1
European/Caucasian (%)	58.0	59.5	54.5	50.0
Hispanic/Latina (%)	26.3	29.7	20.9	15.9
Middle Eastern (%)	0.7	5.4	3.6	2.3
Native American (%)	0.3	0.0	1.8	4.5
Bi-racial/Other (%)	4.0	0.0	5.4	9.1
Reported abuser				
Husband (%)		67.6		63.6
Boyfriend (%)		16.2		34.1
Fiance (%)		2.7		2.3
Ex-husband (%)		8.1		0.0
Ex-boyfriend (%)		2.7		0.0
Co-worker (%)		2.7		0.0
Violence experience				
Verbal/emotional abuse daily (%)		77.8		56.8
Physical abuse at least once per month (%)		58.3		50.0
Physical abuse with weapon at least once (%)		50.0		54.5
Sexual abuse at least once (%)		44.4		54.5
Threaten to kill her at least once (%)		61.1		59.1
Violence in family of origin				
No family violence (%)		29.7		31.8
Only witnessed violence (%)		21.6		6.8
Target of/direct experience of violence (%)		13.5		11.4
Both target of and witness to violence (%)		32.4		50.0

Note. Information regarding the abuser, partner violence, and family of origin violence was derived from interview data and therefore was only available for the study samples.

emergency shelter reference group was all women served by the shelter (graduates and non-graduates) during 1998–2000. The study subsample did not significantly differ, at program entry, from the full client population ($N = 304$) or from non-participating former residents ($N = 267$) with regard to age, employment status, number of children, or ethnicity. However, emergency shelter study participants were significantly more likely than nonparticipants to have had some college education, $\chi^2(1, N = 285) = 5.93$, $p < .05$, and this was also the case among program graduates, $\chi^2(1, N = 150) = 5.49$, $p < .05$.

For the second-stage shelter, we compared the subsample with all those served by the program since its inception ($N = 110$). Study participants, at the time of program entry, did not significantly differ from the overall client population or from non-participating former residents ($N = 66$) on age, education level, employment status, number of children, or ethnicity. Program graduates were more likely than non-graduates to have had some college, $\chi^2(1, N = 110) = 7.70$, $p < .01$, but study participants did not differ from non-participating program graduates.

Measures

Field Interview

A structured interview, incorporating the psychometric measures below, was conducted in both English and Spanish to assess current functioning across life domains,

as well as perceptions of the shelter experience.[8] Life status data regarding finances, housing, employment, and educational achievements were obtained. Importantly, the women were asked whether they experienced any violence since leaving the shelter, as well as about their histories of domestic violence, both in their families during childhood and in the their adult relationships; particular details were obtained about the abusive relationship that initiated the shelter residence.

Regarding the violence in the relationship that prompted shelter entry, a composite index of victimization was created, entailing four separate types of partner abuse: verbal/emotional, physical (with and without a weapon), sexual, and threats to kill. A score of 0, 1, or 2 was assigned for each, based on frequency of occurrence. Due to non-variation on emotional/verbal abuse, this element was eliminated. For the other abuse categories, the categorization codings were: 0 = "no experience," 1 = "at least once" to "3–6 times per year," and 2 = "once per month" to "daily," and these divided the sample into approximate thirds for each abuse type. The composite index summed across the four types, resulting in a variable that ranged from 1 to 6 and was normally distributed ($M = 3.5, SD = 1.9$).

A composite variable also was constructed to index the degree to which each woman experienced various financial hardships since shelter exit. Women were asked whether they had had any of six financial difficulties: having no access to a car, getting behind on bills, running out of food, having their utilities disconnected, being evicted, and declaring bankruptcy. Each individual variable was scored dichotomously, and the set was then summed. The resultant index of financial difficulty ($M = 1.7$, $SD = 1.5$) had modest internal consistency ($\alpha = .64$).

