

TRAUMA-INFORMED AND OPPRESSION-SENSITIVE INTERVENTION FOR THOSE WHO ENGAGE IN INTIMATE PARTNER VIOLENCE

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Introduction

Trauma-informed intervention approaches have long been advocated for a range of problems because trauma is pervasive, life-altering, impacts many life domains, and may hinder the development of therapeutic relationships and a positive therapeutic process (Harris & Fallot, 2001). There is seemingly universal acknowledgment that exposure to trauma and abuse contributes to aggression and other problem behaviors in children, with some of the most effective interventions based on a trauma-informed social information processing model addressing the abused child's faulty ways of interpreting the world (Dodge, Godwin, & Conduct Problems Prevention Research Group, 2013). These difficulties resulting from early trauma often do not resolve when abused children reach adulthood, and not surprisingly, there is an extensive research base indicating that both childhood and adult trauma are linked with abusive and violent behavior in intimate relationships (Capaldi, Knoble, Shortt, & Kim, 2012; Davis et al., 2018).

There is an increasing recognition that models of IPV that do not take trauma into consideration are incomplete and may impede the success of prevention and treatment of violent behavior. Research demonstrates that models of IPV that incorporate trauma are relevant for both military and civilian populations and linked with the most effective interventions (see Taft, Murphy, & Creech, 2016), and there has been some movement in the general IPV intervention field to better train counselors on trauma and its impacts.

In this chapter we also highlight that in order for an IPV intervention to be truly intersectional and inclusive, and meet the needs of the general population, it must also be trauma-informed. To effectively intervene with diverse clients who experience racism, sexism, and other forms of ongoing and historical trauma, it is important that the provider work to understand their experience so that they can assist clients in developing insight and collaborative therapeutic relationships. We do not view trauma-informed intervention as relevant for only a subset of IPV perpetrators, because no abusive client is without any prior trauma or other prior

life event(s) that have shaped the way that they view others and that impacts their behavior in interpersonal relationships.

Defining trauma

As defined in the DSM-5, traumatic stress involves “exposure to actual or threatened death, serious injury, or sexual violence” (APA, 2013, p. 271), and the diagnostic criterion allows for exposure through witnessing such events in person, finding out that a traumatic event has occurred to a close family member or friend, or being exposed in a repeated or extreme fashion to the unpleasant details of a traumatic event (i.e. vicarious traumatization).

We have previously argued that this definition of trauma is too limited and doesn't capture non-physical forms of abuse that are strongly linked to PTSD and other trauma reactions, such as emotional abuse, in which a child or adult is denigrated, humiliated, devalued, or intimidated; significant abandonment and detachment experiences; emotional neglect; and physical neglect (Taft, Murphy, & Creech, 2016). Similar to physical and sexual violence exposure, psychological abuse and neglect can alter core beliefs and emotions regarding safety, closeness, trust, power, and control, which are linked with abusive behavior in adulthood (Lamotte, Taft, & Weatherill, 2016).

Based on empirical evidence, scholars have also called for DSM-5 criteria to be expanded to include experiences of oppression (Holmes, Facemire, & DaFonseca, 2016) because it is too narrow in relation to “threat to life,” when “threat to life” is a constant for particular racial/ethnic groups. Black and Latino men in particular encounter disturbingly high levels of race-based trauma (i.e. racial discrimination) in the US, which has a significant impact on their psychosocial well-being (Myers et al., 2015). These daily experiences trigger pains from the past, intensifying ones survived in the present. Experiencing oppression and racism at the individual, institutional, and structural level is traumatic. Trauma is comprised not only of one-time events, but can be insidious, and Black and Latinx people in America are especially vulnerable to daily instances of race-based trauma. Ultimately, racism is not time-specific, but perpetual.

Of the many forms of trauma that have been examined as predictors of IPV perpetration, one factor that has not been explored sufficiently is race-based trauma. Indeed, “In the US . . . racism and racist structures, as they determine access to land, wealth, and labor, have maintained inequality and perpetuated trauma quite literally from the country's birth as the US” (Leisey & Lewis, n.d., p. 38). Conceptually and theoretically, historical trauma has only recently been included in public health literature as a way of explaining various health disparities (Brave Heart, 1995; Leary, 2001; Sotero, 2006). According to Leisey and Lewis (p. 31, n.d.), “Historical trauma is the result of human actions and/or human-made systems and structures; in other words, there is a group that directly or indirectly caused the collective trauma of another group.”

Trauma-informed social information processing model of IPV

Trauma-informed IPV intervention is supported by the trauma-informed social information processing model (see Taft, Macdonald, Creech, Monson, & Murphy, 2016). As is the case with those exhibiting a variety of problem behaviors, how one perceives and interprets their social world is of central importance, and helping individuals to view others and their environment in a less hostile or threatening way is a key goal for therapy. With respect to individuals with histories of trauma, this process typically involves helping them to make more positive, and fewer negative, interpretations of their social world, because trauma exposure can produce biases and

deficits in social information processing that place individuals at risk for engaging in violence (Taft et al., 2015). Thus, it follows that developing a better understanding of how the client's processing of social information has been impacted by trauma, and helping the client unlearn biases and interpret various social situations in a more accurate fashion, should lead to healthier relationships and a reduction in IPV.

