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## **Transitional Housing for Survivors of Domestic and Sexual Violence: A 2014-15 Snapshot**

### **Chapter 11: Providing Trauma-Specific and Trauma-Informed Services for Survivors and Their Children**

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#### **Submitted to:**

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# **Chapter 11: Providing Trauma-Specific and Trauma-Informed Services for Survivors and Their Children**

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Any and all errors and omissions are the fault of the author, Fred Berman.

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## Note about the Use of Gendered Pronouns and Other Sensitive Terms

For the sake of readability, this report follows the example of numerous publications -- for example, by the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH)<sup>1</sup> and the Missouri Coalition of Domestic and Sexual Violence<sup>2</sup> -- and uses feminine pronouns to refer to adult victims/survivors of domestic and sexual violence, and masculine pronouns to refer to the perpetrators of that violence. This report also uses feminine pronouns to refer to the provider staff of transitional housing programs that serve survivors. The use of those pronouns in no way suggests that the only victims are women, that the only perpetrators are men, or that the provider workforce is entirely female. Indeed, the victims and perpetrators of domestic and sexual violence can be male or female or transgender, as can the staff that support their recovery, and the shortcut herein taken is merely used to keep an already long document from becoming less readable.

Although the terms "victim" and "survivor" may both refer to a person who has experienced domestic or sexual violence, the term "survivor" is used more often in this document, to reflect the human potential for resilience. Once a victim/survivor is enrolled in a program, she is described as a "program participant" or just "participant." Participants may also be referred to as "survivors," as the context requires. Notwithstanding the importance of the duration of violence and the age of the victim, we use the terms "domestic violence" and "intimate partner violence" interchangeably, and consider "dating violence" to be subsumed under each.

Although provider comments sometimes refer to the perpetrator of domestic violence as the "abuser" or the "perpetrator," this report refers to that person as the "abusive (ex-)partner," in acknowledgement of their larger role in the survivor's life, as described by Jill Davies in her often-cited [Advocacy Beyond Leaving](#) (2009).

Finally, although the Office on Violence Against Women funds transitional housing programs to address the needs of not only domestic violence survivors, but also survivors of sexual assault, stalking, and/or dating violence, the preponderance of program services are geared to DV survivors, the large majority of TH program clients are survivors of domestic violence, and much of the literature and most of the provider quotes are framed as pertaining to domestic violence. Consequently, much of the narrative is framed in terms of addressing "domestic violence" or "domestic and sexual violence," rather than naming all the constituencies.

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<sup>1</sup> As stated on page 2 of the NCDVTMH's [A Systematic Review of Trauma-Focused Interventions for Domestic Violence Survivors](#) by Warshaw, Sullivan, and Rivera (2013):

*"Although many couples engage in mutual or low-level violence that does not alter the power dynamics within their relationship, the larger social problem of "battering" is a form of gender-based violence characterized by a pattern of behavior, generally committed by men against women, that the perpetrator uses to gain an advantage of power and control over the victim (Bancroft, 2003; Johnson, 1995; Stark, 2007). Such behavior includes physical violence and the continued threat of such violence but also includes psychological torment designed to instill fear and/or confusion in the victim. The pattern of abuse also often includes sexual and economic abuse, social isolation, and threats against loved ones. For that reason, survivors are referred to as "women" and "she/her" throughout this review, and abusers are referred to as "men" and "he/him." This is meant to reflect that the majority of perpetrators of this form of abuse are men and their victims are women. Further, the bulk of the research on trauma and IPV, including the studies that met the criteria for this review, focus on female victims of abuse. It is not meant to disregard or minimize the experience of women abused by female partners nor men abused by male or female partners."*

<sup>2</sup> As stated on page 2, of the Missouri Coalition's [Understanding the Nature and Dynamics of Domestic Violence](#) (2012)

*"The greatest single common denominator about victims of domestic violence is the fact that the overwhelming majority are women. According to the most comprehensive national study by the U.S. Department of Justice on family violence, the majority of domestic violence victims are women. Females are 84 percent of spouse abuse victims and 86 percent of victims at the hands of a boyfriend or girlfriend. The study also found that men are responsible for the vast majority of these attacks—about 75 percent. (Durose et al., 2005) And, women experience more chronic and injurious physical assaults by intimate partners than do men. (Tjaden & Thoennes, 2000) That's why feminine pronouns are used in this publication when referring to adult victims and masculine pronouns are used when referring to perpetrators of domestic violence. This should not detract from the understanding that, in some instances, the perpetrator might be female while the victim is male or of the same gender."*

## 1. Executive Summary

Chapter 11 focuses on the experience of trauma by adult survivors and their children; the impacts of that trauma; and how programs support participants in recovering from and addressing that trauma.

The Section 2 narrative begins with definitions and contextual explanations of trauma, trauma-specific services, and what it means to take a "trauma-informed" approach:

**"Individual trauma** results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has **lasting adverse effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." ([SAMHSA<sup>3</sup>, 2014a, p.7](#))

As explained in [SAMHSA \(2014\)](#), the long-lasting adverse effects of the event are a critical component of trauma. They may be experienced immediately after the event or may have a delayed onset, and their duration may be short or longer-term. Examples of adverse effects include an individual's inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, and thinking; to regulate behavior; or to control the expression of emotions. In addition to these more visible effects, there may be an altering of the trauma survivor's neurobiological make-up and adverse impacts to her ongoing health and well-being.

In some situations, the individual may not even recognize the connection between the traumatic events and the effects. Helping people who are suffering from the effects of trauma make the connection between their experience of trauma and troubling behaviors or feelings can be helpful in supporting recovery.

SAMHSA publications explains the difference between "trauma-specific services" and being "trauma-informed," as follows:

- *"The term '**trauma-specific services**' refers to evidence-based and promising prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma." [SAMHSA \(2014, p.xix\)](#)*
- *A **trauma-informed [approach]** is a strengths-based service delivery approach 'that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment' (Hopper, Bassuk, & Olivet, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services." [SAMHSA \(2014, p.xix\)](#)*
- *"A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization." [SAMHSA, \(2014a, p.9\)](#)*

Section 2 briefly reviews the nature and sources of trauma; how the repeated physical, sexual, emotional, and psychological abuse that constitute domestic violence result in cumulative or chronic trauma; and how, when that violence is directed at a person who is scarred by an early childhood or adolescent experience of physical or sexual violence, the impact -- referred to as **complex trauma** -- is even more devastating. ***The experience of physical or sexual abuse during childhood or adolescence and/or witnessing violence against her mother are significant risk factors for a woman's experiencing domestic and/or sexual violence as an adult.***

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<sup>3</sup> The Substance Abuse and Mental Health Administration of the U.S. Department of Health and Human Services

Living in chronic or persistent poverty is another risk factor. The Section 2 narrative explores the **traumatic nexus of poverty, homelessness, and domestic and sexual violence**, which has adversely affected the lives of many of the homeless women in mainstream shelters and transitional housing (TH) programs (or in unsheltered situations), as well as the women and adolescent girls and boys who have become trapped in the sex trade and human trafficking (as discussed in greater detail in [Chapter 8](#) on "OVW Constituencies"). The narrative also discusses how **historical / generational trauma** increases the vulnerability of Native Americans and African Americans to the traumatic impact of poverty and domestic and sexual violence in their own lives.

The narrative observes that although physical and sexual violence are typically the manifestations of abuse that police and courts use in deciding whether there has been an actionable offense, those acts of physical and sexual violence, as horrible as they may be, are often only the **visible** components of the violence. The accompanying emotional and psychological violence, backed up by the **threat** of further physical and sexual violence, allow an abusive partner to exert the kind of domination and subjugation that [Stark \(2012\)](#) calls "**coercive control**," which demeans and debases the victim, and deprives her of her autonomy.

Although as the narrative discusses, there are some typical responses to these kinds of trauma, every survivor's situation and experience is unique, and must be individually addressed.<sup>4</sup>

Before turning to the specifics of addressing trauma, the Section 2 narrative concludes with a discussion of **how trauma can adversely affect a survivor's participation** in the programming and services offered by a shelter or TH program, and how, in turn, program requirements and sanctions for noncompliance may re-traumatize participants. People who have been exposed to chronic or complex trauma may have developed coping strategies that are at odds with program expectations or that compromise their ability to achieve the kind of "outcomes" that the program or funder is looking for. Participants suffering from the effects of trauma -- or traumatic brain injury (TBI)<sup>5</sup> -- may have trouble following through on commitments, may appear to be unmotivated, may exhibit "isolating" behavior and avoid meetings, may engage in "oppositional" behavior with staff, may be prone to becoming agitated or belligerent, may have a hard time trusting others or feel targeted by others, may struggle with substance dependence, or may just have low energy levels.

As discussed at greater length in [Chapter 4](#) ("Taking a Survivor-Centered/Empowerment Approach: Rules Reduction, Voluntary Services, and Participant Engagement"), the **voluntary services approach seeks to avoid the re-traumatization that coercive requirements and behavioral sanctions can trigger**, and to replace even-well-intended requirements with a victim-centered approach, that supports the survivor in exercising the autonomy and decision-making power over her own life that she was deprived of by her abusive (ex-)partner.

Although there is increasing awareness that trauma can have cognitive, emotional, and behavioral impacts that may manifest as lack of motivation, difficulty following through on commitments, or low energy, a small number of providers appear to take an approach to participant selection which problematically assumes that these survivors are not be "ready to take advantage of" the assistance the program can offer.<sup>6</sup>

The Section 2 narrative observes that some of these less trauma-informed responses to challenges posed by "difficult" survivor behaviors may also reflect staff concerns about their program's limited capacity to work

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<sup>4</sup> However, as discussed elsewhere, survivors that participate in groups with other survivors may benefit from feeling less alone in their victimization, from recognizing how similar tactics and rationales are used by other perpetrators of abuse, and/or by coming to understand that their low energy, emotional distress, and difficulties with other people, for example, are manifestations of trauma caused by the abuser, and not evidence, as he may have asserted, of their personal defects.

<sup>5</sup> See discussion of TBI in the section on "Disability" in [Chapter 7](#) ("Subpopulations and Cultural/Linguistic Competence")

<sup>6</sup> As discussed in [Chapter 2](#) and [Chapter 6](#), such processes may be at odds with Fair Housing laws, anti-discrimination laws, the VAWA voluntary services requirement and the OVW's warnings<sup>6</sup> against "procedures or policies that exclude victims ... based on their actual or perceived age, immigration status, race, religion, sexual orientation, gender identity, mental health condition..." and against "requiring survivors to meet restrictive conditions in order to receive services...."

with participants with mental health and behavioral health issues, and/or their program's ability to assist only a fraction of the survivors who could benefit from a TH program, and their choice to focus on survivors whom they feel they can make a real difference for. Other such responses may reflect concerns about the potential loss of HUD or other funding<sup>7</sup> if the program cannot demonstrate an "adequate percentage" of "positive" participant outcomes or if such participants' longer lengths of stay in the program will prevent them from serving the number of participants that they committed to serve during the grant period. Such program responses illustrate the challenge of implementing a trauma-informed approach in an operating environment shaped by other imperatives and constraints.

Section 3 begins with a discussion about the consequences of trauma, the ***signs and symptoms of chronic or complex trauma, and how those manifestations might be confused with mental illness***. After citing key resources that inventory and describe useful treatment approaches, the narrative offers a brief description of a few of the more common approaches, cautioning, however, that ***different modalities may be more effective for some people than others; that approaches may need to be altered to address the needs and sensibilities of survivors from different cultural communities; and that different approaches may need to be taken when working with survivors facing additional challenges, such as an ongoing risk of violence***.

Only a few of the providers we interviewed discussed specific treatment approaches (it wasn't a topic in our interview protocol), and the chapter includes only two provider comments about treatment modalities.

The more substantial focus of Section 3 is on the elements of ***trauma-informed care, and how providers take a trauma-informed approach in their work***. The narrative contains several charts explaining core principles of a trauma-informed approach and key considerations in assessing the extent to which program or agency services, policies, and practices are trauma-informed. After a more generalized look at what it means to be trauma-informed and to provide trauma-informed services, the narrative describes research exploring what being trauma-informed means in the context of services for survivors of domestic and sexual violence.

The final narrative portion of Section 3 describes some of the available resources for helping programs and organizations become more trauma-informed, and for ***measuring the extent to which the work they do and the way they do that work is trauma-informed***. Although the importance of taking a trauma-informed approach is relevant to the full gamut of health and human services, as well as educational programming, most of the resources described in this section focus on how organizations serving survivors of domestic and sexual violence can assess the extent to which their services are trauma informed, and the steps they can take to become more trauma-informed. Section 3 concludes with extensive comments from providers about how they are, and try to be, trauma-informed.

Whereas Section 3 generally focuses on adults, Section 4 addresses ***the needs of and services for children and families who have experienced trauma***. The narrative begins with a discussion about the impacts on children of exposure to violence, citing research describing the resilience of children and adolescents and suggesting that the majority of youth who experience a one-time event, can regain their previous level of functioning, over time. However, ***children with early and prolonged exposure to domestic violence may experience profound and enduring impacts, potentially affecting multiple aspects of brain function, including cognitive and learning skills, memory, regulation of behavior and emotion, and social development***.

The Section 4 narrative notes that a number of studies have indicated that ***a child's relationship with a caring parent is one of the most important protective factors for children exposed to trauma, and can have an invaluable buffering effect in how a child responds to the stress of witnessing violence***. Sadly, one of the

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<sup>7</sup> As noted in Appendix A: Project Description and Methodology, 42% of TH providers interviewed for this project receive HUD grants to support transitional housing and/or rapid rehousing projects serving survivors of domestic and sexual violence. As described in [Chapter 1](#) ("Definition of Success and Performance Measurement"), [Chapter 12](#) ("Funding and Collaboration: Opportunities and Challenges"), and other chapters, these programs are all subject to annual performance reviews in which participant outcomes and lengths of stay are evaluated against nationally established standards.

ways that perpetrators of abuse punish their victims is by attempting to undermine their relationships with their children, including preventing them from ministering to a child who is in crisis.

Another traumatizing way that abusive partners undermine their victims' relationships with the children is via **court challenges to their custody rights**. The narrative describes the grounds for two of the most common challenges -- so-called "**failure to protect**" and "**parental alienation**" -- and how legal and judicial advocates respond. The narrative includes a caution that victims seeking custody should consult with their lawyer as to whether mentioning the violence they have experienced will be helpful or harmful to their case.

Section 4 continues with extensive descriptions of online resources providing guidance and information about specific approaches to addressing trauma in children and to working collaboratively with the child and parent.

Section 4 concludes with a broad cross-section of providers' comments about their varied approaches to working with children -- or not, as the case may be. In the few pages prior to those comments, the narrative attempts to summarize some of what providers told us about their challenges and approaches. That narrative cites the statement in the [OVW's annual solicitation of TH grant proposals](#), that "applicants may not use grant funds to provide direct services to children...." Thus, TH providers can only provide children's services if they have other sources of funding for that purpose -- and not all providers do. Although there are other federally funded sources of care and treatment for children, availability and accessibility of funded programming varies widely across the country, so that **some programs appear to lack both the resources to address the needs of survivor children, and the access to community partners who can provide gap-filling services**.

**Recommendation:** Given all that is known about the potential adverse consequences of inadequately addressing the impacts of early childhood exposure to violence, it seems inappropriately risky to wait -- as a number of programs told us they do -- until a child enters kindergarten, so that the local school department can assess for developmental delays or other effects of their exposure to violence. In fact, not all school departments have the resources to identify and appropriately respond to such needs; and if staff there believe that a child in a TH program will only be in their district for a few months, assessing and developing an IEP ([Individualized Education Program](#)) for that child may not be their highest priority.

Perhaps the OVW could explore, in cooperation with the Family and Youth Services Bureau of the US Department of Health and Human Services, providing staff training on strategies for appropriately engaging parents of pre-school-age children in discussions about the potential impacts of untreated trauma and about the options and possible benefits and drawbacks of the parent requesting a child assessment through the local [Medicaid Early and Periodic Screening, Diagnostic and Treatment \(EPSDT\) program](#), or through the local [Early Intervention, Early Head Start](#), or [Head Start](#) programs, depending on the child's age and access to such programs. With [income eligibility for Medicaid/CHIP coverage](#) ranging (depending on the state) from 140% to more than 300% of the federal poverty limit, many, if not most of the children of TH program participants are likely to be eligible.

Few of the providers we interviewed described any staff involvement in the process of developing an IEP for a school-aged child. More often, providers told us that they leave that to the parent to work out with the school. A number of providers told us about parents that are apprehensive about stigmatizing their children by requesting special education services. Given how advocating for their child could be extremely intimidating for a parent in a TH program (as it is for many mainstream parents), and given that a parent whose primary concern is about the stigma may not have enough information to make an informed choice about whether or not to pursue an IEP for their child, it may be helpful for the OVW to sponsor provider staff training about IEPs: why they may be helpful, how they are developed and monitored, how to minimize any stigma, and how to discuss the topic with parents. It may also be helpful to assure staff that supporting a parent in navigating the process of advocating with the school on behalf of their child is not a violation of the OVW's limitations on providing services for children.

Section 4 concludes with provider comments about their approach to supporting children and families, after which a brief Section 5 includes narrative and comments on **court-ordered visitation** and **custody exchanges**.

## 2. Introduction and Overview

### (a) Definitions and Context

*"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." (SAMHSA, 2014a, p.7)*

The adverse impacts of trauma may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. Examples of adverse effects include an individual's inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions. In addition to these more visible effects, there may be an altering of one's neurobiological make-up and adverse impacts to the trauma survivor's ongoing health and well-being. (SAMHSA, 2014)

In some situations, the individual may not recognize the connection between the traumatic events and the effects. Helping people who are suffering from the effects of trauma make the connection between their experience of trauma and troubling behaviors or feelings can be helpful in supporting recovery:

*"People who have histories of trauma will often be unaware of the connection between the traumas they've experienced and their traumatic stress reactions. They may notice depression, anger, or anxiety, or they may describe themselves as "going crazy" without being able to pinpoint a specific experience that produced the trauma symptoms. Even if clients recognize the events that precipitated their trauma symptoms, they may not understand how others with similar experiences can have different reactions. Thus, a treatment goal for trauma survivors is helping them gain awareness of the connections between their histories of trauma and subsequent consequences. Seeing the connections can improve clients' ability to work on recovery in an integrated fashion." (SAMHSA, 2014, p.120)*

*"The term 'trauma-specific services' refers to evidence-based and promising prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.*

*A **trauma-informed [approach]** is a "strengths-based service delivery approach 'that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment' (Hopper, Bassuk, & Olivet, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services." (SAMHSA, 2014, p.xix)*

*"A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization." (SAMHSA, 2014a, p.9)*

### (b) Sources and Types of Trauma

The term trauma is typically used to describe an experience that overwhelms the body's system for coping with stress and leaves people feeling helpless, vulnerable, and out of control. Traumatic events threaten our physical and/or emotional well-being in ways that can lead to fundamental changes in how we view ourselves, others, and the world around us (SAMHSA, 2014; Herman, 1992; Macy, Behar, Paulson, Delman, & Schmid,

[2004](#)). Traumatic experiences can range from one-time events (e.g., a horrific traffic accident), to experiences that last for years (e.g., war), to experiences that span generations (e.g. slavery, efforts to physically and culturally eradicate Native Americans). Different people experience potentially traumatic events differently: as an extreme example, one soldier may experience deployment to a war zone as traumatic, while another may not. [SAMHSA \(2014a\)](#)

As [Warshaw, Sullivan, & Rivera \(2013\)](#) explain, **intimate partner violence is a powerful and potentially debilitating source of trauma, based on power and control:**

*"Intimate partner violence (IPV) is a widespread and devastating phenomenon, with millions of women being assaulted by intimate partners and ex-partners across their lifespan ([Black et al., 2011](#)).*

*Although many couples engage in mutual or low-level violence that does not alter the power dynamics within their relationship, the larger social problem of "battering" is a form of gender-based violence characterized by a pattern of behavior, generally committed by men against women, that the perpetrator uses to gain an advantage of power and control over the victim (Bancroft, 2003; [Johnson, 1995](#); [Stark, 2007](#)). Such behavior includes **physical violence and the continued threat of such violence but also includes psychological torment designed to instill fear and/or confusion in the victim**. The pattern of abuse also often **includes sexual and economic abuse, social isolation, and threats against loved ones**. . . .*

*The term IPV refers to an ongoing pattern of **coercive control**<sup>8</sup> maintained through physical, psychological, sexual, and/or economic abuse that varies in severity and chronicity. It is not surprising, then, that IPV survivors' responses to this victimization would vary, as well. Many women recover relatively quickly from IPV, particularly if the abuse is shorter in duration and less severe and they have access to resources and support ([Bonanno, 2004](#)). Others, particularly those who experience more frequent or severe abuse, may develop symptoms that make daily functioning more difficult.*

*Ongoing abuse and violence can induce feelings of shock, disbelief, confusion, terror, isolation, and despair, and can undermine a person's sense of self. These, in turn, can manifest as **psychiatric symptoms (e.g., reliving the traumatic event, hyperarousal, avoiding reminders of the trauma, depression, anxiety, and sleep disruption)**. Some trauma survivors experience one or more of these symptoms for a brief period of time, while others develop chronic posttraumatic stress disorder (PTSD), a disorder that is a common response to overwhelming trauma and that can persist for years.*

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<sup>8</sup> [Stark \(2012\)](#) explains that although the American legal and criminal justice systems focus on the specific acts of physical or sexual violence that are used to enforce coercive control, such violence is only a part of "**a pattern of domination that includes tactics to isolate, degrade, exploit and control them as well as to frighten them or hurt them physically.**"

*"Some countries have either included 'psychological' or 'emotional' abuse in their definitions of domestic violence or, as in France, created a separate criminal statute prohibiting 'psychological abuse.' In September 2012, England expanded its cross-governmental definition of domestic violence to encompass coercive control. The new definition recognizes that patterns of behavior and separate instances of control can add up to abuse -- including instances of intimidation, isolation, depriving victims of their financial independence or material possessions and regulating their everyday behavior. . . .*

*By ignoring or minimizing the tactics used in coercive control, current [American] domestic violence laws also miss many of its most devastating effects. There is mounting evidence that the level of 'control' in abusive relationships is a better predictor than prior assaults of future sexual assault and of severe and fatal violence. This is because **coercive control targets a victim's autonomy, equality, liberty, social supports and dignity in ways that compromise the capacity for independent, self-interested decision making vital to escape and effective resistance to abuse**. Moreover, in a significant minority of abuse cases, offenders are able to subjugate and entrap female partners without the use of violence. Arrest for assaults, the provision of shelter or legal protections against violence are vital for short-term safety. But the long-term safety and independence of battered women can only be secured if current protections against domestic violence are extended to encompass coercive control." (pp.3-4)*

Survivors are also at risk for developing depression and PTSD ([Cascardi, O'Leary, & Schlee, 1999](#); [Stein & Kennedy, 2001](#)). For those who have also experienced abuse in childhood and/or other types of trauma<sup>9</sup> (i.e., cumulative trauma<sup>10</sup>), the risk for developing PTSD is elevated ([Campbell, Greeson, Bybee, & Raja, 2008](#); [Pimlott-Kubiak & Cortina, 2003](#)). Experiencing childhood trauma and/or severe longstanding abuse as an adult can also disrupt one's ability to manage painful internal states (affect regulation), leaving many survivors with coping mechanisms that lead to further harm (e.g., suicide attempts, substance use). Trusting others, particularly those in caregiving roles, may be especially difficult.