Participants rated their current satisfaction with several life domains (including housing, finances, employment, healthcare, relationship with her family, and her ability to be a good parent) on five-point scales (1 = "very dissatisfied," 2 = "satisfied," 3 = "neither satisfied nor dissatisfied," 4 = "satisfied," 5 = "very satisfied"). Construction of an overall life satisfaction index was attempted but abandoned because the internal consistency was unacceptable ($\alpha = .48$). Therefore, the satisfaction ratings for the individual domains were used in the analyses.

Open-ended questions (e.g., concerning shelter experiences) were coded independently by two research assistants and then analyzed for inter-rater reliability. Kappa coefficients were computed for the second-stage program sample on each of the key domains. Average reliability coefficients ranged from .82 to .95. The overall inter-rater reliability was .89.

[8]We express our appreciation to Christina Rahn, Leah McKechnie, Danielle Wallace, Ann Koppenhafer, Marisa Agama, Guadalupe Vidales, Rachel Jochem, and Jennifer Whitson for their assistance.

Depression

The Center for Epidemiologic Studies-Depression scale (CES-D; Radloff, 1977) was administered in the interview. The CES-D is widely used as a measure of depression in both normal and clinical samples. It contains 20 items, corresponding to common symptoms of depression (e.g., feeling lonely, feeling as though one's life is a failure, being unable to get "going"). The participant rates the frequency of each symptom within the last week on a scale of 0–3 ("rarely," "some of the time," "occasionally," and "most of the time"). The average score for a nonclinical population is 9; the clinical level symptom score is 16.

Our pilot studies with different women from the same agency during their emergency shelter stay and 1 month thereafter revealed a high proportion with CES-D scores in the clinical range. Approximately 2 weeks into their shelter entry, 31 women were assessed, having a mean CES-D score of 31.3 ($SD = 11.0$). At shelter exit, the mean for 29 women was 21.8 ($SD = 14.9$); and 1 month after shelter exit, the mean for 23 women was 22.3 ($SD = 15.1$).

Trauma Symptoms

These were assessed with the Impact of Events Scale (IES; Horowitz *et al.*, 1979), which has two general symptom categories pertaining to a traumatic experience: intrusion (e.g., thinking about the event despite not wanting to do so or having dreams about it) and avoidance (e.g., staying away from reminders of it or not wanting to talk about it). The respondent rates the frequency of each of 15 symptoms in the past month on scales of 0, 1, 3, 5 (representing, "not at all," "rarely," "sometimes," and "often"). The symptom level considered to be indicative of clinical problems is 19.

Our pilot studies with emergency shelter clients found very high IES scores. Two weeks after shelter entry, the mean ($N = 31$) was 52.2 ($SD = 10.6$); at shelter exit, the mean ($N = 29$) was 44.1 ($SD = 18.4$); and 1 month post-shelter, the mean ($N = 23$) was 41.1 ($SD = 21.3$).

Procedure

Potential interviewees were designated from the case files at both shelters in consultation with program staff.

The initial telephone contact (and all subsequent contacts) was made with considerable attention to confidentiality and safety. When it was necessary to leave a call-back number, the caller heard a message indicating that it was the office of the "UCI Women's Survey." Typically, many attempts at contact were required before actually being able to speak with the prospective participant. When contact was ultimately made with the former client, the purpose of the study was explained and participation was solicited. If the woman agreed, a convenient time and place for the interview was established.

All interviews were conducted in-person, except when the participant lived outside of southern California, in which cases (six emergency shelter clients and five second-stage clients) the interview was conducted by telephone. All in-person interviews occurred in public places, usually a restaurant where the woman's meal was purchased for her. Additionally, participants were given $20 as compensation for their time. Each interview generally lasted about 2–2 1/2 hr. Some women were accompanied by their children, for whom diversionary material (picture books, toys) and refreshments were provided. One telephone interview could not be used because a signed consent form (arranged to be sent by mail) was not received. As well, two in-person interviews could not be used, one because the batterer was present at the start of the interview and the other because the participant was interviewed before being in the community for the required 6 months. Great care was taken throughout to provide for the care and safety of participants and interviewers.[9]

Combined Samples

Given the size of the subsamples, we examined whether there were differences between them that would mitigate aggregation. No significant differences were found on any of the key variables. The only variable that differed significantly was time since shelter exit. Women from the emergency shelter were in the community for less time than those of the second-stage shelter. We, therefore, combined the shelter samples for our analyses.