McFall (1982) developed a highly influential model that involves three sequential stages through which elements of social information are transformed into responses or task performances. During the first step, the encoding stage, incoming information is received, perceived, and interpreted in relation to meaning structures available to the individual. Difficulties at this stage may be caused by inattention or distraction, as well as misinterpretation of social information. The second step, the decision-making stage, involves generating possible responses and evaluating response options. Response choice is influenced by the individual's understanding of what is expected in the situation, appraisals of one's ability to carry out various responses, and potential costs and benefits of the response options. The final step is the enactment stage, during which the individual carries out the selected response and monitors and evaluates its impact. A number of factors can influence social information processing at any stage, such as mood state, stress level, and substance use.

A very large research base demonstrates social information processing deficits among those who engage in IPV (Anglin & Holtzworth-Munroe, 1997; Clements, Holtzworth-Munroe, Schweinle, & Ickes, 2007; Eckhardt, Barbour, & Davison, 1998; Eckhardt & Jamison, 2002; Eckhardt & Kassonov, 1998; Holtzworth-Munroe & Anglin, 1991; Holtzworth-Munroe & Hutchinson, 1993; Marshall & Holtzworth-Munroe, 2010). Researchers have long argued that trauma and PTSD are strongly linked with aggressive behavior in part because those with PTSD are more likely to perceive threats in their environment due to their prior experience of trauma and life threat (e.g. Novaco & Chemtob, 1998; Taft, Vogt, Marshall, Panuzio, & Niles, 2007). In other words, these individuals become physiologically and cognitively wired to misperceive social cues and inappropriately respond with aggression. Consistent with this notion, our group has shown PTSD "hyperarousal" symptoms to be most strongly linked with IPV (Taft, Street, Marshall, Dowdall, & Riggs, 2007; Taft, Schumm, Marshall, Panuzio, & Holtzworth-Munroe, 2008), and our work also demonstrates indirect effects of PTSD through social information processing deficits (Taft et al., 2008, 2015). Other researchers have found that those with PTSD may be more likely to misperceive ambiguous partner behaviors as rejecting and this may contribute to social information processing deficits and IPV (Sippel & Marshall, 2011).

Several other problems can result from trauma, such as depression, alcohol use problems, and traumatic brain injury, that may also elevate IPV risk through their impact on social information processing (see Heyman, Taft, Howard, Macdonald, & Collins, 2012). Further, the experience of trauma can have a profound effect on the way that individuals view the world, and even absent a psychiatric diagnosis, there are several core themes affected by trauma that may have an impact on how one processes social information, such as difficulties with trust, power and control, self- and other-esteem (Monson et al., 2006; Resick & Schnicke, 1992). These themes may be particularly important to address in trauma-informed IPV interventions as they may represent core beliefs that underlie and maintain abusive behavior.

Racial discrimination is connected to biases in social information processing, inasmuch that survivors of race-based trauma are more likely to be leery or suspect malicious intentions of others in order to maintain their own safety and survival (Taft, Murphy, Elliott, & Keaser, 2001). However, when those perceptions of threat transfer to how one views their intimate partner, the sequence may transform from a protective mechanism to one behaving harmfully against their

partners (Holtzworth–Munroe, 1992). This is especially important to take into account when working with men of color who may face chronic trauma by way of repeated daily ethn racial discrimination.

Scholars have posited a relationship between structural racism and IPV perpetration, with various mediators such as stress or unemployment further explaining the connection. Powell (2008) suggested more than ten years ago that experiencing racial discrimination and oppression impacts social information processing, which may thereby partially explain higher rates of IPV perpetration among Black men. Though few studies have moved beyond theory into testing these ideas, Reed et al. (2010) was the first to examine this relationship empirically. She and her colleagues found that Black men who survived high levels of racial discrimination were almost twice as likely to perpetrate IPV than those who experienced low levels of race-based discrimination. Another recent study confirmed that there is indeed an indirect effect between racial discrimination and IPV perpetration via attributional biases. Using longitudinal data, Sutton and colleagues (2019) found that racial discrimination experienced in adolescence was indirectly linked to IPV perpetration in young adulthood through anger and hostile attribution bias. Simply put, racial discrimination predicts greater anger and stronger appraisals of others as malicious (due to deficits in social information processing), which in turn are linked to IPV perpetration. Furthermore, the tested model explained nearly 18% of the variance in IPV perpetration, meaning that a substantial portion of IPV perpetration that occurs amongst Black men can be explained by surviving racial discrimination.

Process considerations

Process factors refer to the nonspecific factors that may influence treatment outcomes beyond the use of specific therapy techniques, such as the therapeutic alliance, motivational readiness for change, and group cohesion. Some in the field have argued that standard IPV programs downplay the importance of process factors shown to promote success in other areas of directed behavior change (Daniels & Murphy, 1997; Jennings, 1987; Murphy & Baxter, 1997), and these programs may resort to confrontational tactics that are anti-therapeutic (Mankowski, Haaken, & Silvergild, 2002; Murphy & Baxter, 1997; Taft & Murphy, 2007) and that reinforce negative core themes around issues related to power and control (Murphy & Baxter, 1997; Safran & Muran, 1996). This is concerning because across a range of populations, process factors are often more influential in determining successful outcome than type of intervention employed (Krupnick et al., 1996).