While keeping in mind that victimization can lead to mental health symptoms, it is also important to remember that for women who are currently experiencing IPV **what may look like psychiatric symptomatology (e.g., an "exaggerated" startle response on hearing a door slam) may in fact be an appropriate response to ongoing danger. Although wariness, lack of trust, or seemingly paranoid reactions may be manifestations of previous abuse, this "heightened sensitivity" may also be a rational response that could protect a woman from further harm.** Similarly, a survivor's seemingly passive response to abuse can be misinterpreted, as well. While passivity might be a response to previous experiences of trauma, for survivors of IPV, it may be an intentional strategy used to avoid or minimize abuse that is beyond their control ([Goodkind, Sullivan, & Bybee, 2004](#); [Stark, 2007](#))."<sup>9</sup> (pp. 2-3)

[Warshaw \(2011\)](#) cites numerous studies indicating that "women who are physically or sexually abused as children or who witness their mothers being abused appear to be at greater risk for victimization in adolescence and adulthood by both intimate and non-intimate perpetrators," and that "women who experience adolescent IPV are more likely to experience IPV as adults," including one study that found that **"women who experienced childhood physical or sexual abuse were almost 6 times more likely to experience adult physical or sexual victimization."**

Thus, for example, in [Jasinski et al.'s \(2005\)](#) study of homeless women in Florida, "86% of the women who experienced physical victimization as a child also experienced physical victimization as an adult (p<.001). When sexual victimization was included, 92% of the women who had experienced childhood violence also had been victimized as an adult." (pp. 62-63) The authors note that, "as children, many saw women brutalized, abused, and degraded. Often the women experiencing this violence were our respondents' mothers. In addition to the trauma of witness and enduring abuse, seeing women mistreated in these ways relayed powerful meanings." Or as one participant put it, "All my life, I have seen men beat women." (p.61)

[Warshaw \(2011\)](#) observes that,

*"Low-income women (those most likely to be seen in both intimate partner violence shelters and the public mental health system) have the highest risk of being victimized throughout their lives. In one study [[Bassuk et al. \(1997\)](#)], the lifetime prevalence of severe physical or sexual assault among very low-income women was found to be 84%; 63% of those studied had been physically assaulted as children, 40% had been sexually assaulted as children, and 60% had been physically assaulted by an intimate partner. . . . Although intimate partner violence itself is associated with a wide range of psychological consequences, women living in disenfranchised communities face multiple sources of stress in addition to violence, including social*

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<sup>9</sup> In addition to childhood abuse, [Warshaw \(2011\)](#) mentions sexual assault, historical, cultural or refugee trauma. [Goodman, Saxe, and Harvey \(1991\)](#) make a compelling case that homelessness of itself is psychologically traumatic. [Goodman et al. \(2009\)](#) detail how poverty and IPV are mutually exacerbating sources of trauma.

<sup>10</sup> As will be elaborated on shortly, [Courtois \(2010\)](#) distinguishes between the "cumulative trauma" that occurs with chronic interpersonal victimization and the "complex trauma" that results when "repetitive, prolonged, or cumulative ... interpersonal [victimization], involving direct harm, exploitation, and maltreatment ... occur[s] at developmentally vulnerable times in the victim's life, especially in early childhood or adolescence...." Indeed, many survivors of adult IPV have also lived through physical, psychological, and/or sexual abuse as children.

*discrimination, poorer health status and reduced access to critical resources, all of which can increase psychological distress."*

[Goodman et al. \(2009\)](#) describe how "IPV and [persistent] poverty co-occur at a high rate, magnify each other's effects, and, in each other's presence, constrain coping options." They explain how persistent poverty and IPV each contribute to the victim's stress, sense of powerlessness, and social isolation, and "combine to produce posttraumatic stress disorder, depression, and other emotional difficulties." (p.306)

Specifically, [Goodman et al. \(2009\)](#) cite research showing how low income women are at a higher risk of IPV, and that the lower the income, the higher the risk.<sup>11</sup> They observe that chronic poverty and its concomitants -- housing instability, living in substandard conditions and in potentially unsafe neighborhoods, unable to reliably provide for one's family, always a crisis away from homelessness -- are intrinsically stressful and contribute to a sense of powerlessness. And they explain how the tactics of the abusive partner exacerbate that stress and sense of powerlessness, by intentionally isolating the victim from her social networks and informal supports; rendering her entirely dependent on him for housing, transportation, childcare, permission to work, and even for access to the income she has earned, if she was allowed to work; and essentially leaving her with no viable way out of her situation:

*"As we have seen, IPV and poverty create parallel effects, potentially magnifying the impact of each, and potentially creating reinforcing vulnerabilities. Further compounding the damaging nature of this pairing is that the coping tactics needed to achieve greater safety and stability in one domain may be undermined by the realities of the other domain. In other words, the experience of living with IPV in the context of poverty not only creates challenges, the options available for remedying the situation are limited. Without simple physical safety, handling the overwhelming nature of poverty (which itself, as noted earlier, reduces physical safety) becomes all the more challenging, and without material resources, women have few tools to keep themselves safer in the face of an abusive partner. In the context of IPV, for example, a woman living in poverty may make the correct assessment that searching for a job could trigger her abusive partner's controlling or violent behavior and is therefore unsafe. Conversely, in the context of poverty, an IPV survivor may make the correct assessment that her social network cannot provide support: friends or family do not have money to spare for her to leave town or have her glasses fixed; there is too little social capital in the community that could hold her husband accountable; there is no couch in a friend's house for her and her children to sleep on. Those strategies are therefore foreclosed to her." (p.317)*

Unlike a onetime traumatic event, ***cumulative or chronic trauma*** involves ongoing or repeated exposure to similar or different types of trauma over an extended period of time (e.g., ongoing experience of domestic violence; repeated experience of rape and sexual abuse; ongoing exposure to chronic poverty, deprivation, and oppression; participation in extended military conflict; life in a warzone; etc.). These kinds of sustained or repeated experiences of trauma can wear down a person's resilience and their ability to adapt.

As described by [SAMHSA \(2014\)](#), the impact of extended or repeated doses of trauma is cumulative: "People who are traumatized multiple times often have more serious and chronic trauma-related symptoms than those with single traumas." The effect can be further exacerbated when a person is re-traumatized before

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<sup>11</sup> [Goodman et al. \(2009\)](#) observe that "household income level is one of the most, if not the most, significant correlates of partner violence ([Cunradi, Caetano, & Schafer, 2002](#); [Vest et al., 2002](#)). The lower the income, the more likely there will be violence ([Bachman & Saltzman, 1995](#); [Greenfeld et al., 1998](#); [Vest et al., 2002](#)). Among 19,000 women in a pooled multistate sample, those with incomes below US\$25,000 were almost twice as likely to experience abuse as those with higher incomes ([Vest et al., 2002](#))." (p.308) Likewise, "lifetime rates of physical IPV for women reliant on Temporary Assistance for Needy Families (TANF, more popularly known as "welfare") range from 30% to 74%, depending on the way that IPV is measured ([Barusch, Taylor, & Derr, 1999](#); [Colten, Cosenza, & Allard, 1996](#); [Lloyd & Taluc, 1999](#); [Tolman & Rosen, 2001](#))." (p.308)

they have had time to heal from prior experiences of trauma. Individuals in chronically stressful, traumatizing environments -- like physically, psychologically, and sexually violent relationships -- are particularly susceptible to traumatic stress reactions, substance use, and mental disorders.

Re-traumatization can occur not only through recurrent experience of traumatic stresses, but also through exposure to situations that replicate or recall prior traumatic experiences (e.g., specific smells, types of interactions, feeling emotionally or physically trapped, etc. If a person remains in the situation in which they experienced trauma, they may be more likely to re-experience trauma, may be more likely to be re-triggered by surrounding cues, and may thus encounter more obstacles to recovery.

Not surprisingly, the impact of trauma may depend on the extent and personal importance of the losses that result from the traumatic experience(s), both in the short term and the long term. Such losses can range from the material to the deeply personal (e.g., a ruined car, stolen property, an intentionally destroyed photo album, physical injury, sexual violation, shattered intimacy, loss of trust, alienation from family or community members that were prior sources of compassion and support). (pp. xviii, 46-47, 49)

As described in [Courtois \(2010\)](#), the kind of prolonged physical, sexual, psychological, and emotional abuse that domestic violence survivors, survivors of chronic sexual abuse, and survivors of trafficking endure -- categorized as **complex trauma** -- can have an even more devastating impact on the victim:

*"Complex traumatic events and experiences can be defined as stressors that are: (1) repetitive, prolonged, or cumulative (2) most often interpersonal, involving direct harm, exploitation, and maltreatment including neglect/abandonment/antipathy by primary caregivers or other ostensibly responsible adults, and (3) often occur at developmentally vulnerable times in the victim's life, especially in early childhood or adolescence, but can also occur later in life and in conditions of vulnerability associated with disability/ disempowerment/dependency/age /infirmity, and so on.*

*Such complex stressors are often extreme due to their nature and timing: some are actually life-threatening due to the degree of violence, physical violation, and deprivation involved, while most threaten the individual's emotional mental health and physical well-being due to the degree of personal invalidation, disregard, deprivation, active antipathy, and coercion involved. Many of these experiences are chronic rather than one-time or time-limited and they can progress in severity over time as perpetrators become increasingly compulsive or emboldened/entitled in their demands, as trauma bonds develop between perpetrator and victim/captive, and/or as their original effects become cumulative and compounded and the victims increasingly debilitated, despondent, or in a state of adaptation, accommodation, and dissociation. Because such adversities occur in the context of relationships and are perpetrated by other human beings, they involve interpersonal betrayal and create difficulties with personal identity and relationships with others..."*

Thus, the impact of traumatic experiences on adults and children -- the type, intensity, and duration of physical, psychological, and emotional consequences and after-effects -- varies depending on many factors including: the severity and duration of the trauma; the magnitude and types of losses resulting from the trauma; the extent of other exposures to traumatic experiences, either in the past or on an ongoing basis; individual biological and psychological traits, including health and coping styles and skills; age; family and community history; attachment to caregiver; the level of social support; ([van der Kolk, McFarlane, & Weisaeth 1996](#); [Brewin, Andrews, & Valentine, 2000](#); Pat-Horenczyk, et al., 2009; [Gone, 2009](#)).

Generally speaking, adults and children exposed to a traumatic event commonly exhibit some symptoms in the short-term, such as physical complaints, changes in eating and sleeping patterns, and feelings of anxiety, fear, and even guilt or shame. These symptoms can be intense immediately following a traumatic event but often diminish with time and support. However, when traumatic events are experienced without needed supports, when the trauma involves a betrayal by the people who might ordinarily be counted on for support (i.e., an intimate partner, a parent, or other family members), when traumatic experiences are layered on top of one another or continuing, the physiological and psychological impacts are magnified, the challenges to

daily functioning become more profound, and the risk of future victimization increases. ([Cook et al., 2003](#); [Felitti et al., 1998](#); [van der Kolk et al., 2005](#); [SAMHSA, 2014](#))

In their review of the literature, [Goodman, Fels, & Glenn \(2006\)](#) observe that

*"A range of factors increase homeless women's risk of adult sexual victimization, including childhood abuse, substance dependence, length of time homeless, engaging in economic survival strategies (such as panhandling or involvement in sex trade), location while homeless (i.e. sleeping on the street versus sleeping in a shelter) and presence of mental illness. Many of these factors ... coexist, interact with, and exacerbate each other over time, creating a complex and distinctive context for each woman."*

*"A number of studies have emphasized the correlation between childhood sexual abuse and homelessness among adult women. For example, one study of women seeking help from a rape/sexual assault crisis center found that childhood sexual abuse was reported by 43% of the homeless participants, compared to 24.6% of the housed participants.... [Another] study found that homeless women with histories of childhood sexual abuse were twice as likely to experience adult violent victimization as those without such histories. For homeless women with serious mental illness, the connection between child sexual abuse and adult victimization is even stronger. In one study of women with serious mental illness and histories of homelessness, the chance of re-victimization for women who had experienced child physical or sexual abuse was close to 100%..."*

Thus, as previously noted, [Jasinski et al. \(2005\)](#) reported that 92% of the homeless women in their study who had experienced childhood physical or sexual violence were also victimized as adults.

As explained by [Courtois \(2010\)](#), this correlation between childhood sexual violence and adult domestic violence, can be understood in the context of complex trauma:

*"Complex trauma generally refers to traumatic stressors that are interpersonal, that is, they are premeditated, planned, and caused by other humans, such as violating and/or exploitation of another person. In general, interpersonal traumatization causes more severe reaction in the victim than does traumatization that is impersonal, the result of a random event or an 'act of God.' . . .*

*Rather than creating conditions of protection and security within the relationship, abuse by primary attachment figures instead becomes the cause of great distress and creates conditions of gross insecurity and instability for the child including misgivings about the trustworthiness of others. . . . The victimization might take place on a routine basis or it might happen occasionally or intermittently. Whatever the case, the victim usually does not have adequate time to regain emotional equilibrium between occurrences and is left with the knowledge that it can happen again at any time. This awareness, in turn, leads to states of ongoing vigilance, anticipation, and anxiety. Rather than having a secure and relatively carefree childhood, abused children are worried and hypervigilant. The psychological energy that would normally go to learning and development instead goes to coping and survival.*

*Child abuse, occurring in the context of essential relationships, involves significant betrayal of the responsibilities of those relationships. In addition, it is often private and the child is cautioned or threatened to not disclose its occurrence. Unfortunately, when such abuse is observed or a child does disclose, adequate and helpful response is lacking, resulting in another betrayal and another type of trauma that has been labeled secondary traumatization or institutional trauma. It is for these additional reasons that complex traumatization is often compounded and cumulative and becomes a foundation on which other traumatic experiences tragically occur over the course of the individual's lifespan. Research studies have repeatedly found that when a child is abused early in life, especially sexually, it renders him/her much more vulnerable to additional victimization. Such child victims can become caught in an ongoing cycle of violence and re-traumatization over their life course, especially if the original abuse continues to go unacknowledged and the after-effects unrecognized and untreated. . . .*

As documented by [Felitti et al. \(1998\)](#) and discussed by [Edleson \(2006\)](#) and [Kitzmann et al. \(2003\)](#) witnessing or, more broadly, exposure to domestic violence -- even if the child is not directly abused -- can be a significant source of trauma, which, in combination with other traumas or "adverse childhood experiences," can have serious consequences As described by [Cook et al. \(2003\)](#),

*"[Child] complex traumatic exposure refers to children's experiences of multiple traumatic events that occur within the caregiving system – the social environment that is supposed to be the source of safety and stability in a child's life. Typically, complex trauma exposure refers to the simultaneous or sequential occurrences of child maltreatment—including emotional abuse and neglect, sexual abuse, physical abuse, and witnessing domestic violence—that are chronic and begin in early childhood. Moreover, the initial traumatic experiences (e.g., parental neglect and emotional abuse) and the resulting emotional dysregulation, loss of a safe base, loss of direction, and inability to detect or respond to danger cues, often lead to subsequent trauma exposure (e.g., physical and sexual abuse, or community violence)." (p.5)*

### **A Word about Historical Trauma**

As noted in [Chapter 7](#) ("Subpopulations and Cultural/Linguistic Competence"), there is a conviction among members of the Native American community that current high rates of domestic and sexual violence are related to the historical trauma of cultural genocide, oppression, and dislocation that they experienced at the hands of the white European settlers who colonized North America and, over the next three centuries, shaped the United States as we know it today. Historical trauma, as briefly described in [SAMHSA \(2014\)](#), is presented below. Not mentioned in [SAMHSA \(2014\)](#) are two significant publications that address historical trauma affecting Native Americans ([Brown-Rice, 2013](#), "**Examining the Theory of Historical Trauma Among Native Americans**") and African Americans ([DeGruy, 2005](#)), "**Post Traumatic Slave Syndrome**"). Whether or not these and other research efforts definitively establish a causal effect between current levels/symptoms of trauma and historic sources of trauma afflicting members of these communities, commitment to cultural competence would seem to dictate the need for awareness and understanding of the historical context in which present-day trauma is experienced by African American and Native American survivors.

*"Historical trauma, known also as generational trauma, refers to events that are so widespread as to affect an entire culture; such events also have effects intense enough to influence generations of the culture beyond those who experienced them directly. The enslavement, torture, and lynching of African Americans; the forced assimilation and relocation of American Indians onto reservations; the extermination of millions of Jews and others in Europe during World War II; and the genocidal policies of the Hutus in Rwanda and the Khmer Rouge in Cambodia are examples of historical trauma. In the past 50 years, research has explored the generational effects of the Holocaust upon survivors and their families.*

*More recent literature, [see especially the aforementioned [Brown-Rice, 2013](#)] has extended the concept of historical or generational trauma to the traumatic experiences of Native Americans. Reduced population, forced relocation, and acculturation are some examples of traumatic experiences that Native people have endured across centuries, beginning with the first European presence in the Americas. These tragic experiences have led to significant loss of cultural identity across generations and have had a significant impact on the well-being of Native communities ([Whitbeck et al., 2004](#)). Data are limited on the association of mental and substance use disorders with historical trauma among Native people, but literature suggests that historical trauma has repercussions across generations, such as depression, grief, traumatic stress, domestic violence, and substance abuse, as well as significant loss of cultural knowledge, language, and identity ([Gone, 2009](#)). Historical trauma can increase the vulnerability of multiple generations to the effects of traumas that occur in their own lifetimes." [SAMHSA \(2014, p. 40\)](#)*

### **(c) Manifestations and Impacts of Trauma**

There are a range of emotional, physical, cognitive, behavioral, social, and developmental responses to the experience of trauma; these responses vary depending on a variety of factors touched upon in the prior pages of this section. As [SAMHSA \(2014\)](#) observes, "These reactions are often normal responses to trauma but can still be distressing to experience. [Although they are sometimes misdiagnosed and taken as evidence of mental illness<sup>12</sup>,] such responses are not signs of mental illness, nor do they indicate a mental disorder. Traumatic stress-related disorders comprise a specific constellation of symptoms and criteria." (p.61)

The following is a condensed version of a chart in [SAMHSA \(2014\)](#)<sup>13</sup> enumerating various possible reactions to trauma. Some reactions are more serious and potentially harmful or injurious than others; readers are referred to the discussion in [SAMHSA \(2014\)](#) (pp. 61-89) for help understanding and responding to the needs and symptoms the participants in their programs manifest:

- **"Immediate Emotional Reactions** (e.g., numbness and detachment; anxiety or severe fear; guilt (including survivor guilt); exhilaration as a result of surviving; anger; sadness; helplessness; feeling unreal; depersonalization (e.g., feeling as if you are watching yourself); disorientation; feeling out of control; denial; constriction of feelings; feeling overwhelmed)
- **Delayed Emotional Reactions** (e.g., irritability and/or hostility; depression; mood swings, instability; anxiety (e.g., phobia, generalized anxiety); fear of trauma recurrence; grief reactions; shame; feelings of fragility and/or vulnerability; emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)
- **Immediate Physical Reactions** (e.g., nausea and/or gastrointestinal distress; sweating or shivering; faintness; muscle tremors or uncontrollable shaking; elevated heartbeat, respiration, and blood pressure; extreme fatigue or exhaustion; greater startle responses; depersonalization)
- **Delayed Physical Reactions** (e.g., sleep disturbances, nightmares; somatization (e.g., increased focus on and worry about body aches and pains); appetite and digestive changes; lowered resistance to colds and infection; persistent fatigue; elevated cortisol levels; hyperarousal; long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease)
- **Immediate Cognitive Reactions** (e.g., difficulty concentrating rumination or racing thoughts (e.g., replaying the traumatic event over and over again); distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes); memory problems (e.g., not being able to recall important aspects of the trauma); strong identification with victims)
- **Delayed Cognitive Reactions** (e.g., intrusive memories or flashbacks; reactivation of previous traumatic events; self-blame; preoccupation with event; difficulty making decisions; magical thinking: belief that certain behaviors, including avoidant behavior, will protect against future trauma; belief that feelings or memories are dangerous; generalization of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day); suicidal thinking)

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<sup>12</sup> For example, [Courtois \(2010\)](#) observes that

*"Many of the major characteristics [of a person who has complex trauma] resemble the symptom picture of emotional lability, relational instability, impulsivity, unstable self-structure/sense of self, and self-harm tendencies most associated with borderline personality disorder (BPD; American Psychiatric Association, 1994). The BPD diagnosis has carried enormous stigma in the treatment community where it continues to be applied predominantly to women clients in a pejorative way, usually signifying that they are irrational and beyond help. In recent years, this diagnosis that has come to be understood as a posttraumatic adaptation to recurrent and severe childhood abuse, attachment trauma, and personal invalidation, giving therapists another way to understand and treat it."*

<sup>13</sup> The authors of [SAMHSA \(2014\)](#) attribute the chart to [Foa, Stein, & McFarlane \(2006\)](#); [Pietrzak et al. \(2011\)](#); and Briere, J. & Scott, C. (2006) *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Thousand Oaks, CA: Sage Publications.

- **Immediate Behavioral Reactions** (e.g., startled reaction; restlessness; sleep and appetite disturbances; difficulty expressing oneself; argumentative behavior; increased use of alcohol, drugs, and tobacco; withdrawal and apathy; avoidant behaviors)
- **Delayed Behavioral Reactions** (e.g., avoidance of event reminders; social relationship disturbances; decreased activity level; engagement in high-risk behaviors; increased use of alcohol and drugs; withdrawal)
- **Immediate Existential Reactions** (e.g., intense use of prayer; restoration of faith in the goodness of others (e.g., receiving help from others); loss of self-efficacy; despair about humanity, particularly if the event was intentional; immediate disruption of life assumptions (e.g., fairness, safety, goodness, predictability of life))
- **Delayed Existential Reactions** (e.g., questioning (e.g., 'why me?'); increased cynicism, disillusionment; increased self-confidence (e.g., 'if i can survive this, i can survive anything'); loss of purpose; renewed faith; hopelessness; reestablishing priorities; redefining meaning and importance of life; reworking life's assumptions to accommodate the trauma (e.g., taking a self-defense class to reestablish a sense of safety)" (pp. 62-63)

As described by [Cook et al. \(2003\)](#), [Courtois \(2010\)](#), and [Felitti et al. \(1998\)](#), trauma heightens the risk of substance abuse and mental illness; [SAMHSA \(2014\)](#) explains that, in turn, substance abuse and mental illness heighten a person's vulnerability to trauma:

*"Bi-directional relationships exist between trauma and substance use as well as trauma and mental illness. For example, abuse of alcohol and drugs increases the risk of a traumatic experience and creates greater vulnerability to the effects of trauma; substance abuse reduces a person's ability to take corrective and remedial actions that might reduce the impact of the trauma. Likewise, traumatic stress leads to a greater likelihood of substance abuse that, in turn, increases the risk for additional exposure to trauma. Paralleling this bidirectional relationship, mental illness increases vulnerability to the effects of trauma and raises the risk for substance use disorders and for encountering additional traumatic events." (pp. 46-47)*

The impacts of trauma, especially complex trauma, experienced during childhood are similar, but potentially even more profound and enduring. The seminal **ACES (Adverse Childhood Experiences) study**<sup>14</sup> by [Felitti et al. \(1998\)](#) interviewed some 9,500 adults to assess the impact of childhood psychological, physical, or sexual abuse; violence against the mother; or living with household members who had substance abuse problems, who had a mental illness or were suicidal, or, who, at some point, were incarcerated.

*"[The study] found a graded relationship between the number of categories of childhood exposure and each of the adult health risk behaviors and diseases that were studied (P<.001). Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4- to 12- fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, >50 sexual intercourse partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The seven categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life." (p.245)*

As described in [Courtois \(2010\)](#),

*"It is now understood that **ongoing abuse or adversity over any developmental epoch but especially over the course of childhood can have major impact on the individual's development in a variety of ways and involve all life domains**. In fact, recent studies have documented that abuse and other trauma result in changes in the child's neurophysiological development that, in turn, result in changes in learning patterns, behavior, beliefs and cognitions, identity development, self-worth, and relations with others, to name the*

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<sup>14</sup> See also the [TED Talk by pediatrician Nadine Burke Harris](#) about the ACES Study.