RESULTS

Perception of Shelter Services

In examining the psychosocial adjustment of our study participants, all of whom had a community intervention, we first briefly note their evaluation of the shelter services received. They were overwhelmingly positive about their shelter experiences, and 84% maintain contact with the agency. They reported generous emotional support from staff, assistance with tangible needs, and physical safety as important aspects of their shelter stay. They also benefited from person-specific instrumental support provided by the agency, including referrals for childcare, employment, education, housing, legal assistance, and public assistance. Given their length of stay in the shelters, the quality of the provisions there, and their very positive evaluation of the services received, there is considerable reason then to look for success post-shelter.

Violence Experience Post-Shelter

Within Romantic Relationships

Approximately 60% of the participants have been in at least one romantic relationship since shelter exit, and 17% of these women were married. Of those who have had romantic partners since leaving the shelter, *96% of them have had violence-free relationships*—one woman from each program had one experience of sexual assault and no other physical violence. Apart from these reports, seven women described experiencing emotional/verbal abuse from a romantic partner since shelter exit.

Outside of Romantic Relationships

Post-shelter, seven participants experienced physical violence or sexual abuse (i.e., unwanted sexual touching, physical assault by a stranger, mugging, or robbery) outside of intimate relationships, and only a few reported other victimization (burglary of car/home). In contrast, almost 60% reported verbal/emotional abuse from others (co-workers, strangers, children, and other family members).

Life Constraints

Employment and Finances

At shelter entry, 56% of the women were employed. However, 50% of them had to quit their jobs in order to move into the shelter; they had to relocate, feared the abuser would find them at work, and/or needed to care for their children. Upon shelter exit, 73% were employed; at the time of the interview, 75% reported having a job.

[9]All interviewers received several sessions of safety training with a specialist consultant, Alon Stivi, whom we thank for his time and extraordinary expertise.

Table II. Financial Status of Participants ($N = 81$)

	Prior to shelter (%)	Current/since shelter (%)
Employment status		
Employed, at least part time	55.5	75.3
Monthly income		
Less than $5,000	22.2	11.1
$5,000–14,999	18.5	22.2
$15,000–24,999	17.3	20.9
$25,000–34,999	21.0	22.2
$35,000 and over	21.0	23.5
Financial assistance		
Regularly receives public assistance	—	50.6
Regularly receives alimony/child support	—	23.4
Regularly receives help from family/friends	—	3.8
Financial difficulties		
Had no access to a car	—	55.6
Gotten behind on bills	—	50.6
Run out of food	—	30.9
Had utilities turned off	—	24.7
Has been evicted	—	7.4
Had to file for bankruptcy	—	5.0

Although almost one-quarter of the women reported their current annual income to be above $35,000, many struggled financially, as shown in Table II. Over one-third of them were at or below the poverty threshold for a family of three, which is $13,874 per annum (U.S. Census Bureau, 2001). Less than one-quarter regularly received child support or alimony, even though many were eligible for it. Roughly half reported that they regularly received public assistance. After leaving the shelter, many encountered serious financial difficulties, such as having their utilities turned off or running out of food. Having financial difficulties was found to interact with receipt of public assistance in association with depression (presented later).

Housing and Transportation

The vast majority maintained stable housing after leaving the shelter. At the time of interview, 90% were renting a house or apartment, and approximately 7% had been able to purchase a home; only two women had made housing arrangements not requiring payment of rent. The majority (68%) lived only with their children; 15% lived with their current partner. Eleven percent (eight women from the emergency shelter and one woman from the second-stage shelter) transitioned to another shelter after exiting those residential programs.