Trauma histories can significantly impact the process of therapy, and it may require greater effort on the part of the provider to facilitate a positive therapeutic environment. Previously discussed themes that may be affected by trauma, such as difficulties with trust, self-esteem, or power and control often play out in therapeutic relationships. Therefore, our efforts to facilitate a positive alliance take on even greater importance when working with a highly traumatized population.

The most heavily studied process factor in IPV intervention research has been the therapeutic alliance, which refers to agreement on the goals and tasks related to therapy, as well as the bond formed between client and therapist (Bordin, 1979). Though it is admittedly often difficult to form a positive therapeutic alliance with abusive clients, a strong alliance is crucial in motivating these individuals for changing their behavior. If abusive clients do not believe the therapist is there to help them, and do not agree with the goals and tasks of treatment, they will not work towards developing new coping strategies and better ways to handle their anger. Further, clients

will have difficulty in exploring how prior unresolved trauma may impact their current abusive behavior if they do not have a positive therapeutic relationship (Sonkin & Dutton, 2003). Multiple studies have now shown that a positive therapeutic alliance is associated with reductions in abusive behavior in IPV intervention programs (Brown & O’Leary, 2000; Rosenberg, 2003; Santiago, del Castillo, Carbajosa, & Marcuello, 2013; Taft, Murphy, King, Musser, & DeDeyn, 2003), as well as greater program compliance (Brown, O’Leary, & Feldbau, 1997; Cadsky, Hanson, Crawford, & Lalonde, 1996; Rondeau, Brodeur, Brochu, & Lemire, 2001).

Prochaska and DiClemente’s transtheoretical model (1982, 1992) has been used extensively across a range of clinical fields to describe how individuals undergo intentional behavior change (Evers et al., 2012; Heather, Honekopp, & Smailes, 2009; Levesque, Gelles, & Velicer, 2000; Prochaska, Johnson, & Lee, 2009). One key element of the model focuses on five stages of change (pre-contemplation, contemplation, preparation, action, maintenance) representing distinct cognitive markers which individuals pass through in order to undergo successful behavior change. This model may be particularly relevant with regard to those pressured or mandated to receive IPV intervention, considering they are particularly likely to be in earlier stages of change (O’Hare, 1996) and lack accountability for abusive behavior. Confrontational therapist tactics with other “resistant” populations are associated with higher client resistance and poorer outcomes, whereas higher therapist expressions of support and empathy are predictive of less resistance and better outcomes (Miller, Benefield, & Tonigan, 1993; Miller, Taylor, & West, 1980). In IPV intervention, more confrontational provider behaviors may lead the client to negatively react and not join with the provider in working to change behavior. In contrast, some work has shown motivational techniques to facilitate intervention compliance and enhance outcomes in IPV intervention (Alexander, Morris, Tracy, & Frye, 2010; Murphy & Maiuro, 2009; Scott, King, McGinn, & Hosseini, 2011; Taft, Murphy, Elliott, & Morrel, 2001).

Taking a trauma-informed therapeutic approach does not mean that we “collude” with clients in their victim-blaming, denial, or minimization of abuse (Corvo & Johnson, 2003; Voith, Logan-Greene, Strodthoff, & Bender, 2018). Rather, we are clear with the individual that they are responsible for their abusive behavior, but take this stance in the context of a relationship where there is genuine interest in understanding the client and recognizing how the client has learned their abusive patterns. We work to understand the prior traumas and negative life events that the client has experienced and how this impacts their current relationships, communicating to the client that we recognize they are not abusive by nature. When we work to understand them and how their problems developed, we get away from stigmatizing or labeling them simply as “batterers” and show that we are listening to their stories. Rabbi Daniel Cotzin Burg simply summarizes the point by emphasizing that, “to humanize is not to justify acts of terror . . . [in fact] . . . dehumanization removes accountability” (Burg, 2011). Spending time in early sessions to understand the client’s experiences, including their trauma histories, leads our clients to more openly discuss their abusive behavior and make genuine efforts to change. Validating the client’s difficulties is also very therapeutic. Again, this does not mean that we validate statements suggesting victim-blaming or minimization of IPV, but rather to validate their personal struggles and acknowledge the impacts that trauma and related problems have had on them. The provider should be careful to maintain a stance of understanding and validation while not joining the client in rejecting their own role in their problems.

Group cohesion – the connectedness of the group and the degree to which the members are able to work together constructively to further the therapeutic work – has been associated with positive therapeutic outcomes in diverse clinical populations (Ellis, Peterson, Bufford, & Benson, 2014; Gallagher, Tasca, Ritchie, Bafour, & Bissada, 2014; Joyce, Piper, & Ogrodniczuk,

2007; Schnur & Montgomery, 2010), including men in IPV intervention programs (Rosenberg, 2003; Taft et al., 2003). A primary goal of the provider in trauma-informed IPV intervention is to develop a collective sense that group members need to take positive and proactive steps to change their behavior. Facilitation of a positive group environment is likely to be especially important when working with trauma-exposed groups. Trauma-exposed individuals may have a more difficult time trusting others, and establishing and maintaining relationships may be particularly challenging. The sharing of experiences in the group context among those who have difficulty with relationships may be especially powerful given that these group members may have no other sources for advice or support. Moreover, when individuals have experienced a similar trauma, they may develop an especially powerful bond. Providers are likely to be more effective if they can facilitate an environment in which group members teach one another and process issues, rather than “teaching” the information in a more didactic format. While discussion of the myriad strategies and principles important in facilitating positive group process is beyond the scope of this chapter, we refer the reader to Yalom’s (1995) work on the fundamental principles and practices for experiential group psychotherapy, and our prior discussion of how trauma relates to these principles and practices (Taft, Macdonald et al., 2016).