*most common. Although some individuals who were traumatized as children manage to escape relatively unscathed at the time or later (often due to personal resilience or to having had a restorative and secure attachment relationship with a primary caregiver that countered the abuse effects), the majority developed a host of aftereffects...."*

As described by [Cook et al. \(2003\)](#)

*Exposure to traumatic stress in early life is associated with enduring sequelae that not only incorporate, but also extend beyond, Posttraumatic Stress Disorder (PTSD). These sequelae span multiple domains of impairment and include: (a) self-regulatory, attachment, anxiety, and affective disorders in infancy and childhood; (b) addictions, aggression, social helplessness and eating disorders; (c) dissociative, somatiform, cardiovascular, metabolic, and immunological disorders; (d) sexual disorders in adolescence and adulthood; and (e) re-victimization.... (p.5)*

The following is a condensed version of a chart in [Cook et al. \(2005\)](#) enumerating possible reactions by children to complex trauma. Some reactions are more serious and potentially harmful than others: (p.392)

- **"Attachment** (e.g., problems with boundaries; distrust and suspiciousness; social isolation; interpersonal difficulties; difficulty attuning to other people's emotional states; difficulty with perspective taking)"
- **"Biology** (e.g., sensory-motor developmental problems; analgesia [i.e., insensitivity to pain]; problems with coordination, balance, body tone; somatization [i.e., experiencing psychological distress via physical symptoms]; increased medical problems across a wide span (e.g., pelvic pain, asthma, skin problems, autoimmune disorders, pseudo-seizures))"
- **"Affect Regulation** (e.g., difficulty with emotional self-regulation; difficulty labeling and expressing feelings; problems knowing and describing internal states; difficulty communicating wishes and needs)"
- **"Behavioral Control** (e.g., poor modulation of impulses; self-destructive behavior; aggression toward others; pathological self-soothing behaviors [e.g., cutting, head-banging, etc.]; sleep disturbances; eating disorders; substance abuse; excessive compliance; oppositional behavior; difficulty understanding and complying with rules; reenactment of trauma in behavior or play (e.g., sexual, aggressive))"
- **"Cognition** (e.g., difficulties in attention regulation and executive functioning; lack of sustained curiosity; problems with processing novel information; problems focusing on and completing tasks; problems with object constancy<sup>15</sup>; difficulty planning and anticipating; problems understanding responsibility; learning difficulties; problems with language development; problems with orientation in time and space)"
- **"Self-Concept** (e.g., lack of a continuous, predictable sense of self; poor sense of separateness; disturbances of body image; low self-esteem; shame and guilt)"

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<sup>15</sup> According to [Grace \(2012\)](#):

*"Mastering the concept of **object permanence** is a major milestone in a baby's life. The term was first coined by famed child psychologist Jean Piaget, who studied infants' responses to a toy appearing and then being removed from a child's line of sight. In his simple but effective research, Piaget would show a baby a toy and then place it under a blanket. Babies who had a clear concept of object permanence would grab at the blanket, trying to uncover the toy while babies who had not yet reached that milestone might be upset because the toy was gone. Piaget found that most babies seemed to have an understanding of object permanence at about 8-9 months of age, during the Sensory Motor Stage of Cognitive Development, but as all babies vary, so does the age when they reach this ... milestone."*

- **"Dissociation"**<sup>16</sup> (e.g., distinct alterations in states of consciousness; amnesia; depersonalization and de-realization; two or more distinct states of consciousness; impaired memory for state-based events)" (p.392)

Even apart from the exposure to abuse and neglect, the experience of homelessness is likely to seriously and adversely impact children's social, emotional, and cognitive development. (Anooshian, 2005) For example, a review and meta-analysis of data from twelve studies of the mental health of homeless children found mental health problems in "24% to 40% [of] homeless school-age children, a rate 2 to 4 times higher than poor children aged 6 to 11 years in the National Survey of America's Families." (Bassuk, Richard, & Tsertsvadze; 2014). When the traumatic stresses associated with exposure to violence are added to the mix, the impact is that much greater.

#### **(d) How Trauma Can Affect Participant Engagement and How Voluntary Services, Rules Reduction, and an Empowerment Approach Can Reduce Re-Traumatization**

As suggested in the preceding sections, survivors of trauma, and especially complex trauma, may present with a complicated range of physical, cognitive, emotional, and behavioral responses to that trauma, which may have been misunderstood by service providers, in the absence of an awareness of trauma and its impacts. Indeed, with a trauma-informed lens, behaviors that might have been mistakenly labeled as "uncooperative" or "difficult" or "lazy" or stemming from a "lack of motivation" may instead be recognized as manifestations of traumatic brain injury, or as coping strategies that reflect the profound impact of the physical, psychological, emotional, and sexual abuse that survivors have lived through and fled.

Program participants who have experienced trauma may continue to be in danger from their former abusive partner or assailant or trafficker, or feel that they (or a loved one) are in danger and need to remain vigilant.

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<sup>16</sup> SAMHSA (2014) notes that

*"Dissociation is a mental process that severs connections among a person's thoughts, memories, feelings, actions, and/or sense of identity. Most of us have experienced dissociation—losing the ability to recall or track a particular action (e.g., arriving at work but not remembering the last minutes of the drive). Dissociation happens because the person is engaged in an automatic activity and is not paying attention to his or her immediate environment.*

*Dissociation can also occur during severe stress or trauma as a protective element whereby the individual incurs distortion of time, space, or identity. This is a common symptom in traumatic stress reactions. **Dissociation helps distance the experience from the individual. People who have experienced severe or developmental trauma may have learned to separate themselves from distress to survive.** At times, dissociation can be very pervasive and symptomatic of a mental disorder, such as dissociative identity disorder (DID; formerly known as multiple personality disorder) . . . Dissociative disorder diagnoses are closely associated with histories of severe childhood trauma or pervasive, human-caused, intentional trauma, such as that experienced by concentration camp survivors....*

*. . . The characteristics of DID can be commonly accepted experiences in other cultures, rather than being viewed as symptomatic of a traumatic experience. For example, in non-Western cultures, a sense of alternate beings within oneself may be interpreted as being inhabited by spirits or ancestors (Kirmayer, 1996). Other experiences associated with dissociation include depersonalization—psychologically "leaving one's body," as if watching oneself from a distance as an observer or through de-realization, leading to a sense that what is taking place is unfamiliar or is not real. If clients exhibit signs of dissociation, behavioral health service providers can use grounding techniques to help them reduce this defense strategy.*

*One major long-term consequence of dissociation is the difficulty it causes in connecting strong emotional or physical reactions with an event. Often, individuals may believe that they are going crazy because they are not in touch with the nature of their reactions. By educating clients on the resilient qualities of dissociation while also emphasizing that it prevents them from addressing or validating the trauma, individuals can begin to understand the role of dissociation." (pp. 69-70)*

According to Cook et al. (2005), **"Dissociation ... places a child at risk for further victimization, other forms of trauma (e.g., accident-proneness), and learning difficulties.** It also compounds the problems associated with dysregulated affect and attachment (e.g., reducing emotional awareness and compromising bonding with adults or peers)."

In that hypervigilant state of mind, they may be especially vulnerable to being re-traumatized by trauma-related reminders or “triggers” within the service environment -- sights, sounds, smells, or experiences that remind them of the traumatic event(s) they experienced.

Common triggers in service settings include experiences such as meeting with new people, being asked personal questions, being informed about program expectations or deadlines, fear of punishment for having failed to meet an expectation or deadline, receiving a lot of information about next steps, being in a chaotic environment, hearing raised voices or witnessing conflict involving other program participants and/or staff, participating in a medical exam, etc. When faced with such triggers, people may respond in ways that appear unreasonable, confusing, or frustrating to providers. Examples include fight responses like yelling, swearing, or fighting; flight behaviors like withdrawing, avoiding, or ignoring; or freeze responses like seeming confused or disconnected, spacing out, or becoming unresponsive. ([Hodas, 2006](#); [Hopper, Bassuk, & Olivet, 2010](#))

People who have been exposed to chronic or complex trauma may have learned ways of surviving that may be at odds with program expectations or that may compromise the ability of the participant to achieve outcomes that are consistent with the program's or funder's notion of success. Difficulties may include trouble following through on commitments, avoiding meetings and other isolating behaviors, engaging in oppositional behavior with staff, becoming easily agitated and/or belligerent, demonstrating a lack of trust, feeling targeted by others, maintaining involvement in actively abusive relationships, struggling with parenting, and/or active substance abuse ([Hopper, Bassuk, & Olivet, 2010](#)).

Help-seeking behavior may also be impacted. People who have experienced complex trauma are more likely to view the world and other people as unsafe, and not-to-be-trusted. Lack of trust and a constant need to be alert for danger makes it difficult for families to ask for or accept help from providers, or to form relationships. Survivors may interpret providers’ efforts to help as controlling. When that help doesn’t quickly yield results, providers’ inability to “fix” or address the need or problem they were targeting may be seen by traumatized survivors as purposeful and punishing. Survivors who have been re-traumatized by what they perceive as unrealistic demands and/or a harsh response by staff may become increasingly wary of further engagement and/or offers of help, and may drop out of services altogether (Harris & Fallot, 2001; [Prescott et al., 2008](#)).

The following chart, excerpted from Table 3 (“How common trauma reactions may explain some 'difficult' behaviors or reactions within homeless service settings”) in [Hopper, Bassuk, & Olivet, 2010, p.149](#), enumerates some of the trauma-related behaviors that might be taken as “evidence” that a survivor is not “ready” or “appropriate” for transitional housing, or that a TH program coordinator might take as “evidence” that a TH participant doesn't “deserve” an extension beyond her baseline six months of assistance:

<b>"Difficult" Behaviors or Reactions within Homeless Service Settings</b>	<b>Common Trauma Reactions</b>
Has difficulty getting motivated to get job training, pursue education, locate a job, or find housing	Depression and diminished interest in everyday activities
Perceives others as being abusive, loses touch with current-day reality and feels like the trauma is happening over again	Flashbacks, triggered responses
Avoids meetings with counselors or other support staff, emotionally shuts down when faced with traumatic reminders	Avoidance of traumatic memories or reminders
Lacks awareness of emotional responses, does not emotionally respond to others	Emotional numbing or restricted range of feelings
Has difficulty keeping up in educational settings or job training programs	Difficulty concentrating or remembering
Is triggered by rules and consequences. Has difficulty setting limits with children.	Feeling unsafe, helpless, and out of control
Seems spacey or "out of it." Has difficulty remembering whether or not they have done something. Is not responsive to external situations.	Dissociation
Has difficulty trusting staff members; feels targeted by others. Does not form close relationships in the service setting.	Difficulty trusting and/or feelings of betrayal

"Difficult" Behaviors or Reactions within Homeless Service Settings	Common Trauma Reactions
Puts less effort into trying--does not follow through on appointments, does not respond to assistance	Learned helplessness
Has ongoing substance abuse problems	Use of alcohol or drugs to manage emotional responses

The OVW's adoption of the voluntary services model, the elimination by DV shelters and transitional housing programs of unnecessary rules and coercive participant requirements, and implementation by many programs of an "empowerment" approach have all been important elements of the effort to ensure that emergency housing and services are places of healing that don't re-create the kind of abusive environment survivors fled.

However, a few of the comments included in [Chapter 2](#) ("Survivor Access and Participant Enrollment") suggest that these "difficult" behaviors and coping mechanisms are sometimes interpreted as signs that a survivor will "not do well" in a voluntary services environment, and that **survivors who haven't demonstrated their ability to "make good use" of shelter program-leveraged resources may therefore not be referred for, or selected by, a TH program.** Similarly a few of the quotes in [Chapter 6](#) ("Length of Stay") suggest that some survivors who have been accepted into transitional housing, but have not fully "engaged" in programming, or who have **"not taken adequate advantage" of program assistance that might have helped them make targeted "progress," may not be offered the same opportunity to continue receiving assistance as TH participants who are "working the program."**

As discussed in [Chapter 2](#) and [Chapter 6](#), these types of decisions may be at odds with **Fair Housing laws, anti-discrimination laws, the VAWA voluntary services requirement** and the **OVW's warnings<sup>17</sup> against "procedures or policies that exclude victims ... based on their actual or perceived age, immigration status, race, religion, sexual orientation, gender identity, mental health condition..." and against "requiring survivors to meet restrictive conditions** in order to receive services...."

By contrast, [Wisconsin's Violence Against Women with Disabilities and Deaf Women Project \(2011\)](#), contends that these severely traumatized clients, who can be more difficult to serve and whose behaviors and communication styles can exhaust the patience of program staff, deserve the same compassion and support as other survivors, who may seem more compliant and receptive to assistance:

*"When domestic violence, sexual assault and disability organizations were asked who they find the most challenging to serve, they said people who: have multiple complicating factors such as inability to maintain employment, substance abuse, and homelessness; do not want to be helped; have mental health issues; don't take their medication; do not follow the "treatment plan;" "lie" or change their stories; do not follow the rules; or do not seem motivated to help themselves.*

*Our responsibility in a trauma-informed organization is to notice our judgments, impatience, disrespect, and maybe our misuse of power and control with someone who is coping with trauma in the best ways she can at this time. With a better understanding of trauma and its impact, we can think more carefully about our individual and organizational responses to victims/survivors with and without disabilities." (p.16)*

Some of the less inclusive responses to the challenges posed by "difficult" survivor behaviors may reflect staff concerns about their program's limited capacity to work with participants with behavioral health issues, and/or their program's ability to assist only a fraction of the survivors who could benefit from transitional housing; or they may reflect concern about the loss of HUD or other funding if the program cannot demonstrate an "adequate percentage" of positive participant outcomes or if participants' "excessive" lengths of stay cause the program to fall below the targeted numbers of survivors to be served during the grant

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<sup>17</sup> See "Activities that Compromise Victim Safety and Recovery" in [OVW 2016 solicitation for TH grant proposals](#) (pp. 3-4).

period.<sup>18</sup> In any case, they illustrate the challenge of creating a trauma-informed program in an operating environment that is shaped by other imperatives and constraints.

[Jennings \(2007\)](#) describes the importance of a helping relationship grounded in trust and respect:

*"All trauma-specific service models, including those that have been researched and are considered emerging best practice models, should be delivered within the context of a relational approach that is based upon the empowerment of the survivor and the creation of new connections. The betrayal and relational damage occurring when a child is repetitively abused and neglected sets up lifetime patterns of fear and mistrust which have enormous impacts on his or her ability to relate to others and to lead the kind of life he or she wants. Recovery cannot occur in isolation. It can take place only within the context of relationships characterized by belief in persuasion rather than coercion, ideas rather than force, and mutuality rather than authoritarian control—precisely the beliefs that were shattered by the original traumatic experiences (Herman, 1992)." (p.22)*

Similarly, one of the fundamental principles of Trauma-Informed Care, as articulated in [Guarino et al.'s \(2009\)](#) **Trauma-Informed Organizational Toolkit**, and as elaborated on later on in this document, is

**"Supporting Consumer Control, Choice and Autonomy:** *Helping consumers regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy; keeping consumers well-informed about all aspects of the system, outlining clear expectations, providing opportunities for consumers to make daily decisions and participate in the creation of personal goals, and maintaining awareness and respect for basic human rights and freedoms."* (p.17)

Likewise, [SAMHSA's \(2014a\)](#) articulation of six key principles fundamental to a trauma-informed approach to services (more fully discussed in the section of this document on Trauma-Informed Care) includes:

**"Collaboration and Mutuality:** *Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships, and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach."*

**"Empowerment, Voice, and Choice:** *Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. . . . Operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery. Staff are empowered to do their work as well as possible by adequate organizational support."* (p.11)

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<sup>18</sup> As noted in Appendix A: Project Description and Methodology, 42% of TH providers interviewed for this project receive HUD grants to support transitional housing and/or rapid rehousing projects serving survivors of domestic and sexual violence. As described in [Chapter 1](#) ("Definition of Success and Performance Measurement"), [Chapter 12](#) ("Funding and Collaboration: Opportunities and Challenges"), and other chapters, these programs are all subject to annual performance reviews in which participant outcomes and lengths of stay are evaluated against nationally established standards.

### 3. How (Adult) Survivors Are Helped to Heal from the Trauma

Helping people to heal from trauma can take many forms ranging from providing therapeutic interventions that address trauma-related symptoms to adopting systemic approaches that attempt to ensure that entire organizations are equipped to recognize and respond to trauma in the lives of consumers. Increasingly, a distinction is being made between “trauma-specific services” and “trauma-informed care” (also referred to as a “trauma-informed approach”). As explained in [SAMHSA \(2014\)](#),

- **Trauma-Specific Services** are “prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.” (p.xix) Trauma-specific services are discussed in the next section.
- **Trauma-Informed Care** is a “strengths-based service delivery approach ‘that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment’ ([Hopper, Bassuk, & Olivet, 2010, p.133](#)). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services.” (p.xix)

Trauma-specific services are discussed in the next section. Trauma-informed care is discussed in section (c).

#### (a) Trauma-Specific Services

##### (i) *A Little More on Symptoms and Diagnosis*

The term “trauma-specific services” refers to therapeutic interventions or treatment services that address the trauma-related responses that develop during or after a traumatic experience and that interfere with a trauma-survivor’s day-to-day functioning. As discussed in an earlier portion of this section, it is common for anyone who has a traumatic experience to have a range of physical, emotional, cognitive, or behavioral responses to that experience. Common responses include: headaches, stomach aches, fatigue, changes in eating or sleeping patterns, anger, sadness, nightmares, flashbacks, increased agitation, irritability, anxiety, trouble concentrating, feeling numb or disconnected, difficulty trusting others, feelings of guilt or shame, denial, and/or avoidance avoiding reminders of the event ([Levin, 2011](#); [SAMHSA, 2014, pp. 62-63](#)).<sup>19</sup>

As discussed in that earlier narrative, people’s responses to trauma vary based on personal traits, the type and magnitude of the trauma and the losses attendant to the trauma, and other factors. As also noted, the impacts of repeated or recurrent or continuing traumas add up; people who have experienced trauma previously -- especially childhood trauma -- are likely to have a stronger reaction than those who haven’t. Furthermore, persons with mental health issues and/or substance use/abuse issues are more vulnerable to trauma, and likewise, persons who have experienced chronic or complex trauma are more vulnerable to mental illness (e.g., depression) and developing alcohol or drug dependence.

As [Warshaw, Sullivan & Rivera \(2013\)](#) note,

*“Many women recover relatively quickly from IPV, particularly if the abuse is shorter in duration and less severe and they have access to resources and support. Others, particularly those who experience more*

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<sup>19</sup> Thus, statistics from the National Intimate Partner and Sexual Violence Survey (2010) indicate that women who have experienced rape or stalking by any perpetrator or physical violence by an intimate partner in their lifetime are more likely to report asthma, diabetes, and irritable bowel syndrome than women who did not experience these form of violence. They are also more likely to report frequent headaches, chronic pain, difficulty sleeping, activity limitations, and poor physical and mental health than women who did not experience these forms of violence. ([Black et al., 2011](#)).

*frequent or severe abuse, may develop symptoms that make daily functioning more difficult. . . . Some trauma survivors experience one or more ... symptoms for a brief period of time, while others develop chronic **posttraumatic stress disorder (PTSD)**, a disorder that is a common response to overwhelming trauma and that can persist for years. Survivors are also at risk for developing depression, which has been found to significantly relate to the development of PTSD. For those who have also experienced abuse in childhood and/or other types of trauma (i.e., cumulative trauma), the risk for developing PTSD is elevated. Experiencing childhood trauma and/or severe longstanding abuse as an adult can also disrupt one's ability to manage painful internal states (affect regulation), leaving many survivors with coping mechanisms that incur further harm (e.g., suicide attempts, substance use). Trusting others, particularly those in caregiving roles, may be especially difficult." (pp.2-3)*

**Post-Traumatic Stress Disorder (PTSD)** is a common mental health condition related to direct exposure to, or in-person witnessing of, certain types of trauma<sup>20</sup> -- actual or threatened death, serious injury, or sexual violence. The core symptoms of PTSD include: (a) re-experiencing the traumatic event through nightmares or flashbacks and/or intense or prolonged distress after exposure to reminders; (b) avoiding memories, thoughts, feelings, or external reminders of the event; (c) negative thinking and mood that may include blame of self or others, diminished interest or participation in significant activities, feeling numb and disconnected, inability to recall key features of the traumatic event, estrangement from others, inability to experience positive emotions; and (d) issues of arousal such as difficulty falling or staying asleep, angry outbursts, difficulty concentrating, hypervigilance, exaggerated startle response, and reckless or self-destructive behavior. ([National Center for PTSD, 2016](#); [Friedman, n.d.](#)) A person need not have all the possible symptoms associated with PTSD to be diagnosed with the condition. A [webinar](#) and companion [slide deck](#) by Matthew Friedman, director of the National Center on PTSD, explains the diagnostic criteria, as of the May 2013 release of DSM-5 (the latest version of the American Psychiatric Association's Diagnostic and Statistical Manual). Note that a diagnosis of PTSD is only made after the symptoms have persisted for **more than one month**. A person experiencing many of the same symptoms in the immediate (3 to 30 days) aftermath of exposure to trauma might be diagnosed with [Acute Stress Disorder \(ASD\)](#).

[Courtois \(2010\)](#) explains how survivors who have experienced complex trauma may not evidence all of the diagnostic symptoms of PTSD, even though they clearly suffer from a post-traumatic stress condition; she and others advocated (unsuccessfully) for inclusion in the DSM-5 of a new category of post-traumatic stress that would be called Complex PTSD:

*"Recent studies have documented that abuse and other trauma result in changes in the child's neurophysiological development that, in turn, result in changes in learning patterns, behavior, beliefs and cognitions, identity development, self-worth, and relations with others, to name the most common. Although some individuals who were traumatized as children manage to escape relatively unscathed ... the majority developed a host of aftereffects, some of which were post-traumatic and met criteria for Posttraumatic Stress Disorder (PTSD). But the PTSD diagnosis ... does not account for many of the after-effects seen in children and later in adults [who were] abused as children, and is not, in fact, a diagnosis for childhood PTSD. As of yet, no such diagnosis has been included in the DSM...."*

*In recognition of this omission and the misfit encountered in applying many of the complex trauma reactions to the criteria of "standard" PTSD, a review of the most common aftereffects of chronic childhood abuse resulted in their organization into seven criteria sets that were included in a new diagnostic conceptualization labeled Complex PTSD or DESNOS (Disorders of Extreme Stress Not Otherwise Specified). (Herman, 1992 and [Herman, 1992a](#))*

*'Complex PTSD' was suggested as a means of organizing and understanding the often perplexing array of*

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<sup>20</sup> Or repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., program staff repeatedly exposed to deeply disturbing details of domestic/sexual violence, child abuse, etc.).