Because public transportation provisions in southern California are greatly inadequate for serving the mobility needs of the metropolitan areas (characterized by urban sprawl), access to a car determines the ability to find and maintain employment. Most women (73%) had access to a car during their shelter stay, and 86% had access at the time of our follow-up.

Life Satisfaction

The majority of the women reported being satisfied or very satisfied with their housing situation (59%), job situation (57%), relationships with their family (63%), availability of healthcare (70%), and ability to be a good parent (84%). Of the women who had children in need of childcare, 66% were satisfied with their childcare arrangements. In contrast, only 23% reported satisfaction with their financial situation, and 44% reported being dissatisfied or very dissatisfied in this realm (compared to 27% dissatisfied with their job situation).

Psychological Functioning: Depression and Trauma Symptomatology

The CES-Depression ($M = 16.9$, $SD = 12.4$) and IES ($M = 31.4$, $SD = 17.4$) scores for graduates of both shelters were in the clinical range. The emergency shelter graduates' IES mean scores were slightly higher than their second-stage shelter counterparts, but there were no significant differences between the shelters either for trauma symptoms, $t(79) = 1.02$, *ns*, or for depression, $t(79) = .304$, *ns*. Regarding depression, a substantial percentage of women from both shelters (43%) had scores above the clinical level of 16. The IES score mean is quite high and

78% of emergency shelter participants and 73% of second-stage participants had scores within the clinical range.

Regression Analyses

We sought to identify the variables most strongly associated with depression and trauma symptoms. Conceptually relevant variables were screened by examining zero-order correlations between the family violence history and current life functioning measures and the CES-D and IES scores. Variables with significant correlations ($p \leq .05$) were included in subsequent regression analyses, providing a wide net for prospective control variables. Partner-related domestic violence was included in the analyses for its theoretical relevance and proximity to current life status. Possible interactions of key independent variables were assessed. Variables remaining significant are given in Tables III and IV.

Hierarchical linear regressions were used to examine the relationships between the depression and trauma measures and possible predictors. Because of their temporal priority and theoretical relevance, pre-screened violence history variables were entered on the first step. Pre-screened finance-related variables (household income and/or the financial difficulties composite index) were entered on the second step, because these objective financial status variables can be expected, a priori, to have effects on psychological well-being. On the third step, variables that reflected current life satisfaction (with housing, financial situation, and ability to be a good parent) were tested. For depression, a fourth step that included the significant interaction between the financial difficulties index and receipt of public assistance was added. A stepwise selection method for entry into the models was used, with an inclusion criterion of $\alpha = .05$ and an exclusion criterion of $\alpha = .10$. Separate models were constructed for depression and trauma.

For depression, the final model included family of origin sexual abuse, satisfaction with housing situation, satisfaction with ability to be a good parent, and the interaction between the financial difficulties index and receipt of public assistance $F(6, 71) = 7.42$, $p < .001$. These variables accounted for 33.4% of the variance in depression, as given in Table III. Adjusting for the other variables in the model, depression was higher for women who had been sexually abused in their family of origin and lower for women more satisfied with their housing and their parenting abilities. Financial difficulties were related to level of depression, but the effect was curiously interactive with receiving public assistance. Figure 1 shows that as level of financial difficulties increase, depression is progressively higher for those who received public assistance, whereas, for those who had not received public assistance, depression levels plateau.

Table III. Summary of Hierarchical Linear Regression Analysis for Variables Predicting Depression ($N = 77$)

Variable	B	$SE(B)$	β
Step 1			
Family of origin sexual abuse	7.13	3.35	0.24*
Step 2			
Family of origin sexual abuse	6.70	3.17	0.22*
Financial difficulties	2.88	0.87	0.35**
Public assistance	4.84	2.62	0.19
Step 3			
Family of origin sexual abuse	6.01	2.92	0.20*
Financial difficulties	2.39	0.82	0.29**
Public assistance	4.75	2.40	0.19
Satisfaction with housing situation	−3.05	0.89	−0.33**
Satisfaction with ability to be a good parent	−4.14	1.92	−0.21*
Step 4			
Family of origin sexual abuse	5.84	2.85	0.19*
Financial difficulties	0.75	1.10	0.09
Public assistance	−0.94	3.56	−0.04
Satisfaction with housing situation	−2.81	0.88	−0.30**
Satisfaction with ability to be a good parent	−4.38	1.88	−0.22*
Financial difficulties × public assistance	3.34	1.57	0.35*