Oppression-sensitive IPV intervention

Amidst the broad call for evidence-based intervention for IPV perpetration, especially ones effective among racial minorities (Babcock et al., 2016), we contend that oppression-sensitive IPV interventions which recognize oppression as historical trauma could help improve treatment outcomes for Black, Native American, and Latino men. Although culturally focused programming for African American men has been explored (Gondolf & Williams, 2001), we emphasize why implementing culturally tailored programs that are also trauma-informed is so crucial.

Dr. Oliver Williams has been writing about the potential of culturally tailored programming for Black men since the early 1990s (Williams, 1994, 1995), which, in particular, were thought to have a positive impact on Black men with higher racial pride (Gondolf & Williams, 2001). This is notable because as Kirmayer, Gone, and Moses (2014) highlight, denigration of identity may be linked to lower self-esteem, which in turn may perpetuate IPV perpetration. Perhaps racial pride needs to first be built up, or experiences of racism need to be processed before programming can have meaningful impacts. In essence, culturally sensitive programming may only be meaningful if the program and process is truly trauma-informed and guided by a humanistic approach. Though one experimental study found that, when compared to a conventional cognitive behavioral therapy intervention, culturally focused programming for Black men did not yield additional benefit (Gondolf, 2007), the expert assessing treatment integrity questioned the fidelity of the counselor who conducted the culturally focused counseling sessions (Gondolf, 2010).

Clearly, further research studies are needed to advance our knowledge on the potential of culturally specific IPV intervention for Black men. Even a small degree of intentionality could have substantial impacts. For example, in one IPV treatment study, when group facilitators sent hand-written notes to those who missed a treatment session, this reduced dropout rates among Black clients, but not white clients, suggesting that out-of-session supportive therapist communications may be particularly important for the former group (Taft et al., 2001).

Evaluation of culturally sensitive intervention for Latino men is even scarcer compared to research on Black men. Such programs have been manualized (Welland & Ribner, 2010) but

we were unable to locate any published quasi-experimental or randomized controlled trials examining treatment effects. As for programming for indigenous men, although there has been a call for tailored programming (Day, Jones, Nakata, & McDermott, 2012), we could not locate manualized publication or the results of empirical testing.

As the evidence for trauma-informed treatment for people who engage in IPV grows (Schauss, Zettler, & Russell, 2019), it is essential that these interventions address the historical and ongoing trauma of racism where applicable (Aymer, 2011). If not, the impacts of addressing childhood or other trauma alone will be limited. Leisey and Lewis (n.d.) note that social and psychological service providers “must be historical trauma-informed and fully take into account the community’s history, experience of historical trauma, and ways in which intervention might be perpetuating trauma, retraumatizing, and/or increasing the effects of a historical trauma response.” Moreover, “As long as systems are unchallenged by those that influence them, groups whose power appears in oppressive structures will maintain historical trauma in groups they influence” (p. 73, n.d.).

Example of trauma-informed group intervention #1: *Strength at Home*

Strength at Home is a group IPV intervention based on the trauma-informed social information processing model holding that trauma may negatively impact one’s ability to interpret and respond to social situations and social cues effectively, and highlights the importance of cognitive behavioral strategies to monitor one’s thoughts and responses to interpersonal situations (Taft, Macdonald et al., 2016). The intervention derives from a unique fusion of interventions for trauma and IPV, integrating elements of cognitive processing therapy for PTSD (Resick, Monson, & Chard, 2008), couples therapy for PTSD (Monson et al., 2012), and a cognitive behavioral intervention for IPV (Murphy & Scott, 1996). The program consists of 12 two-hour weekly sessions, co-led by one to two providers. Throughout the program, group members complete in-session practice exercises and are provided “practice assignments” to consolidate and apply information learned in group.

The model derives from prior theory and research indicating that those who are exposed to trauma and other negative life events are more likely to exhibit irrational beliefs, problematic thinking, and faulty interpretations of others’ intentions (Holtzworth-Munroe, 1992; McFall, 1982; Anglin & Holtzworth-Munroe, 1997; Eckhardt et al., 1998). Through the improvement of social information processing, conflict and risk for aggression and violence should decrease. Core themes that underlie social information processing and relationship problems, including those related to power and control conflicts, low self-esteem, and trust difficulties are also addressed throughout the program.

See Figure 39.1 for how the *Strength at Home* intervention components map onto the social information processing model. Decoding skills are developed through increased insight into how trauma-related problems and core themes underlying negative life events impact how we receive, perceive, and interpret social information from others, including intimate partners. Considerable work throughout group focuses on assisting group members in identifying and replacing negatively biased thoughts. Group members are also taught to develop more realistic expectations of outcomes and consider the costs and benefits of responses, and group leaders use the group process to assist in enhancing self-efficacy (Decision Skills Stage). To assist group members in enacting more effective responses, skills in communication, stress and anger management, and responsiveness to social feedback are emphasized.