*aftereffects [as a single] overarching diagnosis. Moreover, the diagnosis was a way to de-stigmatize aftereffects and symptoms by acknowledging their origin as outside the individual and not due to the character (or character defect) of the individual. Unfortunately, these negative points of view have been held by many mental health practitioners over the years [and] impacted their compassion for and treatment of traumatized individuals.*

*Sadly, Complex PTSD was not included as a freestanding mental health diagnosis in the DSM IV.... In the meantime, many therapists who treat children and adults with complex trauma histories and complex trauma reactions use this conceptualization because it matches what they see in their clients' presentations and helps them to explain and organize the symptoms and to further organize their treatment. . . .*

*The 'traditional' ... criteria that make up the original diagnosis of PTSD ... were derived from the study of war trauma and adult soldiers and included: (1) intrusive re-experiencing of traumatic memories, (2) emotional numbing and avoidance of reminders of the trauma, including memory loss, and (3) hyper-arousal, in addition to various associated features such as depression and anxiety and other co-morbidities.*

*Complex traumatic stress disorders routinely include a combination of additional DSM-IV TR Axis I and Axis II (developmental/personality) disorders and symptoms, Axis III physical health problems, and severe Axis V psychosocial impairments. . . . The seven categories of additional aftereffects include the following:*

- 1. **Alterations in the regulation of affective impulses**, including difficulty with modulation of anger and of tendencies towards self-destructiveness. This category has come to include all methods used for emotional regulation and self-soothing, even those that are paradoxical, such as addictions and self-harming behaviors;*
- 2. **Alterations in attention and consciousness, leading to amnesias and dissociative episodes and depersonalization**. This category includes emphasis on dissociative responses different than those found in the DSM criteria for PTSD. Its inclusion in the CPTSD conceptualization incorporates findings that dissociation tends to be related to prolonged and severe interpersonal abuse occurring during childhood and, secondarily, that children are more prone to dissociation than are adults;*
- 3. **Alterations in self-perception**, predominantly negative and involving a chronic sense of guilt and responsibility, and ongoing feelings of intense shame. Chronically abused individuals (especially children) incorporate abuse messages and posttraumatic responses into their developing sense of self and self-worth;*
- 4. **Alterations in perception of the perpetrator**, including incorporation of his or her belief system. This criterion addresses the complex relational attachment systems that ensue following repetitive and premeditated abuse and lack of appropriate response at the hands of primary caretakers or others in positions of responsibility;*
- 5. **Alterations in relationship to others**, such as not being able to trust the motives of others and not being able to feel intimate with them. Another "lesson of abuse" internalized by victim/ survivors is that other people are venal and self-serving, out to get what they can by whatever means including using/abusing others. Abuse survivors may be unaware that other people can be benign, caregiving, and not dangerous;*
- 6. **Somatization and/or medical problems**. These somatic reactions and medical conditions may relate directly to the type of abuse suffered and any physical damage that was caused or they may be more diffuse. They have been found to involve all major body systems and to include many pain syndromes, medical illnesses and somatic conditions;*
- 7. **Alterations in systems of meaning**. Chronically abused and traumatized individuals often feel hopeless about finding anyone to understand them or their suffering. They despair of being able to recover from their psychic anguish.*

**(ii) Taking a Cautious Approach to Diagnosis of Mental Illness ... It Could Be Trauma (or TBI)<sup>21</sup>**

Clinicians who base their diagnoses only on the presenting symptoms may incorrectly attribute those symptoms to mental illness or chronic substance abuse, when in fact, they have their origins, at least in part, in trauma. As noted previously, exposure to trauma heightens the risk of mental illness, and conversely, mental illness and substance abuse heighten vulnerability to trauma. But it is also true that trauma-related symptoms may mimic mental health issues such as anxiety disorders, bipolar disorder, or borderline personality disorder ([Luxenberg, Spinazzola, & van der Kolk, 2001](#)). When trauma survivors are diagnosed *solely* on the basis of presenting symptoms, mental health and other providers are likely to miss the underlying traumatic experiences that may be the source -- at least in part -- of the emotions and /or behaviors and the necessary focus of treatment, which impacts recovery ([Cook et al., 2005](#); [D'Andrea et al., 2012](#)).<sup>22</sup> And, as described by [Courtois \(2010\)](#) (above), people who experience prolonged exposure to trauma from an early age develop ways of surviving that are more far-reaching than the current PTSD diagnosis can capture. The effects of early, chronic trauma include: difficulty forming and sustaining relationships and trusting others; trouble identifying, expressing and managing feelings and extreme emotional responses; engaging in more risk-taking behaviors; diminished concentration, reasoning and problem-solving skills; disconnection; and poor self-concept.

Or, as [Warshaw, Sullivan & Rivera \(2013\)](#) note,

*"For women who are currently experiencing IPV what may look like psychiatric symptomatology (e.g., an "exaggerated" startle response on hearing a door slam) may in fact be an appropriate response to ongoing danger. Although wariness, lack of trust, or seemingly paranoid reactions may be manifestations of previous abuse, this "heightened sensitivity" may also be a rational response that could protect a woman from further harm. Similarly, a survivor's seemingly passive response to abuse can be misinterpreted, as well. While passivity might be a response to previous experiences of trauma, for survivors of IPV, it may be an intentional strategy used to avoid or minimize abuse that is beyond their control. Choosing to remain in an abusive relationship is often based on a strategic analysis of safety and risk. It is also influenced by culture, religion, and the hope (not always unfounded) that abusers can change." (p.3)*

Although DV providers may not be clinically trained to treat trauma, they can help survivors and treating clinicians better understand the context in which patterns of thinking and behavior may have developed.

In the same way that it is important to understand the etiology of a person's symptoms in order to avoid misdiagnosing a trauma-related condition (or a head injury-related condition) as a mental health problem, it is also important to understand how cultural differences impact the manifestations of trauma. In their meta-analysis of the literature on cultural-, race-, or ethnicity-related factors that might limit the universal applicability of the diagnostic criteria of PTSD, [Hinton & Lewis-Fernández \(2010\)](#) found "substantial evidence of the cross-cultural validity of PTSD...." However, they identified the need for "further research [on] the

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<sup>21</sup> The signs and symptoms of traumatic brain injury (TBI) and suggestions for working with participants with TBI are discussed in the "Disabilities" section of [Chapter 7](#) ("Subpopulations and Cultural/Linguistic Competence") of this report.

<sup>22</sup> A Brief by the [National GAINS Center \(2006\)](#), "After the Crisis: Trauma and Re-traumatization," based on work by [Kammerer & Mazelis \(2006\)](#), affirms that concern:

*"The impact of experiencing traumatic events includes responses such as isolation, hypervigilance, substance abuse, dissociation, self-injury, eating disorders, depression, anxiety, hearing voices, risky sexual behavior, and other psychological reactions that begin as coping mechanisms and end up as compounding problems. Too often, coping responses to experiencing trauma are pathologized and designated by mental health diagnoses--including Post-Traumatic Stress Disorder (PTSD), depression, anxiety, panic disorders, personality disorders, obsessive compulsive disorders, psychotic disorders, and eating disorders—without a full understanding of their interrelation with trauma. Immediate, intermediate, and long-term support, including peer support, for trauma survivors that fosters connection is essential to the healing process."*

relative salience of avoidance/numbing symptoms, the role of the interpretation of trauma-caused symptoms in shaping symptomatology, and the prevalence of somatic symptoms." They also suggested "the need to modify certain criteria, such as the items on distressing dreams and on foreshortened future, to increase their cross-cultural applicability." Using in-depth cross-cultural case examples, and drawing on a team of more than two dozen experts, [Wilson & So-Kum Tang \(2007\)](#) looked at the same kinds of questions about the cultural applicability of tools and approaches for diagnosing trauma and related conditions, and found that "despite the best intentions of Western psychology, one model does not fit all cultures." Based on that research, they offer some insights and guidelines for professionals serving an international and multi-generational clientele, including refugees.

### **(iii) Approaches to Treatment<sup>23</sup>**

**Note:** The following information about approaches to treatment is *not* intended to suggest that program staff should attempt to implement clinical treatment modalities that they aren't trained and supported in using. Instead, as [SAMHSA \(2014\)](#) suggests, "having some knowledge of them" (p.137) will inform the services they *do* provide, and their understanding of treatment alternatives, enabling them to offer more appropriate referrals.

Much of the following narrative is drawn from Chapter 6 of [SAMHSA \(2014\)](#) (which provides summary information and links for some of the trauma-specific service modalities currently employed); and [Warshaw, Sullivan, & Rivera \(2013\)](#) (which reviewed research investigating the efficacy of trauma-specific interventions that had been tailored to address the needs of DV survivors). [Jennings \(2007\)](#) is a compendium of information about dozens of trauma-informed and trauma-specific treatment models, for men, women, adults, parents, and children, with contact information and information about any research on efficacy.

Some of the interventions (in [Warshaw, Sullivan, & Rivera \(2013\)](#) and [Jennings \(2007\)](#)) have been specifically adapted for survivors, some have not. Some focus on adult survivors, some address issues specific to parenting, and some focus on children. Some interventions are designed to be administered in the short-term aftermath<sup>24</sup> of trauma, and some are best utilized after the immediate crisis period. Some are exclusively focused on trauma, while others are intended for use in addressing trauma and co-occurring mental health or substance use problems. Some interventions are present-focused, primarily addressing coping skills,

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<sup>23</sup> Other sources of information about trauma, assessing trauma, and trauma treatments are:

- The International Society for Traumatic Stress Studies (ISTSS) website maintains links to [downloadable treatment guidelines for PTSD \(2008\)](#) using a range of modalities tailored to the needs of different demographics. The website also maintains a link to the [2012 ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults](#).
- The [U.S. Department of Veteran Affairs / National Center for PTSD Published International Literature on Traumatic Stress \(PILOTS\) Database](#) is an online database providing professionals and members of the public free summaries and links to "worldwide literature on PTSD and other mental health consequences of exposure to traumatic events. Unlike other databases, the PILOTS Database does not restrict its coverage to articles appearing in selected journals. It attempts to include all publications relevant to PTSD and other forms of traumatic stress, whatever their origin without disciplinary, linguistic, or geographic limitations." Information addressed includes types of trauma, approaches to assessment and treatment, etc.

<sup>24</sup> Typically, TH programs only serve survivors in the immediate aftermath of traumatic violence if there are no shelter vacancies. See [NCTSN/NCPTSD \(2006\)](#) for recommendations pertaining to *Psychological First Aid* in the immediate aftermath of a traumatic event. [SAMHSA \(2014, p.140\)](#) cites [Litz & Gray's \(2002\)](#) caution that, "No formal interventions should be attempted [in the first 48 hours], but a professionally trained, empathic listener can offer solace and support."

psychoeducation<sup>25</sup>, and symptom management; these approaches are typically best for survivors in early recovery. Some interventions are past-focused, encouraging the survivor to tell her trauma story, so that she can better understand the impact of that trauma on her current behavior, emotion, and thinking, so she can work through "emotions that were too overwhelming to experience in the past," and so she can more effectively cope with ongoing traumatic experiences. "For clients who are stable in their recovery and have histories of ... trauma [that] has been repressed, a past-focused orientation may be helpful. Some clients may benefit from both types, either concurrently or sequentially."

Some of the most common treatment approaches, which have been widely adapted to address specific subpopulations and circumstances, are:

- **Cognitive Behavioral Therapy (CBT):** "Cognitive-behavioral therapy is based on the idea that our thoughts cause our feelings and behaviors, not external things, like people, situations, and events. The benefit of this fact is that we can change the way we think to feel / act better even if the situation does not change." ([website of the National Association of Cognitive Behavioral Therapists, as of 4/29/2016](#))
- **[Prolonged] Exposure Therapy:** "[Prolonged] Exposure therapy for PTSD asks clients to directly describe and explore trauma-related memories, objects, emotions, or places. Intense emotions are evoked (e.g., sadness, anxiety) but eventually decrease, desensitizing clients through repeated encounters with traumatic material. Careful monitoring of the pace and appropriateness of exposure-based interventions is necessary to prevent re-traumatization. . . . The effectiveness of exposure therapy has been firmly established; however, adverse reactions ... have also been noted. . . . [Therefore,] studies and routine use of exposure [therapy] have consistently excluded high-complexity clients such as those with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality." ([SAMHSA, 2014, p.143](#))
- **Cognitive Processing Therapy (CPT):** "CPT was developed for rape survivors and combines elements of ... exposure therapy ... and cognitive therapy. The exposure therapy component ... consists of clients writing a detailed account of their trauma, including thoughts, sensations, and emotions that were experienced during the event. The client then reads the narrative aloud during a session and at home. The cognitive therapy aspect of CPT uses six key PTSD themes ... safety, trust, power, control, esteem, and intimacy. The client is guided to identify cognitive distortions in these areas, such as maladaptive beliefs [e.g., that they deserved to be raped]. . . . However, CPT has not been studied with high-complexity populations such as individuals with substance dependence, homelessness, current domestic violence, serious and persistent mental illness, or suicidality." ([SAMHSA, 2014, pp. 142-143](#))
- **Eye Movement Desensitization and Reprocessing (EMDR):** According to the [EMDR International Association website](#), EMDR is an eight-stage evidence-based "integrative psychotherapy approach that has been extensively researched and proven effective for the treatment of trauma. . . . The goal of EMDR therapy is to process completely the experiences that are causing problems, and to include new ones

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<sup>25</sup> In the same way that "DV101" workshops offered by shelters and transitional housing programs to help survivors understand how domestic violence has impacted their energy, self-esteem, ability to trust, anxiety level, temper, and other aspects of their physical, psychological, and emotional health, so, **psychoeducation** takes an ecological approach to understanding and contextualizing a participant's mental health. Clients/patients are seen as a partner with the provider in treatment; the better they understand their situation, the better their outcomes will be. Like the survivor-centered approach that many DV programs take, psychoeducation avoids pathologizing a client's condition, instead using a "competence-based approach, stressing health, collaboration, coping, and empowerment." The specific modes of treatment might include cognitive-behavioral therapy or group sessions, stress and coping models, social support models, or narrative approaches. Underlying these approaches is a belief that helping someone "understand their illness or experience in relation to other systems in their lives (i.e., partners, family, school, health care provider, and policymakers)" and leveraging the support /reinforcement that group participation can provide can "reduce isolation and serve as a forum for both recognizing and normalizing experience and response...." ([Lukens & MacFarlane, 2004, p.206](#))

that are needed for full health. 'Processing' does not mean talking about it. 'Processing' means setting up a learning state that will allow experiences that are causing problems to be 'digested' and stored appropriately in your brain. . . . The inappropriate emotions, beliefs, and body sensations will be discarded. . . . The goal of EMDR therapy is to leave [the client] with the emotions, understanding, and perspectives that will lead to healthy and useful behaviors and interactions.

- **Stress Inoculation Training (SIT):** SIT is another form of CBT, "originally developed to manage anxiety [and modified to] treat rape survivors based on the idea that the anxiety and fear that rape survivors experience during their trauma generalizes to other objectively safe situations.<sup>26</sup> SIT treatment components<sup>27</sup> include education, skills training (muscle relaxation training, breathing retraining, role-playing, guided self-talk, assertiveness training, and thought stopping [i.e., actively and forcefully ending negative thoughts by thinking "STOP" and then redirecting thoughts in a more positive direction]), and skills application. The goal is to help clients learn to manage their anxiety and to decrease avoidant behavior by using effective coping strategies." As part of the treatment regimen, the trauma survivor practices using their coping strategies in increasingly challenging "circumstances that elicit higher stress levels ... [and] mimic more realistic circumstances." Through successful navigation of those challenges -- using techniques like "imagery and behavioral rehearsal, modeling, role-playing, and graded *in vivo* exposure" (incrementally facing their fears) -- the client builds their sense of self-efficacy. ([SAMHSA, 2014, pp. 146-147](#))

#### **One Size Doesn't Fit All....**

[Warshaw, Sullivan, & Rivera \(2013\)](#) emphasize the importance of adapting treatment services to the needs of survivors, and not assuming that treatment modalities that work for one subpopulation will also work for other segments of the community. They caution that although various treatment regimens have demonstrated effectiveness in reducing PTSD and depression in a variety of study populations,

*"[They are not necessarily] effective for, desired by, or accessible to all trauma survivors, nor do they address many of the domains affected by longstanding interpersonal trauma. There are a number of issues that may influence how, where, and in what manner to provide trauma treatment to IPV survivors. For example, women still dealing with IPV are generally dealing with a myriad of pressing concerns (e.g., protecting their children, dealing with the legal system, becoming financially more stable). They may have little time and insufficient funds for ongoing therapy sessions or completing homework outside of treatment. Low-income women in particular may have difficulty affording the needed childcare to attend therapy, and as a result of structural oppression, people of color may have less access to insurance to pay for trauma treatment. In addition, perpetrators of abuse may prevent women from seeking treatment or use their knowledge of their partner's treatment to continue their violence or threats. If the couple has children together, it is not uncommon for perpetrators to use women's help-seeking against them, claiming that they are too "mentally ill" to effectively care for the children, which may discourage women from seeking treatment."* (p.3)

Also, as suggested (above) in [SAMHSA \(2014\)](#), and elaborated upon in [Warshaw, Sullivan, & Rivera \(2013\)](#), women experiencing ongoing abuse or living with the fear of future abuse may actually experience heightened trauma as a result of participating in certain narrative treatment modalities. For example, "while exposure therapy is intended to make a prior traumatic incident "lose its power" through repeated recall and

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<sup>26</sup> [SAMHSA \(2014, p.146\)](#) cites Kilpatrick, D. G., Veronen, L. J., & Resick, P. A. (1982). Psychological sequelae to rape: Assessment and treatment strategies. In D. M. Doleys, R. L. Meredith, & A. R. Ciminero (Eds.), Behavioral medicine: assessment and treatment strategies (pp. 473–497). New York: Plenum)

<sup>27</sup> [SAMHSA \(2014, p.146\)](#) cites Meichenbaum, D. (2007). Stress inoculation training: A preventative and treatment approach. In Principles and practice of stress management. (3rd ed.). (pp. 497–516). New York: Guilford Press.

verbalization ... for a person who is still in danger, repeated recall of frightening events may have a very different and adverse effect." (p.4)

[Warshaw, Sullivan, & Rivera \(2013\)](#) note that "treatments designed to reduce PTSD and trauma-related depression were originally created to address single event traumas (e.g., non-partner sexual assault, motor vehicle accidents) or traumatic experiences that occurred in the past and were unlikely to recur (e.g., combat). For many IPV survivors, the abuse or fear of future abuse is ongoing, regardless of their relationship status. Under these circumstances, some treatment components may be especially difficult to tolerate, requiring modifications. For example, 'reliving' the abuse through some forms of exposure therapy can potentially escalate rather than decrease women's distress." (pp. 3-4) They reviewed and compared nine studies involving eight treatment approaches that had been specifically tailored for survivors of IPV, five of which involved modification of CBT for IPV survivors; two strong examples were:

- **Cognitive Trauma Therapy for Battered Women (CTT-BW)** is a "cognitive trauma therapy tailored specifically for IPV survivors suffering from PTSD ... designed in collaboration with advocates and survivors, [and including] standard modalities such as psychoeducation about PTSD and stress management and exposure (talking about the trauma, homework, watching movies about domestic violence) but also included components to address four unique areas of concern ... identified as salient to abused women. These included (1) trauma-related guilt that many survivors reported (guilt about failed marriage, effects on children, decisions to stay or leave); (2) histories of other traumatic experiences; (3) likelihood of ongoing stressful contact with the abuser in relation to parenting; and (4) risk for subsequent re-victimization. Modules were designed to address these concerns, including assessing and reframing negative beliefs about the self and inaccurate cognitions that help to maintain trauma symptoms; assertiveness and self-advocacy skills training; strategies for managing contact with former partners particularly around custody and visitation; and strategies for identifying and avoiding potential perpetrators in the future. Therapy was provided in an individual format in eight to eleven 90-minute sessions for most clients." (p.6) [Kubany, Hill, & Owens \(2003\)](#) and [Kubany et al. \(2004\)](#) obtained positive results from clinical trials using CTT-BW to treat a diverse mix of survivors with IPV-related PTSD who met certain conditions: (1) out of the abusive relationship for at least 30 days with no desire to reconcile; (2) no physical or sexual victimization by anyone in the prior 30 days; (3) moderate or higher abuse-related guilt; (4) not currently abusing alcohol or drugs; and (5) no diagnosis of schizophrenia or bipolar disorder.
- **HOPE: Helping to Overcome PTSD through Empowerment** is a type of Cognitive Behavioral Therapy treatment approach "based heavily on Herman's (1992) multistage model, [involving] three stages of recovery: (1) re-establishing safety and a sense of self-care; (2) remembering and mourning; and (3) reconnection. . . . The treatment prioritizes women's safety needs, does not include exposure therapy, and focuses heavily on women's empowerment. Specifically, therapists focus on women's individual needs and choices and help them develop any skills needed to reach their personal goals. Later sessions focus on building cognitive and behavioral skills to manage PTSD symptoms and triggers, while optional modules are available that address common co-occurring issues such as dealing with substance abuse and managing grief." (pp. 6-7) [Johnson, Zlotnick, & Perez, 2011](#) obtained positive results in a clinical trial targeting women living in domestic violence shelters who had experienced recent abuse, who were still potentially in danger from their abusive partner, and who might or might not continue their relationship with that partner. The women had to meet certain conditions: (1) no diagnosis of bipolar disorder or psychosis; (2) not concurrently in individual therapy; (3) no changes in psychotropic medications over the prior 30 days; and (4) no significant suicidal ideation or risk. The intervention was shelter-based, and a majority of the participants exited the shelter before completing the series of treatment sessions; however researchers measured positive outcomes for women completing at least five of the planned 9-12 individual sessions.