Note. $R^2 = .39$ and R^2 adj $= .33$ for final model; $R^2 = .06$ for Step 1; $\Delta R^2 = .14$ for Step 2; $\Delta R^2 = .15$ for Step 3; $\Delta R^2 = .04$ for Step 4 ($ps < .05$).
*$p < .05$. **$p < .01$.

Table IV. Summary of Hierarchical Linear Regression Analysis for Variables Predicting Trauma ($N = 78$)

Variable	B	$SE(B)$	β
Step 1			
Family of origin sexual abuse	12.80	4.58	0.30**
Step 2			
Family of origin sexual abuse	11.28	4.33	0.27*
Financial difficulties	3.98	1.19	0.34**

Note. $R^2 = .21$; R^2 adj $= .19$ for final model; $R^2 = .09$ for Step 1; $\Delta R^2 = .12$ for Step 2 ($p < .01$).
*$p < .05$. **$p < .01$.

Regarding trauma symptoms, the final model included family of origin sexual abuse and the financial difficulties index, $F(2, 77) = 9.97$, $p < .001$, and accounted for 18.5% of the variance (Table IV). Women who had experienced family of origin sexual abuse and those who scored higher on the financial difficulties index reported significantly more trauma symptoms.

Partner-related domestic violence was not related to either depression or trauma symptoms, but it was significantly associated ($r = .29$, $p < .01$) with the financial difficulties index (i.e., more financial difficulties with higher levels of partner violence), which was significantly related to both measures of psychological well-being. Because there was no direct relationship between partner abuse and depression or trauma symptoms, financial difficulties does not here operate as mediator.

DISCUSSION

There is a dearth of research on the lives of women after their residence in domestic violence shelters and/or the receipt of interventions, with the notable exception

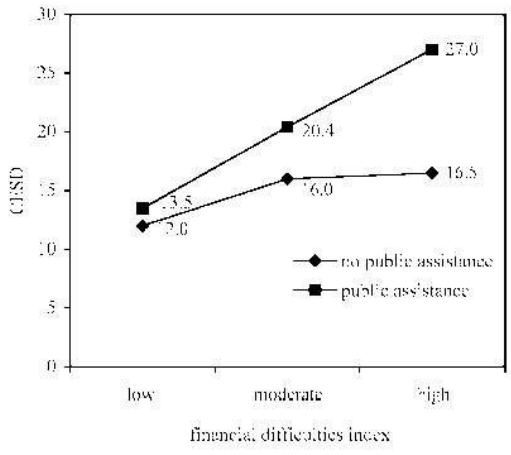

Fig. 1. Depression (CES-D) scores and financial difficulties by receipt of public assistance.

of the exemplary studies by Sullivan and her colleagues. The present study did not evaluate an intervention, but rather examined the psychosocial adjustment of a selected sample of women who received shelter services of high quality and could be expected to do well constructing new lives in the community. Our participants are set apart from other former shelter residents who do not successfully complete shelter programs or who bounce from shelter to shelter in needing assistance, although we did establish their demographic comparability. Despite the quality of shelter service they received and their selectivity as program graduates, it was nevertheless important to examine how successfully these women were in avoiding further violence exposure, in achieving an independent lifestyle, and in attaining psychological well-being.

Very importantly, the vast majority of these women reported living *violence-free* in the community. The participants had been living in the community from 6 months to 7 years, and only two women had experienced any violence in a relationship—in each case, it was one experience of sexual assault and no other physical violence. Remarkably, as well, outside of romantic relationships, their lives were largely free of violence. In view of the commonly reported violence re-exposure rates of approximately 50%, the present study findings constitute an alternative outcome about which community agencies can be hopeful.