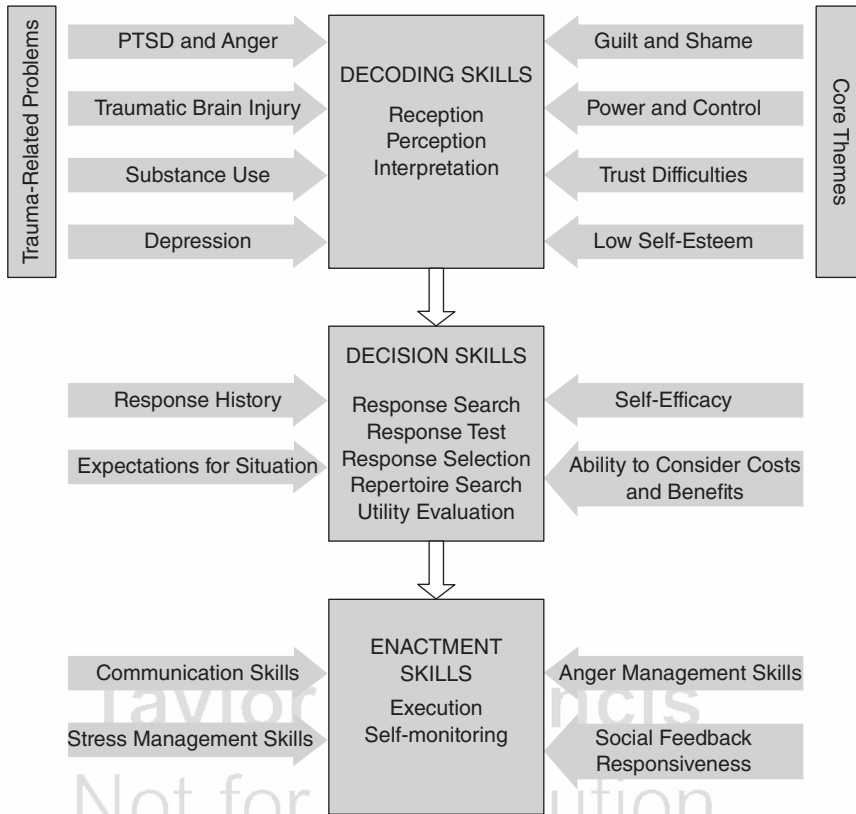


Figure 39.1 Trauma-informed social information processing model

Evidence for Strength at Home

We have published pilot studies (Taft, Macdonald, Monson, Walling, Resick, & Murphy, 2013), implementation studies (Creech, Benzer, Ebalu, Murphy, & Taft, 2018; Hayes, Gallagher, Gilbert, Creech, DeCandia, Beach, & Taft, 2015; Love, Morland, Taft, MacDonald, & Mackintosh, 2015), and a randomized controlled trial (Taft, Macdonald et al., 2016) all attesting to the effectiveness of *Strength at Home* and the feasibility of effectively implementing the program. The program is the only such IPV intervention program shown effective for a military/veteran sample in a clinical trial, and is the only program officially endorsed in a national IPV program rollout in the US Department of Veterans Affairs.

It is particularly important to highlight the randomized controlled trial funded by the Department of Defense (Taft, Macdonald et al., 2016). Controlled trials are critical for determining the efficacy of any IPV intervention program because there are so many factors that can lead to decreases in IPV (e.g. protective orders, court monitoring, shelter seeking in victims, other forms of intervention) that we must compare those who receive the active intervention with those who do not receive the intervention. Simply showing pre-intervention to post-intervention change for an IPV intervention tells us very little about whether the program is effective or not; we must compare those receiving the intervention to a comparison group who receives other (or no) intervention.

For this study of 135 veterans and service members, we compared those assigned to *Strength at Home* to those in an *enhanced treatment as usual* condition. Those in enhanced treatment as usual were free to receive any other care or abuser intervention within or outside of the treatment setting, and they were provided treatment referrals by the study staff if indicated. Results demonstrated significant time-by-condition effects such that *Strength at Home* participants evidenced relatively more reductions in physical and psychological IPV over time, as indicated by veteran/service member and partner reports of IPV on the Revised Conflict Tactics Scales (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). Physical IPV recidivism (Figure 39.2) was also significantly higher in enhanced treatment as usual (43.3%) compared to *Strength at Home* (23.3%) at post-treatment. Differences remained at three-month follow-up, with 26.7% recidivism in enhanced treatment as usual and only 18.5% recidivism in *Strength at Home*.

We have published two follow-up studies of this randomized controlled trial that further attest to the effectiveness of *Strength at Home*. The first (Crech, Macdonald, Benzer, Poole, Murphy, & Taft, 2017) showed that (1) those in *enhanced treatment as usual* further reduced their IPV after receiving *Strength at Home* following the trial; (2) physical IPV was 56% less likely for those receiving *Strength at Home* overall; and (3) participants with and without PTSD benefited from *Strength at Home*, showing that the intervention is broadly efficacious. The second follow-up study (Berke et al., 2017) demonstrated that *Strength at Home* was effective relative to enhanced treatment as usual in reducing symptoms of alexithymia (Figure 39.3), suggesting that the intervention may be impactful at least in part due to its enhancement of the identification and expression of emotions.