The studies reviewed by [Warshaw, Sullivan, & Rivera \(2013\)](#) describe clinical trials assessing the efficacy of different approaches, targeting women with a range of exposures to abuse and violence, and designed to

address specific symptoms or aspects of PTSD. Some approaches incorporated group treatment, some focused on individual treatment. Attrition, whether a reflection of individual discomfort with the treatment process, or a consequence of the circumstances facing the women, was a challenge in most of the studies:

*"A strength of all of the studies was the racial and ethnic diversity across the samples. A number also included or intentionally focused on low-income women. These are important considerations, as these are women who have little access to mental health treatment and/or for whom therapy often has little appeal. Given the relatively high treatment retention rates of some of these studies as well as their potential efficacy, additional such clinical trials with appropriate modifications appear warranted. An additional strength of a number of the studies was that the treatment protocol was developed in collaboration with advocates (and sometimes with IPV survivors, as well). . . .*

*[However,] attrition for a few of the treatments was problematic and could suggest that the intervention was not palatable for some women. Treatment attrition is a concern with any mental health intervention and can be an indication either that the protocol is not meeting the needs of participants or that barriers exist that prevent continued participation [e.g., shelter exit ended participation in in the HOPE study, competing demands for participants' time (e.g., addressing housing, income, and legal issues)]. . . .*

*Not surprisingly, attrition from treatment was not always random. Younger women with lower incomes, less education, and higher rates of depression, guilt, and shame were the most likely to drop out of [one study], which suggests that the program might not work for those who may need it the most and that there may be systemic barriers preventing women from completing treatment. [Another study] found that the women most likely to drop out had reported more frequent and severe victimization (including higher rates of physical and sexual violence) and were more likely to have used alcohol and to have received medical attention and legal support. . . .*

*These findings suggest that treatments must be designed to be accessible to the people for whom they are being developed, that assistance might need to be offered to survivors in the form of transportation and child care, and that holding sessions at convenient times and in convenient locations, particularly in settings where women are already receiving other services, can be particularly helpful." (pp. 13-15)*

[Warshaw, Sullivan, & Rivera \(2013\)](#) observe that "there are a wide range of culturally specific approaches to trauma recovery that are based on the values and healing traditions of particular communities that not only may be more relevant for those communities but which offer approaches that touch on domains affected by trauma not addressed by existing evidence-based practices<sup>28</sup>," and they suggest that more research on such interventions is needed. They also note the prevalence of complex trauma (survivors who have experienced physical, sexual, psychological, and emotional violence over an extended period, often including childhood abuse and neglect) and call for research on the efficacy of models treating IPV survivors with complex trauma:

*"Complex trauma treatment approaches combine emerging data on the neurobiology of trauma with developmental relational perspectives, cognitive-behavioral techniques for managing overwhelming affect states, skill-building strategies to address developmental disruptions and, in some cases, a feminist emphasis on empowerment and social context. A number of these approaches also incorporate non-cognitively based modalities (e.g., meditation, dance, music, or body-centered therapies). Some involve traumatic memory recovery work after preparation, while others do not. All address safety as a priority, recognize that symptoms may be coping strategies, and stress the importance of the survivor-therapist relationship, particularly its role in supporting personal and relational experiences that facilitate the reinstatement of disrupted developmental processes. . . .*

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<sup>28</sup> Evidence-based practices and so-called "promising practices" can be found on the webpage of [SAMHSA's National Registry of Evidence-Based and Promising Practices](#)

*Complex trauma models are typically organized around three treatment phases [which] often overlap and/or occur multi-directionally. The first phase involves establishing safety and stability by building a collaborative therapeutic relationship, managing symptoms, developing emotional regulation and stress management skills, and identifying or creating additional supports. The emphasis on establishing physical and emotional safety before proceeding with more in-depth trauma work may make these models particularly salient for survivors of IPV. Phase two work focuses on trauma recovery, including developing a more integrated and emotionally modulated autobiographical narrative and a gradual reorientation to the present and future that is no longer dominated by the past. Phase three involves creating new meaning and purpose, reestablishing important connections and integrating new skills and capacities, and rebuilding a life that is no longer defined by trauma and its effects. Complex trauma treatment models are strengths-based and empowerment-focused, viewing individuals as survivors rather than as victims, and promoting therapeutic collaboration and choice. They are also attentive to survivors' cultural and spiritual values. Since many IPV survivors have experienced multiple forms of trauma, some of which are ongoing, sequenced multi-dimensional approaches may turn out to be more effective over time." (pp.15-16)*

The descriptions of the previously mentioned treatment modalities included statements indicating that these treatment had not been clinically tested for "high-complexity clients such as those with substance dependence, homelessness, current domestic violence, serious and persistent mental illness." [SAMHSA \(2014\)](#) provides information about some other treatment models designed to help trauma survivors address several presenting problems simultaneously as part of their treatment; some of those models are:

- **Addiction and Trauma Recovery Integrated Model (ATRIUM):** As described in [SAMHSA \(2014, p.148\)](#),  
*"The ATRIUM approach integrates CBT and relational treatment through an emphasis on mental, physical, and spiritual health. This 12-week model for individuals and groups blends psychoeducational, process, and expressive activities, as well as information on the body's responses to addiction and traumatic stress and the impact of trauma and addiction on the mind and spirit. It helps clients explore anxiety, sexuality, self-harm, depression, anger, physical complaints and ailments, sleep difficulties, relationship challenges, and spiritual disconnection. It was designed primarily for women and focuses on developmental (childhood) trauma and interpersonal violence, but it recognizes that other types of traumatic events occur.*  
*The ATRIUM model consists of three phases of treatment. The first stage, or 'outer circle,' consists of the counselor collecting data from the client about his or her trauma history, offering psychoeducation on the nature of trauma, and helping the client assess personal strengths. ATRIUM actively discourages the evocation of memories of abuse or other trauma events in this phase. The second stage, or 'middle circle,' allows clients and counselors to address trauma symptoms more directly and specifically encourages clients to reach out to and engage with support resources in the community. The middle circle also emphasizes learning new information about trauma and developing additional coping skills. The third stage of the program, the 'inner circle,' focuses on challenging old beliefs that arose as a result of the trauma. . . .*  
*ATRIUM was used in one of the nine study sites of SAMHSA's Women, Co-Occurring Disorders and Violence Study. Across all sites, trauma-specific models achieved more favorable outcomes than control sites that did not use trauma-specific models. . . . A manual describing the theory behind this model in greater depth, as well as how to implement it, is published under the title Addictions and Trauma Recovery: Healing the Body, Mind, and Spirit (Miller & Guidry, 2001)."*
- **Beyond Trauma: A Healing Journey for Women:** As described in [SAMHSA \(2014, p.149\)](#),  
*"Beyond Trauma Covington (2003) ... was developed for use in residential, outpatient, and correctional settings; domestic violence programs; and mental health clinics. It uses behavioral techniques and expressive arts and is based on relational therapy. Although the materials are designed for trauma treatment, the connection between trauma and substance abuse in women's lives is a theme*

throughout. **Beyond Trauma** has a psychoeducational component that defines trauma by way of its process as well as its impact on the inner self (thoughts, feelings, beliefs, values) and the outer self (behavior and relationships, including parenting). Coping skills are emphasized; specific exercises develop emotional wellness."

- **Seeking Safety:** As described in [SAMHSA \(2014, pp. 149-150\)](#),

*"Seeking Safety is an [evidence-based] empirically validated, present-focused treatment model that helps clients attain safety from trauma and substance abuse. . . . Seeking Safety ... can be used for groups and individuals, with women and men, in all settings and levels of care, by all clinicians [and non-clinically trained program staff], for all types of trauma and substance abuse.*

*[Sessions] covers 25 topics that address cognitive, behavioral, interpersonal, and case management domains. The topics can be conducted in any order, using as few or as many as are possible within a client's course of treatment. Each topic represents a coping skill relevant to both trauma and substance abuse, such as compassion, taking good care of yourself, healing from anger, coping with triggers, and asking for help. This treatment model builds hope through an emphasis on ideals and simple, emotionally evocative language and quotations. It attends to clinician processes and offers concrete strategies that are thought to be essential for clients dealing with concurrent substance use disorders and histories of trauma." (Najavits, 2002) provides clinician guidelines and client handouts and is available in several languages. A detailed description of the approach is available from [Najavits \(2007\)](#). Training videos and other implementation materials are downloadable from the [Seeking Safety website](#).*

*"Seeking Safety has shown positive outcomes on trauma symptoms, substance abuse, and other domains (e.g., suicidality, HIV risk, social functioning, problem-solving, sense of meaning); consistently outperformed treatment as usual; and achieved high satisfaction ratings from both clients and clinicians. It has been translated into seven languages, and a version for blind and/or dyslexic individuals is available. . . . The five key elements of Seeking Safety are: (1) Safety as the overarching goal: helping clients attain safety in their relationships, thinking, behavior, and emotions. (2) Integrated treatment (working on trauma and substance abuse at the same time). (3) A focus on ideals to counteract the loss of ideals in both trauma and substance abuse. (4) Four content areas: cognitive, behavioral, interpersonal, and case management. (5) Attention to clinician processes (addressing countertransference, self-care, and other issues)."*

[SAMHSA \(2014\)](#) describes several **treatment adjuncts** that may help trauma survivors cope with the symptoms of PTSD and other trauma-related conditions, including relaxation training, biofeedback, and breathing retraining (p.143); mindfulness-based interventions (pp. 153-154); and, pharmacological therapy (pp. 154-155). The authors note that

*"Medications can help manage and control symptoms; however, they are only a part of a comprehensive treatment plan. There are no specific 'anti-trauma' drugs; rather, certain drugs target specific trauma symptoms. Clients receiving pharmacotherapy need careful assessment. Some clients with preexisting mental disorders may need further adjustment in medications due to the physiological effects of traumatic stress. In addition, sudden withdrawal from a pattern of self-administered substances can not only lead to dangerous levels of physical distress, but also exacerbate the emergence of more severe PTSD symptoms. Distress after trauma often lessens over time, which can sometimes make the use of medications unnecessary for some individuals." (pp. 154-155)*

**(b) Provider Comments about the Use of Trauma-Specific Services in their TH Programs**

**Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.**

(#01) We have counselors that aren't on the transitional housing staff and a clinical social worker. But we only refer participants for counseling if there's a clinical need or the woman has requested it. Some have been linked to counseling during their shelter stay, and so they continue. If they need additional counseling, we link them up – our counselors specialize in trauma, children's issues. We have an EMDR counselor.<sup>29</sup> (EMDR is eye movement desensitization and reprocessing. It's a type of therapeutic treatment that helps survivors manage their anxiety and PTSD and develop new coping mechanisms.) The assessments for counseling happen in the shelter system. It would be helpful to have an in-house counselor that deals with trauma.

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(#02) Probably the most helpful thing in working with mothers who have behavioral or mental health issues or PTSD is our weekly staff meeting, where the women's counselors can give me, as a child therapist, more insight as to what's going on with mom.

We work in the group here with Lisa Najavits' Seeking Safety group model,<sup>30</sup> which addresses trauma and/or substance abuse. And often, if the client has co-occurring issues, if they've come here with a diagnosis, such as Bipolar disorder, we strongly encourage them to either get on or stay on their medications. But we also try to teach them how to cope with the anxiety and depression that goes along with trauma, using some of the skills they've learned in that group, such as [grounding techniques](#).

Often -- maybe close to 100% of the time -- they have no knowledge of PTSD, and they have not made the connections between their behaviors, their anxieties, and that trauma. So helping them develop that insight helps them get a grasp on things, and they feel more empowered to manage it successfully.

A lot of the mothers have had childhood abuse or neglect in some form or fashion. Not all of them, but a high percentage. A huge part of empowering women is helping them understand how their trauma has affected their parenting, and they don't have to feel like they're bad —through training in [Parent Child Interaction Therapy \(PCIT\)](#), they can learn simple skills that help them connect better with their kids, where connection has been difficult because of the trauma and the anxiety and depression. I think it's a huge part of developing their self-esteem too, if they do that PCIT and they improve on their parenting, they feel stronger as a woman.

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(#03) We have a shelter counseling program for the residents in shelter, and those residents are also – if they've built a strong connection with folks, try and offer some bridge counseling support to residents in transitional housing if they continue to need counseling but are having trouble accessing it in other ways. Our resource center has a counseling program that offers individual counseling for adults and children who have experienced domestic and sexual violence, trafficking. We have drop-in support groups. We have small closed groups. Counsellors are experienced in, have training in somatic experiencing and EMDR as well as other, more traditional counselling methods. They offer family counseling work and play therapy for children. We offer telephone counseling for those that for reasons of safety or access, transportation, or disability aren't able to come onsite to access counseling, they can get telephone counseling.

#### ***Trauma-Specific Services: Questions to Consider***

1. What types of individual or group interventions to address trauma are available to survivors in your program (either in-house or by referral to a community partner)
  - What are the cultural and logistical barriers to accessing and completing these types of interventions?

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<sup>29</sup> For more about EMDR, see the [EMDR Network](#) webpage or the [EMDR Humanitarian Assistance Programs](#) webpage.

<sup>30</sup> For more about Seeking Safety, see the preceding narrative discussion of Seeking Safety or [Najavits \(2004\)](#), which provides clinical guidelines for implementing the model for persons with PTSD and co-occurring substance abuse.

- What factors increase or decrease the likelihood a woman will access and use therapeutic services?
  - Does a survivor's safety concerns or uncertainty about where she will live and how she will support herself and her family undermine her ability to fully engage in treatment services?
  - Is participation in such treatment services beneficial, even if a survivor is distracted by such safety concerns or worries about her future housing or ability to support herself and her family?
2. To the extent that treatment services are offered in groups, how important is it that the women in the group share similar backgrounds (e.g., all experienced domestic violence, all experienced sexual assault, all are African American, all are Asian immigrants, etc.)?
- If a community-based treatment group isn't specifically focused on domestic or sexual violence, can it still be a valuable experience for survivors?
3. What are your key considerations when providing or referring survivors for clinical support?
  4. What kinds of concerns do survivors have about accessing clinical services, and how can they be addressed?

### (c) **Trauma-Informed Care / Taking a Trauma-Informed Approach**

***"Trauma-informed care shifts the philosophical approach from 'What's wrong with you?' to 'What happened to you?' " <sup>31</sup>***

#### ***(i) Basics and Core Principles of a Trauma-Informed Approach***

*"With the growing understanding of the pervasiveness of traumatic experience and responses, a growing number of clinical interventions for trauma responses have been developed . . . . However, from the voice of trauma survivors, it has become clear that these clinical interventions are not enough ... [and] that the organizational climate and conditions in which services are provided play a significant role in maximizing the outcomes of interventions and contributing to the healing and recovery of the people being served."* ([SAMHSA, 2014a, p.6](#))

The terms "trauma-informed care" and "trauma-informed approach" refer to a systemic approach to services that is "grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" ([Hopper, Bassuk, & Olivet, 2010, p. 133](#)).

Or, as [SAMHSA \(2014a\)](#) describes, "A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and **responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively **resist re-traumatization** [of the survivors it is serving]." (p.9)

[SAMHSA \(2014\)](#) recommends universal screening for history and symptoms of trauma by all behavioral health services providers.

*"Universal screening provides a steady reminder to be watchful for past traumatic experiences and their potential influence upon a client's interactions and engagement with services.... Screening should guide treatment planning; it alerts the staff to potential issues and serves as a valuable tool to increase clients' awareness of the possible impact of trauma and the importance of addressing related issues during treatment . . . . Staff members also need to [how] race/ethnicity, native language, gender, culture [or other attributes, like sexual orientation, religious affiliation, etc.] may influence screening results. For example, a woman who has been sexually assaulted by a man may be wary of responding to questions if a male staff*

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<sup>31</sup> Ferencik & Ramirez-Hammond, Ohio Domestic Violence Network, [Trauma-Informed Care Best Practices Manual](#) (2013)

*member or interpreter administers the screening or provides translation services. Likewise, a person in a current abusive or violent relationship may not acknowledge the interpersonal violence in fear of retaliation or as a result of disconnection or denial of his or her experience, and he or she may have difficulty in processing and then living between two worlds—what is acknowledged in treatment versus what is experienced at home. In addition, staff training on using trauma-related screening tools needs to center on how and when to gather relevant information after the screening is complete, [and] how to respond to a positive screening...." (p.25)*

In a trauma-informed program or organization, staff at all levels have a basic understanding of trauma and its potential impacts on individuals, families, and communities.

*"People's experience and behavior are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past (i.e., a client dealing with prior child abuse), whether they are currently manifesting (i.e., a staff member living with domestic violence in the home), or whether they are related to the emotional distress that results in hearing about the firsthand [traumatic] experiences of another person (i.e., secondary traumatic stress experienced by a direct care professional)." (p.9)*

[SAMHSA \(2014\)](#) asserts that in order to understand a person's experience of trauma, a provider must view that trauma in its social-ecological context: the attributes of the affected individual and their life history, the community and cultural context in which that person lives, the cultural meaning of the traumatic events, the types and magnitude of losses associated with the trauma, the individual's coping skills and the availability of family/community support for coping with the trauma:

*"Trauma cannot be viewed narrowly; instead, it needs to be seen through a broader lens—a contextual lens integrating biopsychosocial, interpersonal, community, and societal (the degree of individualistic or collective cultural values) characteristics that are evident preceding and during the trauma, in the immediate and sustained response to the event(s), and in the short- and long-term effects of the traumatic event(s), which may include housing availability, community response, adherence to or maintenance of family routines and structure, and level of family support . . . . Understanding trauma from this angle helps expand the focus beyond individual characteristics and effects to a broader systemic perspective that acknowledges the influences of social interactions, communities, governments, cultures, and so forth, while also examining the possible interactions among those various influences." (p.14)*

Exhibit 1.1-4 in [SAMHSA \(2014\)](#) illustrates the many sociocultural factors that influence the way an individual experiences a traumatic event.



[Guarino et al.'s \(2009, pp. 17-18\)](#) Trauma Informed Organizational Toolkit summarizes eight core principles of Trauma-Informed Care:

Core Principles	Explanation
<b>Understanding Trauma and Its Impact</b>	Understanding traumatic stress and recognizing that many current behaviors and responses are ways of adapting to and coping with past traumatic experiences.
<b>Promoting Safety</b>	Establishing a safe physical and emotional environment where basic needs are met; safety measures are in place; and provider responses are consistent, predictable, and respectful.
<b>Supporting Consumer Control, Choice, and Autonomy</b>	Helping people regain a sense of control over their daily lives. Keeping people informed about all aspects of the system and allowing them to drive goal planning and decision making.
<b>Sharing Power and Governance</b>	Sharing power and decision making across all levels of an organization, whether related to daily decisions or when reviewing and establishing policies and procedures.
<b>Ensuring Cultural Competence</b>	Respecting diversity within the program, providing opportunities for consumers to engage in cultural rituals, and using interventions specific to cultural backgrounds.
<b>Integrating Care</b>	Maintaining a holistic view of consumers that acknowledges the interrelated nature of emotional, physical, relational, and spiritual health and facilitates communication within and among service providers and systems.
<b>Healing Happens in Relationships</b>	Believing that establishing safe, authentic, and positive relationships can be corrective and restorative to trauma survivors.

Core Principles	Explanation
<b>Understanding That Recovery Is Possible</b>	Understanding that recovery is possible for everyone regardless of how vulnerable he or she may appear, instilling hope by providing opportunities for consumer involvement at all levels of the system, and establishing future-oriented goals.

Drawing on the work of Harris and Fallot (2001) and [Elliot et al. \(2005\)](#), [SAMHSA \(2014a, p.11\)](#) describes six principles fundamental to a trauma-informed approach:

Core Principles	How It Is Applied
<b>Safety</b>	Throughout the organization, staff and the people they serve, whether children or adults, feel <b>physically and psychologically safe</b> ; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.
<b>Trustworthiness and Transparency</b>	Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and [with] others involved in the organization.
<b>Peer Support</b>	<b>Peer support and mutual self-help</b> are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term “Peers” refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as “trauma survivors.”
<b>Collaboration and Mutuality</b>	Importance is placed on partnering and the <b>leveling of power differences between staff and clients and among organizational staff</b> from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that <b>healing happens in relationships</b> and in the <b>meaningful sharing of power and decision-making</b> . The organization recognizes that everyone has a role to play in a trauma-informed approach.
<b>Empowerment, Voice and Choice</b>	Throughout the organization and among the clients served, individuals’ strengths and experiences are recognized and built upon. The organization <b>fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma</b> . The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to <b>foster empowerment for staff and clients alike</b> .  Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in <b>shared decision-making, choice, and goal setting</b> to determine the plan of action they need to heal and move forward. They are supported in cultivating <b>self-advocacy</b> skills. <b>Staff are facilitators of recovery rather than controllers of recovery. Staff are empowered</b> to do their work as well as possible by adequate organizational support. This is a parallel process, as staff need to feel safe, as much as people receiving services.

Core Principles	How It Is Applied
<b>Cultural, Historical, and Gender Issues</b>	The organization actively <i>moves past cultural stereotypes and biases</i> (e.g. based on race, ethnicity, sexual orientation, age, religion, gender identity, geography, etc.); offers access to <i>gender-responsive services</i> ; <i>leverages the healing value of traditional cultural connections</i> ; incorporates policies, protocols, and processes that are <i>responsive to the racial, ethnic and cultural needs of individuals served</i> ; and recognizes and <i>addresses historical trauma</i> .

**(ii) Becoming a Trauma-Informed Organization**

Adopting a trauma-informed approach to service delivery typically requires changes to the practices, policies, and culture of an entire organization. Drawing on the work of [Fallot & Harris \(2009\)](#), [Henry et al. \(2010\)](#)<sup>32</sup>, [Hummer & Dollard \(2010\)](#), and [Penney & Cave \(2012\)](#)<sup>33</sup>, [SAMHSA \(2014a, pp.14-16\)](#) outlines a series of questions that programs and organizations can ask themselves as they work to implement a more trauma-informed approach with respect to ten domains: governance and leadership; policy; physical environment; engagement and involvement; cross-sector collaboration; screening, assessment, and treatment services; training and workforce development; monitoring of progress and quality assurance; financing; and evaluation:

Implementation Domains	Questions to Consider When Implementing a Trauma-Informed Approach
<b>Governance and Leadership</b>	<ul style="list-style-type: none"> <li>• How does agency leadership communicate its support and guidance for implementing a trauma-informed approach?</li> <li>• How do the agency’s mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports?</li> <li>• How do leadership and governance structures demonstrate support for the voice and participation of people using their services who have trauma histories?</li> </ul>
<b>Engagement and Involvement</b>	<ul style="list-style-type: none"> <li>• How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services?</li> <li>• How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have a difficulty processing information?</li> <li>• How is transparency and trust among staff and clients promoted?</li> <li>• What strategies are used to reduce the sense of power differentials among staff and clients?</li> <li>• How do staff members help people to identify strategies that contribute to feeling comforted and empowered?</li> </ul>

<sup>32</sup> [Henry et al. \(2010\)](#) is an unpublished manuscript that is not available online; the hyperlink is for Henry et al. (2011), which builds on the previous work.

<sup>33</sup> The hyperlink given for Penney & Cave's (2013) "*Becoming a Trauma-Informed Peer-Run Organization: A Self-Reflection Tool*" is for the publication from which it was adapted: "*Creating Accessible, Culturally Relevant, Domestic Violence- and Trauma-Informed Agencies: A Self-Reflection Tool*," a joint project by the Accessing Safety and Recovery Initiative (ASRI) and the National Center on Domestic Violence, Trauma and Mental Health, with OVC grant funding. Their work developing an accessible, culturally relevant, domestic violence and trauma-informed (ACDVTI) approach to advocacy and services for DV survivors experiencing the mental health effects of trauma and/or psychiatric disability is discussed at the end of this section.

<b>Implementation Domains</b>	<b>Questions to Consider When Implementing a Trauma-Informed Approach</b>
<b>Physical Environment</b>	<ul style="list-style-type: none"> <li>• How does the physical environment promote a sense of safety, calming, and de-escalation for clients and staff?</li> <li>• In what ways do staff members recognize and address aspects of the physical environment that may be re-traumatizing, and work with people on developing strategies to deal with this?</li> <li>• How has the agency provided space that both staff and people receiving services can use to practice self-care?</li> <li>• How has the agency developed mechanisms to address gender-related physical and emotional safety concerns (e.g., gender-specific spaces and activities)?</li> </ul>
<b>Policy</b>	<ul style="list-style-type: none"> <li>• How do the agency’s written policies and procedures include a focus on trauma and issues of safety and confidentiality?</li> <li>• How do the agency’s written policies and procedures recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery?</li> <li>• How do the agency’s staffing policies demonstrate a commitment to staff training on providing services and supports that are culturally relevant and trauma-informed as part of staff orientation and in-service training?</li> <li>• How do human resources policies attend to the impact of working with people who have experienced trauma?</li> <li>• What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, governance, policy-making, services, and evaluation?</li> </ul>
<b>Cross-Sector Collaboration</b>	<ul style="list-style-type: none"> <li>• Is there a system of communication in place with other partner agencies working with the individual receiving services for making trauma-informed decisions?</li> <li>• Are collaborative partners trauma-informed?</li> <li>• How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services?</li> <li>• What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?</li> </ul>
<b>Screening, Assessment, Treatment, and Services</b>	<ul style="list-style-type: none"> <li>• Is an individual’s own definition of emotional safety included in treatment plans?</li> <li>• Is timely trauma-informed screening and assessment available and accessible to individuals receiving services?</li> <li>• Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services?</li> <li>• How are peer supports integrated into the service delivery approach?</li> <li>• How does the agency address gender-based needs in the context of trauma screening, assessment, and treatment? For instance, are gender-specific trauma services and supports available for both men and women?</li> <li>• Do staff members talk with people about the range of trauma reactions and work to minimize feelings of fear or shame and to increase self-understanding?</li> <li>• How are these trauma-specific practices incorporated into the organization’s ongoing operations?</li> </ul>

<b>Implementation Domains</b>	<b>Questions to Consider When Implementing a Trauma-Informed Approach</b>
<b>Training and Workforce Development</b>	<ul style="list-style-type: none"> <li>• How does the agency address the emotional stress that can arise when working with individuals who have had traumatic experiences?</li> <li>• How does the agency support training and workforce development for staff to understand and increase their trauma knowledge and interventions?</li> <li>• How does the organization ensure that all staff (direct care, supervisors, front desk and reception, support staff, housekeeping and maintenance) receive basic training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions?</li> <li>• How does workforce development/staff training address the ways identity, culture, community, and oppression can affect a person’s experience of trauma, access to supports and resources, and opportunities for safety?</li> <li>• How does on-going workforce development/staff training provide staff supports in developing the knowledge and skills to work sensitively and effectively with trauma survivors.</li> <li>• What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work?</li> <li>• What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization’s workforce?</li> </ul>
<b>Monitoring of Progress and Quality Assurance</b>	<ul style="list-style-type: none"> <li>• Is there a system in place that monitors the agency’s progress in being trauma-informed?</li> <li>• Does the agency solicit feedback from both staff and individuals receiving services?</li> <li>• What strategies and processes does the agency use to evaluate whether staff members feel Assurance safe and valued at the agency?</li> <li>• How does the agency incorporate attention to culture and trauma in agency operations and quality improvement processes?</li> <li>• What mechanisms are in place for information collected to be incorporated into the agency’s quality assurance processes and how well do those mechanisms address creating accessible, culturally relevant, trauma-informed services and supports?</li> </ul>
<b>Financing</b>	<ul style="list-style-type: none"> <li>• How does the agency’s budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development?</li> <li>• What funding exists for cross-sector training on trauma and trauma-informed approaches?</li> <li>• What funding exists for peer specialists?</li> <li>• How does the budget support provision of a safe physical environment?</li> </ul>
<b>Evaluation</b>	<ul style="list-style-type: none"> <li>• How does the agency conduct a trauma-informed organizational assessment or have measures or indicators that show their level of trauma-informed approach?</li> <li>• How does the perspective of people who have experienced trauma inform the agency performance beyond consumer satisfaction survey?</li> <li>• What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality?</li> <li>• What measures or indicators are used to assess the organizational progress in becoming trauma-informed?</li> </ul>

Providing trauma-informed services requires an organization/system-wide commitment to translating core principles into practice across all areas of programming. [Guarino et al. \(2009\)](#), [Hopper, Bassuk, & Olivet](#)

(2010), and [SAMHSA \(2014a\)](#). Changes to policies, procedures, and practice may include (a) providing regular training to staff and volunteers on trauma, complex trauma, and traumatic brain injury, and their possible impacts (including participant emotions and behaviors which less well-informed staff might see as reflecting a "poor attitude," "lack of motivation," a "difficult personality," "uncooperativeness," "laziness," or other such negative character traits; (b) reducing potentially triggering or re-traumatizing practices such as excessive questioning, harsh judgments or punitive responses, unscheduled/unannounced meetings to review participant progress, etc.; (c) modifying physical spaces (e.g., windows, soft colors, comfortable chairs, soothing pictures, secure entrance, etc.) to enhance physical and emotional safety in the service environment; (d) emphasizing and encouraging staff attention to developing relationships that enhance participants' sense of emotional safety; (e) giving survivors a voice and a choice in all aspects of services; and (f) enhancing staff supervision to support staff in providing trauma-informed services, to address any adverse impacts on staff, (e.g., secondary traumatic stress), and more generally, to create a culture that supports provider self-care.