Given the absence of violence exposure post-shelter and the appreciable levels of satisfaction reported for most life domains, the results for depression and trauma symptoms are noteworthy. These "cream of the crop" domestic violence survivors reported symptoms of depression and trauma warranting clinical attention. Their mean CES-D score (16.9) is above the commonly accepted clinical cut-off of 16, which confirmatory epidemiological research has found to be exceeded by less than 15% of women (Knight *et al.*, 1997), and 43% of our sample had scores above that cut-off. Their IES Intrusion ($M = 13.6$) and Avoidance ($M = 17.8$) scores are comparable to treatment-seeking clinical samples of battered women (Dutton *et al.*, 1994; Saunders, 1994). Greater depression was found among those having a history of family of origin sexual abuse, decreased satisfaction with their housing situation and ability to be a good parent, and greater financial difficulties despite public assistance receipt. Elevated trauma symptoms were found to be a function of family of origin sexual abuse and post-shelter financial difficulties. While these CES-D and IES scores are much below those of our in-shelter pilot data given earlier, they nevertheless suggest the need for specialized psychological care in the provision of shelter services and in community follow-up.

Domestic Violence Experience and Psychological Functioning

Partner Abuse

Surprisingly, the amount of partner abuse was not found to be related to current depression or trauma symptoms, although it was associated with financial difficulties post-shelter. There may be several reasons for this. First, our measure of partner abuse may have been faulty. We used a composite partner abuse variable, which assessed physical violence, threats to kill, and sexual abuse to represent the totality of intimate violence experience, coded from structured interview categorizations of violence frequency. The well-regarded Conflict Tactics Scale—Revised (CTS-R; Straus *et al.*, 1996) was not used because of time constraints and because of differences in the violence recall interval. We tried numerous alternative computations of our partner abuse data, including approximations to the CTS-R scoring and various partitions of the sample distribution, but found no index of partner violence to be associated with the CESD or IES measures. Other investigators have eschewed the CTS-R in favor of composite index scoring of partner violence, as did Huth-Bocks *et al.* (2001) in using Marshall's (1992) scale with weightings for specific acts of abuse. Huth-Bocks *et al.* did find partner violence to affect maternal depression, but half of their sample had no partner violence exposure.

Another possibility is that the partner violence exposure level for this sample reached a threshold for effects on depression and trauma symptoms, such that greater degrees of partner abuse severity did not have proportionately greater psychological impairment effects. Lastly, because the shelters largely focus on addressing the experience and ramifications of partner abuse, the programs may have remedied or leveled the distress from that domain. Considering that none of the women have reentered abusive relationships—and 60% have had romantic relationships—there is some plausibility in this regard. To be sure, we do not suggest that partner abuse is without continuing effect on a women's later psychological functioning (e.g., self-esteem, career development, and parental efficacy); however, after shelter services, it is perhaps the older wounds of childhood abuse and day-to-day financial struggles that differentiate those who are depressed and traumatized from those who are not.

Family of Origin Abuse

Childhood sexual abuse was found to be a significant predictor of adult depression and trauma, consistent with previous findings (e.g., Beitchman *et al.*, 1992; Kuyken & Brewin, 1994, 1995; Wind & Silvern, 1992; Zlotnick *et al.*, 2001). While the sample may not have been sufficiently differentiated by partner abuse, they did vary in whether they experienced childhood sexual abuse, and this may have produced the differential findings. Kuyken and Brewin's (1995) results (their Table I) show that childhood sexual abuse is much more strongly related to IES score and to depressive episodes than is childhood physical abuse. Other research on depressed women by Brewin and his colleagues (Brewin *et al.*, 1996; Brewin *et al.*, 1999) found that, controlling for baseline depression, post-treatment follow-up depression is related to IES for intrusive memories of childhood abuse. Kuyken and Brewin (1999) reported that women with more intrusive memories about childhood abuse are higher in self-blame and avoidance coping, especially those who were sexually abused. They conjectured that childhood sexual abuse "might impede the development of a healthy self-concept such that a maladaptive self-as-worthless representation is stored at an implicational level and associated with diffuse unprocessed memories of the trauma" (p. 674) and that the intrusive memories, negative cognitions, and depression can exacerbate each other. For our participants, counseling during their shelter stay primarily focused on partner abuse, but women chose their issues, and many did not want to address family abuse histories, being overwhelmed by their current circumstances.