We have been implementing *Strength at Home* across the VA healthcare system in partnership with VA leadership and through funding from the Bob Woodruff Foundation and Blue Shield of California Foundation. Thus far, *Strength at Home* is in place at more than 50 hospitals and close to 1,000 individuals have received the intervention. Through this implementation, those receiving *Strength at Home* evidenced reductions in both physical and psychological IPV, as well as symptoms of PTSD (Crech et al., 2018).

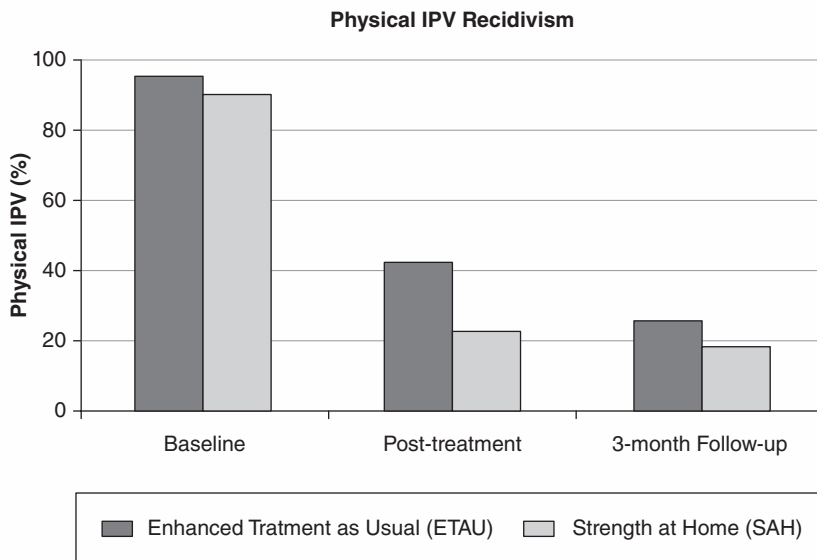


Figure 39.2 Physical IPV recidivism rates by condition

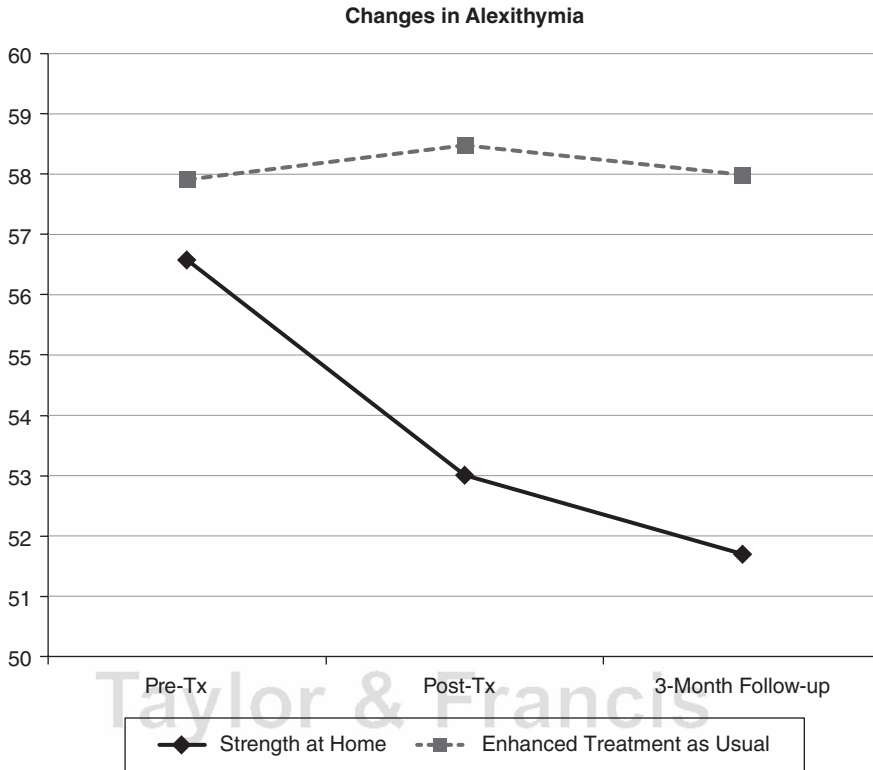


Figure 39.3 Changes in alexithymia by condition

We have recently conducted a NIMH pilot study to evaluate whether reductions in IPV extend to court-mandated civilians receiving *Strength at Home* in Rhode Island. Recent, as yet unpublished data from 20 participants shows large reductions in physical IPV ($t = 2.59$, $p < .05$, $r = .54$) and psychological IPV ($t = 2.48$, $p < .05$, $r = .53$). Interestingly, 88% of participants reported they would “definitely” recommend the program to a friend, and 100% reported the program helped them deal more effectively with their problems. Thus, initial data is quite promising regarding the fit and effectiveness of *Strength at Home* for the civilian population.

Example of trauma-informed group intervention #2: “the men’s group” at St. Pius V parish

The Men’s Group (TMG) in Chicago, Illinois is a spirituality-based, trauma-informed, and voluntary IPV intervention that is culturally specific to Spanish-speaking Latino men. Over 400 men have participated in TMG (without court mandate), and many remain in the group for several years. The program is unique in several ways compared to most IPV intervention programs in the US (Cannon, Hamel, Buttell, & Ferreira, 2016). Here, we first explain why the program is defined as spirituality-based, then focus on the findings related to why it is defined as a trauma-informed program.