[Wilson, Fauci, & Goodman \(2015\)](#) describe the evolution of provider, advocate, and funder communities' interest in trauma informed care, leading up to the work by Goodman et al. in developing a trauma-informed practice metric for domestic violence programs. They observe that,

*"Survivors who find their way to DV programs have usually endured psychological, sexual, and/or physical abuse ([Childress, 2013](#)). Often, abusers have used these overt forms of abuse to maintain ongoing patterns of coercion and control across multiple domains of life, from parenting to socializing to employment (Stark, 2007). For survivors, coping with the ensuing powerlessness and isolation can be daunting (Warshaw, Brashler, & Gill, 2009). Thus, it is not surprising that DV is associated with elevated rates of posttraumatic stress disorder, depression, substance abuse, and other mental health challenges ([Dillon, Hussain, Loxton, & Rahman, 2013](#)). Further, DV often occurs in the context of chronic experiences of social oppression that shape and compound the impact of abuse, particularly for women who are marginalized by virtue of race, class, gender, sexuality, ability, or other social locations ([Sokoloff & Dupont, 2005](#)).*

*In the context of these challenges, many DV programs have espoused the goal of empowerment, or helping to restore the sense of choice and control that abusive partners have tried to take away ([Goodman et al., 2014](#); [Kasturirangan, 2008](#)). Yet, over the last decade, scholars and practitioners have expressed growing concern about the degree to which that goal is achieved in practice ([Kulkarni, Bell, & Rhodes, 2012](#)). Some have observed that DV programs have moved away from a survivor-centered, social change-oriented approach towards a service-driven model where support is constrained by pre-determined definitions of success ([Davies & Lyon, 2013](#); [Goodman & Epstein, 2008](#)). Others have observed that shelters, once seen as the heart of the movement, often establish stringent policies that can replicate coercive patterns of abuse (Glenn and Goodman, in press). Some scholars have even exposed blatant experiences of humiliation, marginalization, and exclusion of survivors within programs themselves —particularly low-income single women of color, LGBT women, or women with severe mental illness (e.g., [Koyama, 2006](#); [Sokoloff & Dupont, 2005](#)).*

*In response to these critiques, a growing number of DV scholars, policy-makers, and practitioners have called for a renewed focus on developing services that support survivors' needs and goals, that avoid replicating dynamics of coercion, that value the importance of a survivor-centered relationship, and that attend to survivors' mental health ([Goodman & Epstein, 2008](#); [Kulkarni, Bell, & Rhodes, 2012](#); [Serrata, 2012](#); [Warshaw et al., 2003](#)). It is no surprise that DV services have embraced TIC in light of these needs. Adopting TIC in the DV context has involved reframing the importance of many essential DV practices (e.g. empowerment, peer support) within a trauma framework. At the same time, TIC has integrated new concepts (e.g. historical trauma) and approaches (e.g. psychoeducation) that are meant to support the trauma-related mental health needs of survivors.*

*Over the past decade, federal and state agencies, community organizations, and researchers have begun to articulate how TIC principles can be translated to the DV context. For example, the National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH) has published numerous tip sheets, webinars,*

*and reports for working with survivors. These resources emphasize that trauma-informed work is social justice driven and closely linked to advocacy work in that it is about 'understanding the effects of trauma and what can be done to help mitigate those effects, while at the same time working to transform the conditions that allow for violence in our world' (Warshaw, 2014, p. 15). That is, a social-justice oriented approach to trauma-informed care prioritizes reducing and ultimately eliminating violence by advocating for survivors and working towards social change. These efforts have resulted in a framework of principles and practices that expands on more general conceptualizations, and includes, for example, reducing further harm; establishing empowering, transparent, caring, and respectful relationships; and being responsive to individual and collective needs (Warshaw, 2014)."*

#### **(d) Resources to Help Providers Strengthen Their Trauma Informed Approach**

The go-to webpages for information about developing or strengthening a DV- and trauma-informed approach are the ***National Center on Domestic Violence, Trauma, and Mental Health's three-part Special Collection on Trauma-Informed Domestic Violence Services***.

- [Part 1 \("Understanding the Framework and Approach"\)](#) provides access to background information on the relationship between domestic violence, trauma, and mental health; research on how trauma impacts the brain; research on resilience; and information about and links to key organizations.
- [Part 2 \("Building Program Capacity"\)](#) provides summary information about and links to resources specifically developed to assist victim services organizations in becoming more trauma-informed, including the NCDVTMH's Tip Sheet series (e.g., tips for creating a welcoming environment, enhancing emotional safety, supporting survivors with reduced energy, making connections with survivors experiencing psychiatric disabilities, etc.); the ASRI/NCDVTMH's Creating Culturally Relevant, Domestic Violence- and Trauma-Informed Agencies Self Reflection Tool (see below); the Ohio Domestic Violence Network's Best Practices guide (see below); some rules reduction resources; a number of non-DV-specific resources to support agencies in developing a more trauma-informed approach; training resources to help advocates in working with participants with challenging combinations of DV- and disability-related needs; and materials to support providers in self-reflection and self-care.
- [Part 3 \("Developing Collaborations and Increasing Access"\)](#) provides summary information about and links to resources describing trauma-specific approaches to service/treatment; resources addressing the importance of, and providing templates for and/or examples of successful collaborations between victim services providers and mental health and/or substance use treatment providers; and resources providing insights from survivors and strategies for enhancing peer support efforts.

#### ***(i) Guidance in Creating/Strengthening Programmatic and/or Organizational Trauma-Informed Approach***

##### ***(A) Ohio Domestic Violence Network - Trauma-Informed Care: Best Practices and Protocols for Ohio's Domestic Violence Programs (second edition, 2013)***

The Ohio Domestic Violence Network's Best Practices Manual ([Ferencik & Ramirez-Hammond, 2013](#)) provides a comprehensive, clearly written, narrative about what trauma is; how survivors react to different kinds of trauma; how different kinds of trauma affect the brain; how survivors remember trauma; how survivors interpret traumatic events and how their cultural lens shapes their understanding of those events; some general guidance on supporting survivors; general guidance on supporting survivors experiencing different emotions; how victim services programs may unintentionally re-traumatize

survivors and how they can do things differently; some key principles<sup>34</sup> and how to put them into practice; the critical importance of an advocate's consistency, non-judgmental demeanor, demonstrated empathy, flexibility, and hopefulness; coping strategies; being a "trauma champion" (whenever trying to understand a survivor's behavior, the advocate's first thought should be, "is this about the violence and abuse?"); hints for effective communication; hints for trauma-informed intakes, group facilitation, safety planning, support for parenting, and exit interviewing; and supporting self-care and addressing vicarious trauma. The manual's appendices include a trauma-informed checklist, suggested best practices in working with adult survivors, and suggested best practices in working with child victims. Although the manual was written largely with shelter providers in mind, it is much more broadly applicable.

**(B) Phillips, H., Lyon, E., Fabri, M., & Warshaw, C. (2015) for the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH) - Promising Practices and Model Programs: Trauma-Informed Approaches to Working with Survivors of Domestic and Sexual Violence and Other Trauma**

The [NCDVTMH's Promising Practices and Model Programs](#) publication (hereinafter [Phillips, et al \(2015\)](#)), summarizes information from interviews with victim services providers and organizations providing services to refugees and survivors of torture, "about how programs are currently conceptualizing trauma-informed and trauma-specific work and how this translates into enhanced or improved services for survivors of domestic and sexual violence." (p.1) The authors describe "five key components of doing trauma-informed work:"

1. **"Carefully listening to what survivors, staff, and community members share about their experiences of trauma and about what helps to support their individual safety, healing, and well-being. . . . All programs described the importance of working from a survivor-defined perspective (i.e., respecting survivors as the experts of their own experiences and supporting survivors' decisions and choices)."**
2. **"A service environment that is responsive to the effects of trauma on survivors, staff, and communities: In understanding that trusting relationships are central to healing from trauma, many programs described a range of services that strive to validate survivors' diverse experiences; enhance their feelings of connection, empowerment and engagement; and reduce their social isolation. All programs described working to provide a physically and emotionally safe environment for both**

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<sup>34</sup> "(1) A commitment to non-violence is essential in a domestic violence service agency. Because advocate-survivor relationships are based on equality, an advocate will not use punitive or coercive interventions because they emphasize power differentials. (2) Each individual seeking services has her own unique history, background, and experience of victimization. Treat each survivor as an individual. (3) Healing and recovery is personal and individual in nature. Each survivor will react differently. Programs and advocates need to be consistent yet flexible. (4) Establishing a connection based on respect and focusing on an individual's strengths provides the survivor an environment that is supportive and less frightening. (5) The experience of domestic violence violates one's physical safety and security. Programs need to provide safe physical spaces for both adults and child survivors. (6) Emotional safety is imperative so that survivors can feel more secure and comfortable. They need to live in an environment where their worth is acknowledged and where they feel protected, comforted, listened to and heard. (7) Healing and recovery cannot occur in isolation but happens within the context of relationships. Relationships fostered with persuasion rather than coercion, ideas rather than force, and empathy rather than rigidity will encourage trust and hope in survivors. (8) When a trauma survivor understands trauma symptoms as attempts to cope with intolerable circumstances, this understanding takes power away from abusers and an individual's abusive experiences. (9) Despite a survivor's experience of abuse, women and children may still feel an attachment to the person who has harmed them. (10) The administration of the agency must make a commitment to incorporate knowledge about trauma into every aspect of service delivery and to revise policies to insure trauma-sensitivity. (11) Advocates need to look at the "big picture" and not just view the adult or child victim as only their "behaviors and symptoms." (12) The manner in which a survivor experiences traumatic reactions will certainly be affected by the culture to which she belongs. (13) Collaborating with a survivor places emphasis on survivor safety, choice, and control. (14) Personal boundaries and privacy are inherent human rights. (15) Assume information will need to be repeated from time to time. Survivors of trauma and loss may have difficulty retaining and processing information. (16) Secondary traumatic stress can cause advocates to lose perspective and slip from understanding to blame." (pp. 81-96)

*survivors and staff, ensuring that programs are warm, secure, inviting, and culturally respectful and resonant. Central to many programs' efforts in providing an emotionally safe, non-judgmental environment is to take care to avoid any further traumatization of survivors, including by not mirroring abusive behaviors in any way; being careful to avoid replicating power and control dynamics; and refraining from punishing, 'policing,' or subjecting survivors to excessive and rigid rules. Programs also noted that providing clear information to survivors about what they can expect from staff and the agency is part of creating an emotionally safe, predictable, and stable environment."*

3. **"Providing information about trauma and healing, including information about trauma triggers (i.e., trauma reminders), to both survivors and staff.** Many programs described how they share information with survivors and staff about the effects of trauma on individuals, organizations, and communities, with a goal of normalizing responses to trauma."
4. **"An ongoing commitment to creating a more trauma-informed organization.** . . . This includes integrating a trauma-informed approach in their policies, their attention to the physical and relational environment, their prevention and social change work, and the organization's overall culture. Some agencies use a specific model to help them understand and respond to the effects of trauma on survivors and staff (e.g., the [Sanctuary Model](#), [Risking Connection](#), or [NCDVTMH's ACDVTI approach](#)). The majority of programs also highlighted their commitment to reducing barriers (e.g., barriers related to mental health concerns or substance use) to accessing services." (pp. 3-4)

*"Many have cultural competency initiatives or committees, and most have completed cultural competency trainings, including Safe Zone trainings on working with lesbian, gay, bisexual, transgender, queer/questioning, and intersex (LGBTQI) survivors, staff, and communities. Several programs said that their cultural competency initiatives intend to create a safer and more welcoming environment for both survivors and staff from traditionally underserved and historically marginalized communities. Programs also shared that increasing accessibility for survivors with a range of disabilities is a part of their work in becoming more culturally competent organizations." (p.6)*

[Phillips et al. \(2015\)](#) describes a range of strategies utilized by the providers they interviewed (and challenges encountered) relative to providing culturally specific, linguistically appropriate, trauma-informed services; incorporating an understanding of collective and historical trauma (especially in serving Native American and African American survivors); and incorporating an understanding of immigration-related trauma.

5. **"A commitment to staff well-being as integral to a trauma-informed approach...** *integrat[ing] a deep understanding of how trauma can affect both survivors and staff into the way that staff are supported and supervised (e.g., reflective supervision, wellness activities for staff members, and supports to address vicarious traumatization).*" (pp. 4-5) *"Staff support is foundational to a program's ability to adopt and sustain a trauma-informed approach."* (p.6)

[Phillips et al. \(2015\)](#) found that, **"most programs incorporate an understanding that trauma, mental health, and substance abuse-related needs are frequently connected."**<sup>35</sup>

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<sup>35</sup> [Warshaw/NCDVTMH \(2013\)](#) notes that,

*"The emergence of trauma theory over the past three decades has created a significant shift in the ways mental health symptoms are conceptualized and in our understanding of the role abuse and violence play in the development of mental health and substance abuse conditions. . . . Trauma theory helps destigmatize the mental health consequences of domestic violence by recognizing the role of external events in generating symptoms and normalizing human responses to traumas such as interpersonal violence. It also creates a more holistic framework for understanding the ways in which the biological, emotional, cognitive and interpersonal effects of abuse can lead to future difficulties in a person's life. And it affords a more balanced approach to mental health treatment -- one that focuses on resilience and strengths as well as psychological harm."*

*"Several of the programs interviewed described seeing trauma as a root cause of many mental health conditions and subsequently provide voluntary onsite counseling and/or therapy. To support survivors' emotional healing, strengths, resilience, and recovery, programs described a variety of trauma-informed and trauma-specific services, including the following:*

- **Recovery and peer support groups** that use a trauma-informed perspective, including peer support groups for people who have experienced trauma, with a focus on doing things together to support health and well-being; gender-specific groups that incorporate information on trauma so survivors can better understand how it affects their own healing, coping, and decision-making; one-on-one peer support; and, in a few programs, intergenerational women's groups, where younger women are mentored by older women and create networks of support
- **On-site trauma-specific counseling services** provided by licensed clinicians, including (a) [Trauma Recovery and Empowerment Model \(TREM\)](#) groups; (b) [trauma-focused cognitive-behavioral therapy \(TF-CBT\)](#); therapy using the [Seeking Safety](#) model; [eye movement desensitization and reprocessing \(EMDR\)](#); [dialectical behavior therapy \(DBT\)](#); and trauma counseling based on [Dr. Judith Herman's stages of trauma recovery](#).
- **Emotional safety planning with survivors**, including "support planning," which includes talking with shelter residents about the stresses of communal living and the potential sources of re-traumatization that may arise, providing information on the effects of trauma and anticipating potential trauma reminders, discussing coping skills, and working with survivors to identify their individual strengths as well as others who may be sources of support.
- **Traditional and culturally based practices** promoting healing from domestic and sexual violence and other lifetime trauma, including practices with a focus on spirituality, religion, or approaches that engage the whole community
- **Creative arts therapies**, including art, music, drama, and movement/dance therapy, for both survivors and their children
- **Wellness programming** such as spiritual support, yoga, meditation, gardening, animal-and pet-assisted therapy, Zumba, healthy nutrition programs, onsite gyms, and arts-based activities."

[Phillips et al. \(2015\)](#) enumerate approaches taken by programs to make mental health services more accessible, including "discovery groups" that provide program participants with an opportunity to make more informed decisions about engaging in counseling or therapy; offering counseling and groups to address specific trauma-related needs, for example, stalking, trafficking, grief and loss, surviving suicide attempts, eating disorders, working in the sex industry, etc.; trauma-informed services supporting the parent-child bond, including those using the [Attachment, Self-Regulation, and Competency \(ARC\)](#) model; simultaneous programming through which survivors attend groups on parenting in the context of domestic violence while children participate in developmentally appropriate therapy groups; etc.

Finally, [Phillips et al. \(2015\)](#) cite some of the challenges described by the programs they interviewed, including "balancing survivors' and staff members' needs for safety when working from a low-barrier approach to drug and alcohol use within shelters," and "challenges in finding local mental health and substance abuse treatment programs for referrals because few shared a trauma-informed philosophy [complicated] by the lack of local mental health and substance abuse treatment providers with proficiency in languages other than English." (p.23)

### **(C) Dr. Sandra Bloom's Sanctuary Model®**

As described on [Sanctuary Model website](#), "the Sanctuary Model represents a theory-based, trauma-informed, trauma-responsive, evidence-supported, whole culture approach that has a clear and structured methodology for creating or changing an organizational culture. . . . The objective of such a change is to

more effectively provide a cohesive, innovative and creative context within which healing from psychological and social traumatic experience and adversity can be addressed - for all of us."

The Sanctuary website provides extensive information about the Sanctuary philosophy and approach. The website's [Publications by Topic webpage](#) provides links to numerous articles on the Sanctuary Model and application to domestic and sexual violence and trauma (e.g., [Bloom, 1997](#) and [Bloom & Sreedhar, 2008](#)).

**(D) Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57.**

[SAMHSA \(2014\)](#), which is heavily quoted in this chapter, provides a comprehensive look at which it means to be a trauma-informed organization providing behavioral health services (mental health and substance abuse treatment services). The publication addresses trauma, its attributes, and its impacts; the relationship between trauma and mental illness and substance abuse; screening and assessment; treatment issues; trauma-specific services; steps toward becoming a more trauma-informed organization; and building a trauma-informed workforce.

**(ii) DV-Specific Tools for Assessing Trauma Informed Practice**

The more provider understand the impact of traumatic stress on physical, mental, and emotional health, the more they realize the importance of providing trauma-informed services. Several tools have been developed to assess the extent to which an agency or program's services take a trauma-informed approach.

**(A) Trauma-Informed Practice (TIP) Scales**

[Sullivan & Goodman's \(2015\) Guide for Using the Trauma-Informed Practice \(TIP\) Scales](#) builds on the effort described in [Wilson, Fauci, & Goodman \(2015\)](#) to identify a core set of DV-specific trauma-informed principles and practices. The instrument (which is also available in [Spanish](#)) uses *survivor responses* to questions relating to six subscales to assess whether a DV-focused program is trauma-informed:

- **Agency** subscale scores reflect the extent to which survivors feel that the program and its staff respect their agency and autonomy by protecting their privacy and offering opportunities for choice and control as to what they work on and the pace at which they share information
- **Information** subscale scores reflect the extent to which survivors feel that staff offer information that increases their understanding of trauma and coping skills.
- **Connection** subscale scores reflect the extent to which survivors perceive that their program creates opportunities for giving and receiving support with peers, and being connected in supportive relationships.
- **Strengths** subscale scores reflect the extent to which survivors feel that staff recognize and value the unique strengths they bring from their family, culture, relationships, and life experiences.
- **Inclusivity** subscale scores reflect the extent to which survivors feel that staff understand and are responsive to various aspects of their identity, including culture, religion, sexual orientation, socioeconomic status, immigration status, and disability status.
- **Parenting** subscale scores reflect the degree to which survivors feel the program helps them understand how exposure to domestic violence may have affected their children and their relationships with their children, and helps them strengthen those relationships through support and education.

**(B) Accessing Safety and Recovery Initiative (ASRI) and National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH) Self-Reflection Tool**

With the help of OVV funding, the Accessing Safety and Recovery Initiative (ASRI) and National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH) developed a [provider self-reflection tool](#) to help victim services organizations provide accessible, culturally relevant domestic violence- and trauma-informed services. The **Creating Accessible, Culturally Relevant, Domestic Violence- and Trauma-Informed (ACDVTI) Agencies** ([ASRI/NCDVTMH, 2012](#)) project brought together six Illinois agencies -- DV

programs, community mental health agencies, and state psychiatric hospitals -- to collaborate on the development of more accessible, culturally relevant, domestic violence- and trauma-informed advocacy and services ***for DV survivors experiencing the mental health effects of trauma and/or psychiatric disability***. The self-assessment instrument asks agency staff to reflect on and answer questions about:

- The organization's commitment to being accessible, culturally relevant, and domestic violence- and trauma-informed;
- The extent to which the agency's physical and sensory environment is welcoming, accessible, inclusive, non-stigmatizing, non-triggering, non-re-traumatizing, and physically safe for people receiving services and for staff;
- The extent to which questions about current and past domestic violence and other lifetime trauma and ongoing physical and emotional safety are incorporated into agency intakes and assessments in a sensitive and culturally relevant way;
- The extent to which program services affirm and are inclusive of survivors' many identities (including identities related to age, disability, language, sexual orientation, gender, culture, ethnicity, religion, and immigration);
- Whether and how staff members are supported through participation in regular training, supervision, and consultation on working with survivors experiencing trauma, substance abuse, and mental health issues; and
- Whether the agency has mechanisms in place for obtaining regular input and feedback from the program participants, and whether those mechanisms specifically address accessibility, culture, trauma, and domestic violence.

### ***(C) Praxis Safety and Accountability Audit***

The [Praxis Safety and Accountability Audit](#) focuses on "how work routines and ways of doing business strengthen or impede safety for victims." Through a series of ***interviews with and observations of staff***, the Praxis process looks at how various operational factors add to or undermine participant safety, and either address survivor needs or leave an unfilled gap between the support they get and what they actually need. Factors considered by the Praxis Safety and Accountability Audit include:

- Program or funder "rules and regulations" or applicable laws;
- Agency practices (e.g., case management procedures, forms, documentation practices, intake or screening processes);
- Agency resources (e.g., caseload, technology, staffing levels, availability of support services and other resources);
- "Concepts and theories" (e.g., philosophical framework, assumptions, and language used to describe participants, their circumstances and actions, and the system's responses ([Pence and Sadusky 2006](#)));
- "Linkages" to previous, subsequent and parallel interveners;
- The "mission" of the overall process, "purpose" of the specific stages of the process, and "functions" of workers at those various stages;
- The "accountability" (of the abusive (ex-) partner for the abuse, of the system to the survivor, and of interveners to each other); and
- The "education and training" of the staff involved.