Life Constraints: Financial Difficulties, Dependence, & Satisfaction

Financial difficulties post-shelter materialized as a highly significant factor in our analyses of depression and trauma symptoms. The direction of the relationships remain unclear. Perhaps most parsimoniously, women's financial difficulties and need for public assistance are a product of residual psychological distress. However, economic independence is known to affect the decision to leave a batterer. By extension, a woman's ability to stay financially self-sufficient can be expected to impact her psychological functioning. Alternatively then, the relationship between post-shelter financial difficulties and trauma symptoms may reflect re-traumatization. Highly depressed women may incur more financial hardships and turn to public assistance because they cannot do it on their own. Alternatively, those unable to achieve self-sufficiency have a weakened sense of efficacy, which may result in greater depression. Receipt of public assistance for those with high financial difficulties may have heightened depression through impacts on self-esteem.

Satisfaction

Surprisingly, women's life satisfaction was not pervasively linked with their depression and trauma levels when other variables were statistically controlled. Only satisfaction with their housing situation and parenting abilities were negatively associated with depression, adjusting for other factors in the regressions. Elevated depression associated with the dissatisfactions may stem from disparities between their expectations and perceived accomplishments in these domains. Our participants, particularly those with children, may have uniquely attended to housing quality (e.g., security, location) or were particularly sensitive to lodging needs after having been essentially homeless. Parental efficacy may have been salient, because of shelter programs on parenting training. Overall, the majority of women were quite satisfied with their lives, except with their financial situation. Satisfaction with finances did have a significant zero-order correlation with depression ($r = -.43$, $p < .001$), but its effect became non-significant when the financial difficulties index entered the model.

Other Study Limitations and Future Directions

The generalizability of study findings is clearly limited by the noninclusion of those shelter graduates whom we were not able to locate or succeed in recruiting. Quite possibly, it is those women who are more impaired, and worse so would be the shelter nongraduates. We assert that the value in the findings about the post-shelter status of this select group is that they are a relatively unstudied population, and they are experiencing psychological distress and life struggles many months post-shelter; those whose shelter residence was less successful can be expected to have greater difficulties with cascading effects on them and their children.

Our study participants were drawn from two shelters but from one agency and general locale. Program services and client needs vary across locations, particularly when patterns of in-migration and out-migration vary across geographic areas and affordances post-shelter are location-specific. Sullivan and colleagues (Sullivan *et al.*, 1992, 1994; Sullivan & Bybee, 1999) reported an average retention rate of 95% across 2 years in a Michigan sample of battered women recruited just after shelter exit; whereas Tutty and colleagues (1999) reported being able to follow-up only 56% of their original Calgary, Canada sample. Neither of these geographic areas is on par with southern California for its population flux or high cost of housing. After leaving a shelter, variation in staff resources for follow-up, battered women's residual distress, job and housing availability, and community integration potential will affect women's residential stability, as well as tracking and follow-up efforts.

Our findings indicate that continuing efforts ought to be made to assist women post-shelter in meeting their long-term needs and to examine the provision of specialized treatment, both in shelter and community, regarding depression and PTSD symptoms, such as intrusive memories of abuse experiences. There would seem to be value in emotional reprocessing of abuse experiences, cognitive therapy regarding the schema associated with trauma and depression, or other cognitive-behavioral approaches to emotion dysregulation and PTSD.

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