Defining the men's group: spirituality-based versus faith-based

Given the self-reported importance of spirituality in the lives of Black, Native, and Latino men (Hubbert, 2011; Fisher-Townsend, 2018; Welland & Ribner, 2010), we highlight TMG as just one example of a program incorporating many of the considerations discussed throughout this chapter. Interview, focus group, and observational data consistently indicate that TMG does not purport that reliance upon God or belief in a specific religion is required in order to change abusive behaviors. Yet, all group participants and administrators rejected the idea that TMG should be classified as a secular program. There are many ways to define “faith-based” or “spirituality-based” social service organizations. The decision in favor of the term spirituality-based was determined because explicitly religious content (i.e. proselytization, worship) was not incorporated as part of the curriculum.

Defining the men's group: trauma-informed

We characterize TMG as trauma-informed largely based on the data collected during multiple observations of group sessions, which indicated that process considerations are paramount to the function and delivery of the program. Some of the most notable elements demonstrating sensitivity to trauma are revealed in how basic communication occurs during group sessions. For example, participants are not interrupted or spoken to in a combative manner, and are encouraged to share their experiences of ethnoracial discrimination, which are recognized as potentially traumatic and thus viewed as central to the process of addressing IPV perpetration. Furthermore, the intervention is not restricted to weekly group sessions alone, but is much more flexible to participant needs, recognizing the need for individualized, group, and extended care. As one administrator noted, “The group is not only every Wednesday . . . it's 24 hours a day, and seven days a week.” While material on how men are impacted by trauma is incorporated into the content, the aforementioned process considerations were equally important in ensuring that the intervention truly operates from a trauma-informed perspective.

Evidence for the men's group

A case study and process evaluation (Davis, Jonson-Reid, Stoops, & Sabri, in press) revealed that the reason men remain engaged in TMG over time (in tandem with peer support) was largely due to the sense of respect they experienced from group facilitators and staff, highlighting the importance of process in practice (see Figure 39.4). This factor is evidence of facilitators and the program founders establishing a commitment to creating a space and group environment that values positive therapeutic alliance. Furthermore, according to interview and observational data, the context of the community environment was noted as a significant factor that facilitated the feasibility and acceptability of this program.

While data for a longitudinal impact evaluation is currently being collected, the results of a few completed qualitative investigations shed light on why participants view the program to be beneficial and how they arrived at seeking help from TMG (Davis, Fernandez, Jonson-Reid, & Kyriakakis, 2019). Next are a few quotes illustrating the qualitative impact of TMG.

What I like most is how my counselor responds to me . . . not in the way I want to hear, because if I wanted for him to respond with what I want to hear, well then, (laughs) I'm wasting my time there. He responds to me like a total professional. After

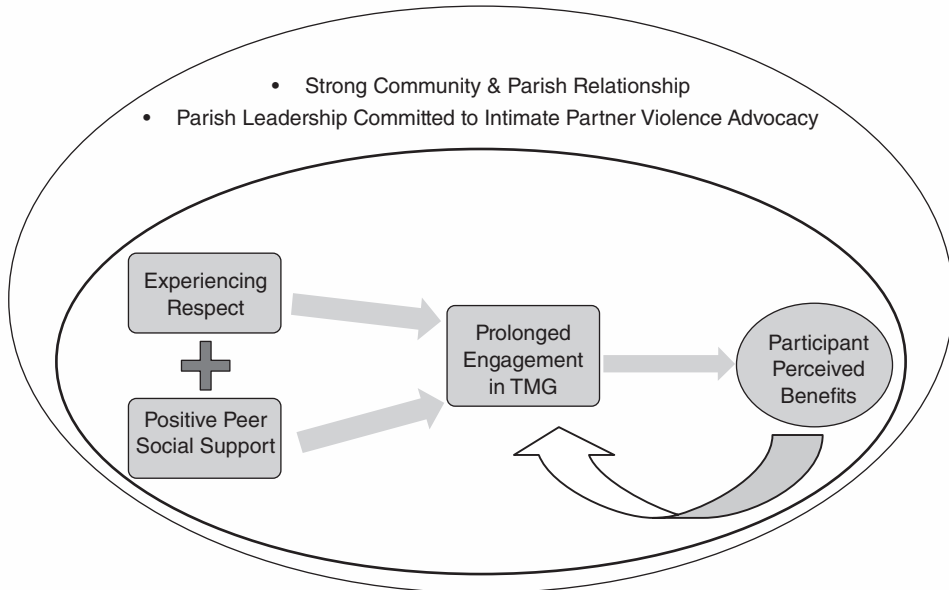


Figure 39.4 Emerging theoretical model for prolonged engagement of non-court mandated men in a parish-based partner abuse intervention program

he's heard me, he has all the time and the patience. Sometimes I've extended myself with him two to three hours. He has a lot of patience.

– Focus group participant

I couldn't argue with my emotions. There came a point I had given up and I knew I needed help, so I looked. My ex-mother-in-law told me about the group and that I could change. . . . Now, after two years [of being a member], I've seen it's a community of men where one helps the other and one can open oneself and without repercussions and without judgment, but they give us tools to help make our lives better and that's why I've stayed in this group because I know that in this group, I have found more than help. I have found friends.