### ***(iii) Non-DV-Specific Trauma-Informed Program or Organization Assessment and Self-Assessment Tools***

#### ***(A) AIR's Trauma-Informed Organizational Self-Assessment***

[Guarino et al.'s \(2009\)](#) organizational self-assessment<sup>36</sup> -- which can be **downloaded and used at no cost** -- is part of a larger [Trauma Informed Organizational Toolkit](#), which provides a roadmap for providers seeking to become more trauma informed. The self-assessment consists of a series of questions which **provider staff** answer about the nature of services offered by their agency or program, and the associated policies and procedures. The self-assessment was initially intended for use by homeless services providers, but is more broadly applicable. (In addition to assessing whole organizations or specific departments or divisions, it can also be used to assess specific service locations, if clients using those sites never interact with any other part of the organization). Topics addressed include:

- Staff training and support/supervision to enhance awareness and understanding of trauma and skills to provide trauma-informed care, and support to address vicarious trauma;
- The physical and emotional safety of the service environment;
- The manner in which participant needs are assessed, the tone of the questions, and how and whether participants are empowered to define their own goals and chart the path to achieve those goals;
- The degree to which participants and former participants are engaged to advise and implement program services; and
- The ability and willingness of the organization to adapt policies and procedures to reflect clients' changing needs and circumstances.

Note that the self-assessment is not designed to generate a numerical score, but rather to engage staff in inventorying and assessing what they do and how they do it, whether they have put in place trauma-informed policies and procedures, whether their service environment incorporates trauma-informed principles, and where their opportunities are for doing better.

### **(B) The A.I.R. Trauma-Informed Organizational Capacity Scale (TIC Scale)**

The A.I.R. [Trauma-Informed Organizational Capacity Scale \(TIC Scale\)](#) is the first psychometrically validated instrument to measure the extent to which an organization and its component parts provide care and services that are trauma-informed. It is adaptable across different health and human service systems, as well as education systems. Responses by staff in different roles, different programs, and at different levels of the organization to the 35-items in the TIC scale inform measures of the organization's trauma-informed approach across five domains: (1) building trauma-informed knowledge and skills; (2) establishing trusting relationships; (3) respecting service users; (4) fostering trauma-informed service delivery; and (5) promoting trauma-informed policies and procedures. A [Fact Sheet](#) provides more information about the TIC Scale and about AIR training and support for using the instrument. Visit the [A.I.R. Trauma-Informed Care webpage](#) for other related materials.

### **(C) Community Connections' "Creating Cultures of Trauma-Informed Care"**

[Community Connections](#) provides training and consultation to support implementation of "[Creating Cultures of Trauma-Informed Care \(CCTIC\)](#)," which is described on its website as follows.

"The Creating Cultures of Trauma-Informed Care (CCTIC) model engages the system or organization in a culture change, emphasizing core values of safety, trustworthiness, choice, collaboration, and empowerment in every facet of program activities, physical settings, and relationships. Implementing cultural shifts of this scope requires the full participation of administrators; supervisory, direct service, and support staff; and consumers." The curriculum, created by Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D.,

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<sup>36</sup> A subsequent version of the Trauma-Informed Organizational Self-Assessment is described in [Trauma-Informed Care for Women Veterans Experiencing Homelessness](#), developed by the National Center on Family Homelessness, under a contract with the U.S. Department of Labor's Women's Bureau ([NCFH / Guarino, 2011](#)). For other related materials, visit the [AIR Trauma Informed Curriculum webpage](#).

"draws substantially" on [Harris and Fallot's \(2001\) \*Using Trauma Theory to Design Service Systems\*](#) to create a step-by-step approach for provider systems and individual agencies to become trauma-informed.

**(e) Provider Comments about How their Programs Take a Trauma-Informed Approach**

***Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.***

(#01) Everything we do is trauma-informed. We recognize people may have substance abuse/mental issues because of trauma. Just because they're in the shelter doesn't mean trauma, or how they've dealt with it, has stopped. We work to de-escalate them. We're aware many things can be triggering and they may react differently than we do. People could be depressed or triggered or be avoidant. We had a woman who never left her house. Everyone said "She just needs to get out." She'd been severely traumatized and we had to get a mental health professional to come to her. We take a harm-reduction approach to substance abuse because we recognize that a survivor struggling with sobriety deserves a safe place to live. Lots of programs kick people out of housing for these issues. We've tried to reduce our rules.

We've had to rethink what a positive outcome is. For a regular program, you'd aim to get the person stable so they won't come back. But for a trauma-informed program, never hearing from the participant again is not a successful outcome. A reasonable outcome is that she will reach out when she needs us.

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(#02) We try to take a trauma-informed approach in every area, although there are some staff that are probably a little less skilled than others. I think we could do better on the initial intake; some of our house managers may not be as sensitive to the issues that we are screening. They try to be, but I think that just because they are not working the day to day cases that they are not as trauma-informed as they could be. But in every other area, we try to take into consideration the trauma that has been disclosed in the intake, and that informs how we bring them to an in-person intake and how we communicate with them.

In the treatment team meeting, the counselor who does the first assessments -- a bio-psycho-social and then an assessment that screens for problem resolution -- informs us on what we need to know about the client's history, which I think is really important. Because we're not just dealing with the most recent crisis; we're dealing with the whole person and her whole experience -- whether it was trauma when she was a child or in her first marriage or whatever else. So the assessment information that our counselor brings is very important, and her work informs all our case management and the practices we implement with the client.

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(#03) When participants reach one of their goals, I'm their biggest cheerleader. It's important to keep reiterating the positives. Often times, victims of domestic violence and sexual assault don't hear the positives.

We reduced our intake paperwork by about five pages. We try to ask the minimum number of questions, optional medical information, and then, "what do you need us to know?" We took away all the questions we don't need. We don't need to know their SSN or every abusive partner they've ever had. We only ask what we need to know for them to be in the program. The contract was two pages and we reduced it to one.

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(#04) We have been focused on trauma-Informed training for the last six months: learning how trauma impacts behavior, and learning to understand the behaviors of the people we serve in terms of the trauma they've experienced, and not framing behaviors as "challenging." Being able to frame behaviors as responses to trauma and understandable reactions to it, rather than as "annoying" or "irritating" or "difficult" enables staff to respond from a place of compassion.

We have plans to look at the physical space of our program to make sure it is set up in the best way possible, even things like what's hanging on the wall to make sure the pictures are not re-traumatizing. The voluntary services approach is already very survivor centered and trauma-informed. It's not restrictive in terms of rules and guidelines, so that supports and service are offered in a way that is convenient for the people we serve.

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(#05) Taking a trauma-informed approach informs our approach to assessing program performance, because we don't measure performance against uniform goals and requirements. We try to house people who are underserved and wouldn't qualify for anything else. We understand trauma presents itself in different ways. We focus on keeping them safe. We take a holistic approach to helping them make personal goals. Everyone's got different needs. There is no single scale to measure success. Everyone's is different. We make it individualized.

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(#06) When they come to our agency, it's because domestic abuse is impacting their lives, not because they are seeking treatment for a mental health need. When they move in, we walk a fine line between providing support and services and respecting the empowerment model that is required with the VAWA funding. Any time a resident comes to talk to us, we can ask how they're doing or if there are any other issues or anything else that they need support. They're not required to tell us everything. We may not know all the things that they're dealing with, and that can be a challenge. We may meet with them and suspect that they are dealing with x, y or z, but we can't force our perceptions on them or make them talk to us about it. We try to be very respectful about what they bring to the table and what they want to share with us and work with us on.<sup>37</sup>

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(#07) When they're working with a case manager on setting goals and the timeline for those goals, we try to get the majority of the input from the participant as opposed to from the case manager. So the words are their words, and the goals and time frame are their goals and time frame, and not ours.

We had a young lady whose assigned house chore was cleaning the restroom. And she would never do that chore. We asked why, and she told us that that's where her perpetrator would always take her when he abused her, to the bathroom. So part of our approach to case management is asking, "Are there certain things or certain conversations that aren't comfortable for you? If so, feel free at any time to tell staff."

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<sup>37</sup> **Author's Note:** Several providers' comments appeared to reflect a need for clarification about whether it is appropriate for staff to raise issues that a survivor has not discussed, or whether that violates the principles of a survivor-centered or empowerment approach. This provider is absolutely correct that it would be inappropriate to force a participant to discuss X or Y, to insist that a participant is experiencing X or Y, or to be otherwise insistent or confrontational.

Some staff we interviewed appeared to believe that they are only "allowed" to ask open-ended questions, and then wait to see whether participants voluntarily mention issues that staff may have concerns about. Sometimes, it might also be appropriate for an advocate to proactively ask a participant whether they are feeling X, or to say that, "I noticed Y and wondered if...." Advocates should consult with their supervisor about whether, based on a participant's circumstances and apparent state of mind, such a staff remark is likely to be taken as helpful, or likely to trigger an adverse reaction.

A similar clarification is needed with respect to appropriate staff boundaries vis-a-vis the voluntary services model, that is, whether it is inappropriate to proactively reach out to participants, encourage them to participate in certain program activities, or encourage them to take next steps on housing or employment, for example, or whether anything more than notification about opportunities or available resources "crosses the line" and violates the principles of voluntary services.

A 2015 NNEDV PowerPoint training on "*Voluntary Services: The Cornerstone of Trauma-Informed Domestic Violence Programs*" by Judy Benitez (no longer available [online](#)) asserts that voluntary services doesn't mean that advocates can't offer suggestions or encouragement for participation (see slide #7). However, advocates should make it absolutely clear to the participant that the decision is hers, and she will not be penalized for choosing not to go along with the advocate..

(#08) We operate our program using the Sanctuary model. We use all of the tenets in all our programs. Our whole philosophy in doing transitional housing is also based on the trauma-informed model. We make all of our decisions as a team -- on everything from how to handle hotline calls, to what money we spend on sheltered women, to how long they stay in shelter, to who goes into the transitional program. Let's say we had a plan to provide rental assistance for so long to a woman in the transitional program, and things have changed. The transitional program coordinator will say, "We're not over the two year limit yet; can we add six more months?" We'll make that decision as a team. I think it really helps staff to have a sounding board, to involve lots of different perspectives, to make decisions non-hierarchically. It's a different way to make decisions, but it really supports the program and I think it results in better decisions for the participants.

Staff in programs like ours are underpaid and overworked, and they get tired. One of the things you sometimes see when that happens is staff getting more judgmental and harsh, more impatient with their clients. With the team decision-making model, staff take much better care of themselves and each other, and they make more compassionate decisions.

The other thing we do is that we try not to make decisions about the women without their being in the room with us. You don't see this as much in our transition program, because the women live elsewhere, but we encourage them to come in and sit with us, talk with us, so that most of our decisions are much more around problem solving and coming to an agreement. What she thinks would work; what we think would work. And we come to an agreement. We find it to be a really empowering model for the women. Women's feedback to us has really been around feeling like they understood the limitations of the program better.

We don't have enough money to do everything; that's the way it is. But when women don't hear about those kinds of obstacles and financial limitations, our decisions feel very personal. It feels like: "they're not helping me because...." When a participant is involved in the process, they feel like they're much more part of the program; they understand the program; they're part of a solution; their ideas are taken into account. We just find the women are much more satisfied long-term.

And hopefully, while we're doing that, we're teaching the women some real practical skills about being able to talk to people, being assertive, speaking up for yourself -- good skills to have when you need to work, as well.

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(#09) We consider ourselves a trauma-informed agency and we now have a trauma-informed care coordinator. We've all received trauma-informed care training, but to me it still feels very ethereal. It's a buzzword that people use, but in practice, I think it's just everyone operating through more of an empathetic lens and being aware of their own traumas. I manage a team of 13 people and we talk about being aware and attuned to the traumas that we've experienced in our lives and how they've affected us; and recognizing that when we're with a client, how they're feeling and reacting is a culmination of all the trauma they've experienced. We have a screening tool we can use to help them talk about the things they've experienced in their life, but it's more about just being aware and empathetic about what they come to the table with.

With our case managers it's being aware that people become homeless because of a reason. They can't just say, "here are some resources, you need to go look for housing." The case managers have to be attuned and informed about what got our participants here and help them get housing from that perspective. So, for example, if they've had a traumatic experience in the past with landlords, they're not going to pick up the phone and just start calling landlords. We'll have to help them integrate that experience and do the work with them so they can either integrate that trauma or not have to be re-triggered in finding housing.

For us, taking a trauma-informed approach means creating a "split list" of performance goals -- understanding our funders' goals and what we have to do to reach them, and working with participants to help them identify their personal goals and figure out how to achieve them. So with Continuum of Care funding, we know the goals we need to reach for HUD, and those would be more of the bread and butter goals. So when we sit down one on one with families in transitional housing, one of the goals is going to be stable, permanent housing, and another is increasing income; so that's what we need to do for HUD. But then we also need to

break it down and just work with the family on their own goals, and what it will take to help them meet their goals. It's like we have one sheet that we fill out for HUD and then we have one sheet that we fill out in working with the family. It's just tailoring the program to meet the needs of our government funder and another to meet the needs of who we really are serving.

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(#10) An ongoing theme of individual supervision is, "are we making decisions that are sensitive to where this person is coming from?" Because in addition to operating transitional housing, we're a trauma-informed therapy organization, and so very focused on understanding the perspective of the client with regard to trauma, but we take that same construct and apply it to race and racism, understanding that the client views things through a cultural lens, and we have to be appreciative of that.

We don't have a ton of rules and regulations. They're predicated on the funder; for example HUD expects program participation.<sup>38</sup> OVW and some of our other funders don't, and housing can't be contingent on it, so we do what our funders want and allow. In terms of the rules, our rules are essentially, "follow your lease." Everyone knows what the landlord expects. You can't do illegal things in your home, you can't damage the property, and basic things like that. Every family is assigned an advocate, and the advocates do home visits as part of their outreach to the clients, and those can be as frequently as weekly or very rare, depending on what the client wants. We check in with them in the unit to make sure that it is still a relatively clean environment, they aren't violating housing codes, they don't have people living in their unit who aren't supposed to live there, and those are all terms of their lease. [Some of the program units are owned by the provider, some are leased by the provider, and some are leased by the participant.]

We want to empower them to uphold their lease, which, frankly, is a new construct for some of these folks. Just realizing that when you're renting somebody else's property, you have to follow certain rules. We help them be successful in that. If they are evicted, and we recognize that it's part of their learning curve, we will place them in another unit and give them another chance. Especially when safety might still be in the balance. We have the flexibility to try and maintain that safe environment until they're ready to be on their own.

My advice to new providers would be very reality based and practical: to only create rules that contribute to the client sustaining their housing. Domestic violence survivors are coming out of controlling environments, and one of the things we don't want to do is replicate that controlling environment. We don't want to mirror the behavior of the abuser by setting up rules for the sake of having rules, or in any way giving the resident the sense that we are trying to control them. That's what they fled. We have to be very careful that we don't re-trigger their trauma, behave in ways that remind them of their assailant, make them fearful of us, or undermine their healing.

In terms of how we deal with rule violations, I think you have to go back to looking at the why the rule of violated. For example, when we have very young parents 20, 22 year olds who are still making relatively immature choices because they've never lived on their own, they really don't know how to parent their kids, they don't know what it's like to manage a budget, and so they make immature decisions which could be a rule violation. Maybe they're not paying their share of the rent, or maybe they let people come over to their house and party, maybe drugs came into the home – something like that. A lot of that is predicated on their immaturity. Yes, it's a rule violation, but the consequences for their rule violation need to be informed by an understanding of the reason that the rule violation occurred. We would look at different kinds of mentoring or counselling or some different kind of advocacy that may help that parent adhere to the rules, as opposed to just punishing them for the violation.

We don't impose sanctions other than if you're not adhering to lease requirements, and we've really tried to help you be a good tenant, if you get evicted you may potentially not be in the program anymore. I would say

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<sup>38</sup> Actually, HUD regulations exempt housing operated by victim services providers from participation requirements.

that probably half of the participants that have been evicted, we've re-located to other program housing. The other half, it's been after a lot of effort to keep them onboard, and they're just not going to do it. I'm afraid part of that is the culture of poverty coming into play that we're having a real hard time intervening with.

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(#11) The biggest thing is trying to not make someone feel re-victimized. So, with the transitional program, there's no curfew. If a participant were to get a third-shift job, they're free to take it. They are able to have visitors. The only thing that we ask is no male overnight visitors except a brother or immediate family. There aren't any other such policies, since you can't enforce them. For example, it doesn't make sense to say that their curfew is 11pm if I'm not sitting outside waiting for them to come home. I know that they actually enjoy the program because of that flexibility. I don't penalize anyone if they can't make a planned meeting. If they're ready to be out in the community, they should be able to live as if they were on their own.

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(#12) The more support a person has, the more people in her life who can offer unconditional support, the better -- if she is open and wanting that. Helping to make that kind of support available, in traditional and maybe non-traditional ways takes resources and people-time, whether through volunteers or paid staff. We're part of something called the [Full Frame Initiative](#), which includes a cohort of 10-12 domestic violence organizations around the nation -- organizations taking the full-frame approach to working with victims of domestic violence and sexual assault, and it's really off the grid in terms of what we've done in the past.

It's not about holistic services; it's about looking at the whole person, not services. It's quite a shift in our thinking and we're not quite a year into it. For example, if you were working with a woman in transitional housing on her support system, and if Saturday night church services were really important to her, you might find yourself taking her there or ensuring that she's able to get there. The Full Frame Initiative talks about five domains of well-being -- social connectedness, stability, safety, mastery, and meaningful access to relevant resources. The common thread in all of these is being trauma-informed. Anna Melbin, who worked at NNEDV on the transitional program for a number of years, is one of the leaders with the Full Frame Initiative.

We struggle with the challenge of how our program can support survivors in making longer-term changes; we see the children of people that we served coming into our program, and we see some of the women, over and over again. Poverty affects people so deeply and generation after generation. The Full Frame approach is an effort to see what we can do in a person-to-person sense to help change things for people.

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(#13) We have a counselor that is available to see our clients, if they want to see her. We collaborate with another domestic violence agency to have her come and provide mental health counseling for our clients. If a client wasn't comfortable with this particular counselor, we would refer her to a local counseling agency, but this is just easier because she's right here and there's no charge for the service.

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(#14) There are barriers specific to the DV; sometimes people have been so controlled for so long that taking initiative and taking control is a really daunting process. We want to support them, but we don't want to create codependent relationships that mirror the relationships they came from. We try to help them overcome their anxiety, which can paralyze them, and support them in getting out on their own to look for housing. By providing both the case management and the counseling to help them overcome some of their fears, and help them regain self-esteem, acknowledge their strengths, and realize that these are things they can do. Although we'll be here to support them, they can do these things on their own. Part of it is just breaking down the steps for clients that get overwhelmed by the whole task, and walking them through the process: you're going to call these five places, maybe role-playing the interaction with the landlord, and talking about how to present yourself in a way that makes you an appealing candidate.

(#15) We've found that in addition to support with parenting, with healing, with the domestic violence education, the residents needed counseling and therapy to overcome the trauma, and that the trauma was getting them stuck, and because of that, they might not be able to find jobs or stay in jobs.

We needed to offer the therapy here, because women didn't actually receive services when we referred them somewhere else. There would be long waiting lists, and they would give up; so we felt we had to have it here.

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(#16) For clients in the off-site transitional housing program, the safe homes, you can see a shift in how they take ownership of their future. By no means are they out of the woods, and the trauma is going to sneak up on them when they least expect it. That's what we try to help people recognize, so they're not surprised by days when they're depressed and feeling really anxious; all of that isn't going to just go away right away.

Many of the women, particularly from the lower income neighborhoods of the city, have lived lives of incredible hardship and violence. They are completely shut down emotionally, so a lot of times they don't want to address any of the traumas. There's all this focus on trauma informed care, and part of our view on trauma informed care is that you can't make people deal with these issues if you can't help them resolve them. You can't make them open up those cans of worms, sit in a support group, talk about how they feel about these injuries. What we can help them with is "what are your rights," "what's the definition of intimate partner violence," and "can you recognize the power and control that's going on in your life without having to talk about how you feel about it."

For many of the women to talk about their feelings would open a floodgate that would immobilize them. Because they're just not there; where they are is at the bottom of Maslow's hierarchy: "How do I not get myself or my kids killed?" "How do I feed my family?" As they become more stable, the service coordinators are able to guide them in terms of, "Here's a program that might work" or "You're talking about how your kids are acting out more now. That's really common; here are some reasons why they might be acting out more." Or, "Have you thought about going for family therapy; we can do family therapy with you, with the kids, to try to help them down that path." You see a lot of the women once they have the housing piece taken care of, have figured out how to pay their rent, how to feed their family -- are much more willing to engage in the therapy and really talk about the systemic violence that they've lived through their whole lives.

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(#17) I think the way we understand where clients might be coming from, the way we have conversations with them, and our open-door policies are all examples of trauma-informed practices. Clients just have to make a phone call to ensure that the staff is available. We try to reduce anything that might look like control, that might look like pressure, that might look like staff are being hierarchical -- even though we use a professional approach, we try to make ourselves available and we try to listen and we try to always be aware that they might be coming from a place of pain or trauma, and that we don't want to make that worse.

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(#18) Our state coalition doesn't provide transitional housing and services itself, but instead implements the OVW grant by allocating funds for use by the many local programs to pay for rental assistance and services to survivors from their local communities. We just completed an assessment that we coordinated with the National Center on Domestic Violence, Trauma, and Mental Health that they've been doing with coalitions across the state. In all of the training we do, in all of the literature we produce, we use a trauma-informed framework. We've provided a number of in-person trainings and webinars to help our programs understand the trauma-informed approach. We're also doing some work right now around LGBTQ communities, and again that work is being done with the trauma-informed framework. By no means are we where we need to be, but we have been invested in that work for a number of years and are continuing to work towards that and help to build programs' capacity.

Also, our state has a 40 hour advocacy training requirement and the Coalition has developed a training module that's research-based and based on current best practices; trauma-informed philosophies and practices are incorporated throughout the entire 40 hour module. We have an AmeriCorps program, which allows us to place 15 AmeriCorps service members with the local programs across the state. And we provide civil legal assistance to survivors around immigration, sexual assault, and domestic violence. We've even integrated a trauma-informed approach into the legal services work by our staff attorneys with survivors.

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(#19) Our clients come from some very recent danger, but also have the longer-term impact of the danger and abuse they went through before they came to us. I think that sometimes our biggest challenge in working with them is not always knowing what might trigger them. When someone comes to us, they're not necessarily breathing a sigh of relief that, "Oh, great. Now I'm in this wonderful shelter or transitional program." They might be saying, "I can't believe this is still going on." We have to be mindful, as staff, and not be judgmental of the choices they make, or how long they may choose to stay with us. Or if they do choose to reengage with a partner, or still want their children to be able to see the abusive partner. Staff having to suspend their own judgment and be as trauma-informed as possible; it's a unique challenge to our work.

Our agency operates under the [Sanctuary Model](#) of trauma-informed care. Our staff is trained from pretty much day one, in what trauma-informed care looks like. Our goal is to make sure it still feels real and fresh to staff as they get into the nitty-gritty of delivering services -- when they've got a client who seems to not want to do what staff feel like is the best thing for them to do, or they don't come to appointments, or they don't make savings deposits, and staff look at the clock and say, "You only have three months in the program. How are you going to afford X, Y, Z?" We really try to help staff remember that if we're trauma-informed, we know that planning for the future is really hard for clients. The closer they get to an exit date, the harder it's going to be to find a good next step. The more likely they're going to do things that are probably counter to their best interests, from our perspective. But for them, it might make complete and total sense.

We do refreshers for our staff on the practical implications of the Sanctuary Model – it sounds good on paper, but in real life, what does it look like? We try to fold the Sanctuary Model into all of our work, and try to use staff meetings and individual one-on-one supervision as opportunities to discuss client challenges from that perspective. "We know that so-and-so has really been driving you crazy. What do you think is going on with her?" We try to help someone dig and discover for themselves what might be the real issue.