– Focus group participant

Without the group, I don't know where I would be now, maybe in jail and she'd [my wife] be in the hospital or vice versa, or one of us in the cemetery or both of us, because the situation was just really bad. Of course, the group has had a positive impact . . . if it wasn't for the group I don't know where my life would be now.

– Interview #6

I have liked the group because of the experiences of the other men, learning from that and reflecting on my own life as well as the tips that Carlos [group facilitator] has given us and how to handle the anger, how to treat others and be more patient and calm. Reading some of the books and [discussing] our experiences with others [also helps].

– Interview #4

Summary and conclusions

We have discussed the role of trauma in IPV etiology, outlined the importance of trauma- and oppression-informed IPV intervention, provided empirically supported examples of these interventions, and given guidance on facilitating a positive therapeutic environment. While there is increasing recognition of the importance of trauma-informed IPV programs, as of yet most state-certified programs do not address trauma in their curriculum, and there is relatively little coordination between IPV intervention programs and those offering services related to trauma. Further, almost every state in the United States has mandated intervention standards which are not based in scientific evidence, most specifying excessive program lengths, and many proscribing a focus on trauma. Another challenge in providing quality trauma-informed IPV intervention is that providers in some community-based programs have little or no training in trauma-informed care, and may have even been instructed during their training to ignore individual's histories of trauma or to interpret these experiences as irrelevant to the goals of IPV intervention. Finally, there is a general lack of adequate services for self-referred clients, and a reliance on lengthy and ineffective court-mandated "batterer" programs that are often stigmatizing and unappealing to those who are self-motivated to work on their problems related to trauma and violence.

If we are to overcome these barriers and make a true shift towards more effective trauma-informed intervention, it is critical that we stop denying the role of trauma in increasing IPV risk, and recognize that acknowledging trauma in the intervention context only serves to enhance and not diminish personal accountability. If we listen to our clients and truly hear their stories of trauma, and the client feels heard and understood, they will be more likely to take responsibility for their abusive behavior and challenge others to do the same. We need to carefully consider the fact that randomized controlled trials do not support interventions that are not trauma-informed, and rather than tinkering around the margins by trying to modify ineffective programs, we should be replacing them altogether with more effective options. It will take bold leadership on the part of many to decide that what we have been doing for so long simply is not working as it should, and at the very least, whatever guidelines are in place should encourage innovation and research on program efficacy, and should not prevent effective programs from operating. A shift to a more trauma-informed approach without stigmatizing labels on our clients should encourage more people to voluntarily seek services. We know of no more basic principle of behavior change than the fact that others will be more likely to listen to us and want to change their problematic behavior if they feel heard and understood themselves.

Critical findings

- Trauma and trauma-related problems are among the strongest risk factors for intimate partner violence (IPV).
- A trauma-informed social information processing model has been used to explain common links between trauma and IPV and validated by numerous studies.
- This model should be expanded to incorporate the role of the experience of racism as a stressor that may impact risk for violence.
- At this time, few trauma-informed interventions for IPV perpetration have been developed, tested, and disseminated to the field.
- Even fewer interventions have been developed and tested for use in ethnic minority communities, who experience unique stressors such as racism and prejudice in addition to high rates of trauma – both personal and historical.

- However, two trauma-informed IPV interventions, *Strength at Home* and The Men's Group, have demonstrated efficacy in reducing IPV amongst trauma-exposed individuals.
- Culturally tailored, oppression-sensitive IPV interventions which recognize oppression as historical trauma could help improve treatment outcomes and are essential to robust trauma-informed care.
- Empirical research on culturally tailored, trauma-informed IPV interventions amongst Black, Latinx, and Native American communities is scarce and represents a serious gap in the literature that must be addressed.

Implications for policy, practice, and research

Policy

- The definition of trauma should be expanded to include non-physical forms of abuse and experiences of oppression (e.g. racism, sexism, homophobia/heterosexism), which have been linked to PTSD and negative psychosocial outcomes in empirical studies.
- Given the strong link between trauma-exposure and IPV use, there should be increased coordination between IPV intervention programs and those offering services related to trauma.
- IPV intervention standards at the state level must be revised in accordance with empirical evidence which suggests the efficacy of trauma-informed interventions.
- IPV intervention services should be adapted and expanded to be inclusive of and appealing to self-referred clients, who may be deterred from seeking help by stigmatizing and overly long mandated intervention programs.

Practice

- Clinicians and intervention programs must be sensitive to clients' experiences of trauma and oppression, how these experiences impact risk for IPV perpetration, and how acknowledgment and validation of these experiences can promote a positive therapeutic alliance and behavior change.
- IPV intervention facilitators should receive training on trauma and its impacts, particularly its association with risk for violence.
- Facilitation of a positive and cohesive group environment is key to promoting positive behavior change and reducing violence use amongst trauma-exposed individuals.

Research

- More research is needed to examine the efficacy of culturally specific, trauma-informed interventions.
- Given the stakes of partner and family safety, randomized controlled trials are essential in IPV intervention research as many non-intervention factors can lead to short-term decreases in IPV (e.g. protective orders, court monitoring, shelter seeking in victims, other forms of intervention) and can overestimate program efficacy in pre- to post-intervention studies.

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