We changed our performance evaluations, our job descriptions, and things of that nature, to make sure they have the sanctuary language in it, and we are providing tools and training to staff and residents on a regular basis to make sure that it's alive and a daily part of what we do... not something in addition to what they're already doing, but part of what we do on a daily basis. Our HR subcommittee goes through policies and procedures and handbooks to make sure that everything has the sanctuary language. Our client engagement committee works with the clients to make sure they understand Sanctuary Model. Hopefully, a survivor coming in would see the difference, based on the language we use, the posters on the wall, and our materials.

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(#20) Just making sure that staff understand how someone's trauma experience impacts the way they seek or receive services. It impacts their ability to just live on a daily basis, and requires us to be accepting of where people are in their own recovery. And be prepared to advocate with other entities, to explain how a history of trauma or violence can impact people ... because there's still that misconception of, "Well, you're out of the abusive relationship that was five years ago," and not understanding the long term impact.

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(#21) I'm thinking about the safety around our building. A lot of people are very leery when they come here because when you leave the shelter it's so different. In a shelter, there's somebody opening the door to let you in and out. When you come here, you have a lot of freedom. We realize the trauma these ladies have gone through and so we provide them with a building that's secure. They have to have codes in order to enter

the building, so no one can just walk in, which could send somebody into trauma. Not having people with free access to the building. Just thinking about how they would feel if people could just come in whenever they please. We wanted to make sure that it was set up so that it would not be a worry for them.

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(#22) Counseling is a great resource and a lot of our ladies don't necessarily have the access to those services. We partner with two agencies that offer free counseling, but sometimes it's another hurdle for participants. Sometimes the most immediate need is housing and they would like to get to counseling, but it gets put off until later. If we had somebody in-house, so that when they came to meet with their case worker and their advocate, they could also have a counseling session; that would be great.

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(#23) Choice is really important and a very large part of the way that I try to lead the program, including making sure that women get a choice in how many times they repeat their story and the level of personal detail they share. We do our best to make sure that we're nonjudgmental and aware of triggers so that we can offer safe meeting places and nonintrusive services, and protect their dignity as grown women. Our agency uses low lighting and pillows and doors that don't slam and things like that to offer a more trauma-informed environment. We just implemented suggestion boxes that are not about what's your grievance, but about how can we make you feel safer and more comforted, and what could we be doing so that people feel like they have a voice and a way to use it. Our agency has a trauma-informed committee that has a tool kit we can use to make sure our staff works to be well so that we can be healthy instruments working in partnerships with clients, and not mean, burned-out people. I think there's a lot of room to grow in that area and the more that we research and find out about what really helps women feel safe and connected.

When I came to this program, there was an interview process and women would be called in for an interview and they'd do the interview and be triggered by having to recall all of their abuse and leave the interview ripped wide open, and then be told that they didn't get selected, and it felt very personal. So I changed that to a random selection so that there would be no limit on the number of times that you apply; getting in is just about the number of spots that we have; so you don't have to embellish your story and tell us that you were raped at knifepoint after the Super Bowl every year. We're able to support women without needing to know all that. And the women feel safe enough to share things on a personal basis with their advocate or have courage to take it to their therapist but their housing isn't contingent on that sharing.

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(#24) (Not a current OVW grantee) I think "trauma-informed" is an expression that everyone uses, without really understanding what it means, so it becomes just a buzzword. Do we deliver services as informed domestic violence advocates? Absolutely. Do we try to recognize how trauma effects your functioning? Absolutely. Do we realize the toll that trauma takes on your life? Absolutely. Do we use clinical supervision to help staff get distance from the challenges they face in working with survivors? I worry that some labels get used so freely that they lose their intended meaning. So we are careful about not throwing around labels like "motivational interviewing," "trauma-informed," "empowerment" unless we really understand what these labels demand of us.

About a year ago, we attended an Undoing Racism conference, where participants expressed concerns about people with social work backgrounds who have studied trauma and think they know about trauma, but have not experienced trauma themselves, and haven't come from situations or worked long enough in the field to have gotten to truly know people who have experienced trauma. They said that "it's great that you are 'trauma-informed' but are you informed about privilege? Are you informed about poverty?"

What they were saying specifically was that the domestic violence movement started with a bunch of white women coming together 30 or 40 years ago and putting together these white models for resolving domestic violence issues, which was mostly about leaving your abuser and coming to a shelter to hide. And that doesn't address the choices that some people are making, for example, people in communities of color, who might

want to stay in contact with their abuser, who are not completely at peace with leaving him behind and never seeing him again. He might be in their life whether they want it or not, especially if there are children.

And that, "a shelter might help me in some ways, but in many ways, it brings me more trauma and more poverty than I started with." So we need more creative models for helping communities of color find solutions around domestic violence which are not necessarily about leaving the violence and coming to a program. And hiding is just about impossible these days whether we want it or not, because of technology.

Part of trauma is being disenfranchised or poor. There are so many ways to be triggered, so our job is to figure out what can we do to avoid re-traumatizing people by subjecting them to situations that remind them of their lack of power in abusive relationships. What I think the participants were saying at that conference was that communities of color are concerned about social workers who've enjoyed white privilege bringing a very clinical, cold analysis of trauma -- without awareness of the power dynamics and larger privilege issues -- or thinking that because they've read about trauma in a book, they understand it. If you're culturally aware and working towards cultural competency, you'll leave the phrase "trauma-informed" alone because you couldn't possibly understand it by reading a book. Just like you can read about military trauma in a book, but if you haven't been there and really connected with a veteran, you just don't know.

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(#25) One of the most important aspects of being trauma-informed has been learning to recognize different symptoms and impacts of trauma and behavioral coping mechanisms -- seeing behaviors as strategies for coping with trauma and as responses to trauma, as opposed to anything pathological or diagnostic. Trying to help staff and volunteers make that shift can be a big piece of creating an open, supportive, client-centered environment.

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(#26) I see my conversations with participants as opportunities to connect their trauma with the way life is going for them, so that they don't see themselves as worthless or failures. "What you're experiencing makes a lot of sense. These are common effects of trauma -- feeling like you're not very motivated, or feeling really tired. What should we try to do to address it?" If they've dropped off the map, if they're not getting their rent in on time, if they have a notice to shut off their lights, if they're not talking to me, that would be a big problem, and a sign they need more support. A trauma-informed approach is more understanding and less punitive. A program that isn't trauma-informed tends to ignore the effects of the trauma that participants have experienced, and therefore doesn't link the barriers and that trauma -- so I don't think it's as helpful.

We understand that working on your mental health can be just as valuable and just as much of a goal as getting financially stable in the program. If one of our clients has lots of nightmares and doesn't sleep well, and takes medication to help, we don't schedule morning appointments, because she's going to be groggy, she's not going to communicate effectively. If I wasn't operating from a trauma-informed perspective, I might say she was not willing to work with me, but I understand that given all that she's experienced and how that manifests itself with her, it's just not a good idea to do a morning appointment. It's as simple as that.

By comparison, the state's welfare reform program is very employment oriented, and participants who don't comply with their self-sufficiency plan are denied full benefits. That kind of compliance, when you've just left a violent relationship and are still recovering, is very hard. We can sometimes help a woman plead her case to get an extension on her deadlines, but it's kind of like advocating for disability benefits, in a sense, on a smaller scale. Trying to plead your case and then having one person decide whether or not you deserve assistance, and if that one person doesn't understand trauma, then they're not going to get it.

(#27) Maybe a participant will have identified as a DV victim coming in, but it's not until several months later, when she trusts us more, that she may begin to talk about other violence she experienced, sexual assault in the relationship, or as a child. And so, we offer counseling specific for those issues.

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(#28) One staff person and I were trained in motivational interviewing. We're also trained in trauma-informed care, so we can understand the barriers participants are facing. Both those trainings have been helpful in meeting people where they're at and helping them make the progress they need to make. We see that a lot of the families and individuals in transitional housing need time to process and decompress, because they've been on the run and in this domestic violence state for so long. So they're not able to do a lot of things that other people think they should pop up and do right off the bat. We see a lot of progress toward the six month mark, the one-year mark, the 18-month mark, versus after 30, 60, or 90 days. They just need to take in that new stability and then start to figure things out, and everyone has their own pace for that. Our goal is to provide support and different options and work with them on their needs. Being trauma-informed means understanding that they've been traumatized and that there are a lot of different ways that they might present and a lot of different behaviors that go with it. Alcohol and drug use could be one of their challenges in moving forward to put together the life that they want.

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(#29) (Not a current OVW grantee) At first I was very resistant to the voluntary services model. When I started with this agency, seven years ago, it was pretty rigid, we had rules and guidelines, we had all these agreements and contracts with clients, and all these consequences when things went sour. We've really come to the other side of that. We got into a place of trauma-informed care, a reduced rules environment. Don't get me wrong, we're still at the beginning, we haven't mastered it yet, but approaching clients with this trauma-informed philosophy has changed our interactions with them. Our clients need housing and a lot of times they can't do anything else until they have safe and stable housing. Of course, with our OVW grant, we had to go to voluntary services. For the most part, our clients want the assistance. They want somebody in their life that's supporting them, that's positive, that can help financially if they need it. But every once in a while, we'll have a client that doesn't want case management. And we've had to say, "That's okay, they need us for housing." And as long as they're maintaining their unit, it's fine.

We're in the process of working on the intake material that we hand to clients to make sure that the language is trauma-informed, and not punitive or threatening; so instead of "if you don't do this, this is what's going to happen," the message is, "Here's what the program looks like. Here's what we expect." We are currently renovating our main campus, and will be making the client spaces trauma-informed. I think for the most part, being trauma-informed is really in the relationship building. It's in the conversations you have with clients, and the way you approach them. The biggest change I've seen with my staff, regarding the difficult situations with clients, is that they think about things more positively instead of negatively. So, for example, instead of, "I don't know why she can't get it together" it's more like, "well, she's struggled in the past with X,Y, and Z, her perp didn't let her write checks, so she's really struggling to do those things." So, staff are coming from a place of more positive intent and more positive thought about the clients. We're all human. We've all experienced some trauma in our life and it does affect us and how we interact in the future. So, being able to say it out loud and come with that different level of respect for clients has been the most beneficial thing.

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(#30) (Not a current OVW grantee) I think for us providing trauma-informed services is a mindset and a recognition that what other people may perceive as deficits in a client's character or behavior, are really the results of trauma. People blanking or spacing out appointments; not showing up for appointments on time; not remembering or following through on commitments; being inconsistent about certain facts or places or things that may have occurred; and/or melting down or tantruming. Being trauma-informed means

understanding that all of those things can be the consequences of traumatic events and can often be linked to traumatic brain injury and/or PTSD. Those are the first things we think about when clients are having difficulties. We find that we have a lot of clients who can't remember things, have very poor short term memory. Many have been strangled, experienced multiple strangulations, and the lack of oxygen to the brain resulted in a brain injury. Just helping clients with practical devices to aid their memory, like helping them get these really big calendar sheets on their wall and to mark things off and use different colors. Also, just helping them talk about whatever difficulties they may have in remembering and communicating and sleeping.

We have clinicians who are grant funded, they're leveraged by MOUs. That is, they work for other agencies, but visit our site. It's really important because at least the clients get to see those people coming in and out of our building, and having private meetings with other clients, and they know the services are there and it demystifies clinical services for them. And hopefully, they would see that it's not a shameful and embarrassing thing. I definitely think it's really helpful to have those services onsite.

They probably don't have that much expertise around DV and sexual assault, even though they're mental health counselors, they're often fairly junior people, poorly paid by our public health system, but they're certainly useful and it's great to have them.

In the last two to three years, we've been pressured so much by our government funders, meaning HUD and the county and the city which supports the county in its efforts, into decreasing our stay lengths and focusing on housing as opposed to DV intervention, that it does tend to get a bit lost. We certainly try to provide trauma-informed services, and we have those visiting mental health therapists who come to our transitional program and shelter, and we have DV support groups, and we make referrals -- but there isn't time for clients to take a couple of months off to focus on recovery. And we would be remiss if we just let them.

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(#31) We train all of our staff in trauma-informed care and emphasize the relationship building. The goal is that the relationship building will increase the number of people who voluntarily choose to participate in services. Sometimes it seems to work, and sometimes not. But I think it helps for our staff to have an understanding of trauma, and why people don't follow through. It's not just victims that don't follow through on things, people in general don't. By helping staff to understand how trauma may impact participants' decisions, by moving from a hierarchical relationships with our clients to more of a partnering relationship, we hope to maximize the number of people who engage with the many services we can provide them. We understand that survivors may have PTSD, may have mental health or substance abuse issues. That's where the trauma-informed care comes in, and understanding conflict resolution and de-escalation. Everybody is trained annually to deal with all three issues. We learn to de-escalate situations before they get to the point of physical argument. When you stop and really think in a trauma-informed way about why someone is reacting the way they are, it helps you be a little more patient and understanding, and you can explain that to other individuals who might be affected by their behavior.

If we have an individual who has mental illness, for example, somebody with schizophrenia who is not medicated or is choosing not to take medications, or who couldn't access their medications when they fled the abusive situation, we ask our mental health crisis service to come and do an assessment with them and work with them to get them back on their medication. We also have the mental health co-op, which has psychiatrists on hand to help people with their medication and also provide some therapy for them. So we do work a lot with the community.

We have the same kinds of relationships to address drug abuse. With anybody who comes through our doors, we try to create a relationship where they're safe enough to tell us when they have issues that might pose a problem so we can address them up front. Most of them tell us; and if they don't, it often comes out anyway.

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(#32) Normally, with anybody that's been through domestic violence or sexual assault, we start out with crisis intervention and trauma therapy; most of the therapies are based around trauma. If at some point during her stay in the transitional program, a survivor who has been making good progress goes into a funk or a depression, perhaps as a delayed effect of the trauma, and if I recognize it or if the participant recognizes it, it's something we'll talk about. If it's something we can't address here with our services and therapy, then I will recommend that they go to the local mental health association to see about getting some counseling there, maybe starting medication therapy, to try to get them to the point that they're functional on their own.

That's one of my main concerns: I don't want to put somebody in a housing program and then at the end of the time have them not be able to do all these things on their own. If I recognize something like that during home visits - if she's still in the same pajamas she was in two weeks ago when I was there - that's something I'll point out and we'll just talk about, "What do you think is going on here? What do you think can help?" And then take her lead on where she thinks she needs to go.

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(#33) (Not a current OVW grantee) Roughly 75% of our families are victims of violence, including domestic violence survivors (60%), human trafficking victims and refugees from war-torn countries where they've lost loved ones and witnessed violence and where the children have witnessed violence. And 10% of our families are homeless veterans, so there also can be exposure to violence in that regard. So in 75% of our population, there's a likelihood of trauma, so there could be anxiety and fear and depression. There is therapy available; there are groups available if they want to talk about their problems with others. We do safety planning with them. There's access to additional counseling outside. We work with a nearby women's center which specializes in domestic violence. Sometimes the services that started in the shelter will continue; for instance we have people who were referred to us from the local DV shelters, and participants may wish to continue in their support groups.

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(#34) There is so much trauma that goes with sex trafficking, and having a safe place where someone can come right from the streets, straight into the house, and start that process of healing, whether it's sleeping, whether it's starting therapy, whether it's just having a safe place to lay your head and lock the door is real critical to the women we serve.

For example, one of our women pretty much came from the street. We brought her in and she must have slept for at least for three or four days. She slept with her door open, because closing or locking the door can be a trigger for people, especially when you've never been able to unlock your own door or someone is holding you captive. If a woman is leaving a pimp or leaving a trick and that person has pretty much controlled them, then taking a shower with the door closed probably hasn't happened. Locking the bedroom door, because she feels safe by herself in there probably hasn't happened. Being able to walk through the house without someone wanting to know her every move probably hasn't happened. Going to the grocery store with our advocate and spend her own money on the food that she wants to buy probably hasn't happened.

Voluntary services is integral to our trauma-informed approach. We don't have a lot of rigid restrictions. Participants can pick and choose the help they want and leave at any time. We use a harm reduction model. If you pick up again after you've been in the program, and you want to go into treatment, we can help you enroll in treatment and still keep your spot. If you've been sober for three months and your pimp called and is starting to stalk you and you come back drunk, we understand exactly how that happened and we'll work with you to figure out how we can help you better equip yourself for that. We do a lot of relationship building, just meeting the client where they're at, that's why everybody's plan is so individualized. This is the most flexible property I manage, and I think that's why people want to stay. They don't feel like they're being bossed around. They're part of the house and they can use their voices and make their own choices.

We work at being transparent. If you keep coming to me and I keep providing you with the same me every time, so you know who I am, that's what works. So I'm always truthful and I always hold my transparency;

that's helped me be successful in direct service. A lot of that is removing your own expectations and allowing the client to have their expectations and just meeting them where they are. If I believe that what you're doing could be of potential harm to you, I need to verbalize that to you, because that's why you're sitting in front of me. But I also need to support you exactly where you're at, too. So supporting your choices without agreeing with them, being clear about my own opinions, and being clear that my opinions are secondary to your choices. Because if you're saying that, "I'm having a really hard time making money. I'm going to go back to prostitution," I can't tell you "no" but I can't tell you "yes" either. I can listen. I can ask non-judgmental questions, like, "why do you feel like that's your best option?" But I won't say, "No, don't do that." I'm just going to meet you where you're at. If we come to work and say we love who we serve, well, then we'd better not put our expectations on them.

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(#35) One thing we talk about is batterer-generated behavior and life-generated behaviors. For example, how does the trauma committed against them inform what is happening with their kids, how has that relationship been impacted by domestic violence, how would it look if the domestic violence didn't exist? It goes back to the difference between a batterer-generated and a life-generated issue. What are the behaviors they want to change? It's about giving people their space while trying to build an understanding of how the domestic violence and their trauma are informing what happened.

I am not going to say that it never gets dicey; it does. For example, we do mandatory reporting of child abuse. But we don't do it without working with the individual. So, the parent will do the report and we're there as their advocate. It may sound contradictory that on the one hand, we're saying they need to make the report, but on the other hand, they want us to be their advocate because they know we will champion who they are as a whole person. We understand and respect that some parents might not want anything to do with us after we tell them that what they've done constitutes reportable child abuse under state law, but that has actually been very rare for us. It has everything to do with how we develop relationships. We're not going to judge somebody. I can talk to you about and support the emotions you are experiencing, but I can also hold you accountable for your behavior. That kind of conversation leaves a lot of space for the survivor. If we are consistent and our advocacy shows that, it's rare that somebody doesn't want us to be there, even though they're dealing with something we initiated.

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(#36) (Not a current OVW grantee) We've done a lot of work to incorporate a trauma based approach, really addressing the trauma they've experienced versus ignoring it. Many of these ladies have experienced things that make it hard for them to communicate, so we really have to go those extra miles, do that extra knocking on the door, make that extra invitation for a cup of coffee, and market ourselves to the folks who are not really looking for our services. We have to explain why we can provide something that might be helpful for them. It's a different approach. A lot of providers look at it as "I'm here, I'm the support person, so you come and talk to me and participate in services every week." We've never taken that approach. Sometimes we may not hear from somebody for three or four weeks and we might say, "Hey, can I take you for a cup of coffee?" or something non-threatening. It's about being equal, not about the service provider and the client. It's about "We're all in this together and what can we do?"

I've found that for people who come from a substance abuse field, that's hard, because they're used to being the boss: these are the rules and you comply with the rules or you're out. We don't operate that way. Sometimes the rules are just guidelines. So we've got to find staff that can just roll with it, and meet people where they are. Our participants are people -- just like us, and most of us working in this field have probably been there and done that, and so we're able to recognize how important it is for staff to be nonjudgmental -- to be able to sit with you and share your story and allow you to say all the ugly, nasty things you might need to say -- without judging you.

We don't give our staff a set of black and white rules, and that can be really frustrating for them. But what might be okay for this client, might be different for somebody else; we're always having to go back to who is this person, what's going on, why is this happening, and how can we adjust? Sometimes it's easy just to say "If you have drugs here, you're out." But we always have to look at what's going on, what's their safety risk outside, and that whole dynamic -- and that's challenging for staff. So sometimes the rules are just guidelines.

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(#37) We don't do "mental health assessments." We provide "trauma-informed services," without any diagnoses. We don't bill to insurance, so we don't have to classify a mental health diagnosis to justify the cost. When we talk with a survivor about her child, we just frame it as "your child has been exposed to trauma just as you have; it doesn't mean there's something wrong with you or your children. It just means that something traumatic happened to them that can have long-term effects. The more strategies they have for coping and dealing with the traumas, the more successful they'll be in overcoming any effects from that trauma."

More clients want to get these services than we have capacity for. If they have a positive experience with it and they know you're doing it in a way that you're trying to help them, and not check up on them, or take away their power, and if you give them what they need, then you will not have any issue. If they do have an issue, then they'll stop coming and that's their choice and we respect that. We always tell them, "We're here for you. Don't worry. You can always come back." So again, I think it's just how you frame your services.

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(#38) We try to sit down with the clients and encourage them, support them and help them to realize that they are worth something, that they're better than their abuser's demeaning words. And we try to get them to attend one counseling session. Just be there to support them and guide them along the way. If they have specific issues, whether it's mental health or substance abuse, we make those referrals as necessary and we'll even accompany them to appointments and make sure they get to particular appointments that are beyond what we can provide at our office. It goes back to always being there, and supporting them with whatever decision they make. We know all about the cycle of violence. We know how many times it takes a person to leave and come back. We'll be there every single time she decides to leave and that's our philosophy.

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(#39) I'm not sure that domestic violence shelters are all doing a great job providing really trauma-informed services, and they don't have a lot of clinical services embedded within the DV services offered to their clients. Maybe these programs are connecting clients with community-based therapists, but it's a real specialized skill set and area of knowledge; one of the reasons we have an embedded clinical program in our direct services is because that level of expertise is really needed. Not for every client; but a lot of clients need somebody who can really understand what they've experienced to help them work through it and come out the other side.

I think it would make a tremendous difference if we could build funding for mental health into this program. We love the voluntary services model -- it's in line with everything we do as an agency -- but I think we also need to be talking a little bit more about trauma-informed care and what that looks like, and the use of clinical interventions to help people move beyond what they've experienced -- especially the most harmed clients, with lingering impacts of the violence they experienced that keep them from being successful and from feeling safe in the world.

Our agency has three full-time clinicians, one part-time clinician. That's really where our embedded clinical program really comes into play, because our advocates work in concert with our clinicians all the time, and clients are very willing and open to work with the clinical staff and the clinical program here to address the needs of their families. We're able to provide interventions directly to children, to children with their parents simultaneously, and to the mothers that address both their own trauma and how they as a parent/caregiver need to support their child as a result of their trauma. We do that in lots of different ways, through different types of individual settings. We offer a four-part workshop for parents once or twice a year that addresses the

impact of trauma specifically on their ability to be a parent that's very, very successful with clients, because we know that's a huge issue for them as well. But also our clinical team is trained in evidence-based treatment interventions that really address the needs of children who've experienced domestic violence.

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(#40) Every person that comes through our doors, whether for shelter, for transitional, for counseling, they all come from a different place, and they all have been through situations that were traumatic for them. Some will come in the door and say, "He just yelled at me, it's not that bad." And I'll say, "But it was bad for you, and we can process that." Or someone will say, "Her boyfriend gave her black eyes and hit her with a two-by-four. What happened to me is not nearly as bad." And I'll say, "What happened to you was bad enough."

Our counselors here are all licensed. There have been some clients that have done counseling for maybe a month or two, stop, and then they'll call and be like, "Can I get back into counseling?" Absolutely. You have something going on now or it's a stressful time, that's what they're there for.

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(#41) When we work with survivors who seem traumatized or depressed, and who seem to be finding it hard to mobilize to address their challenges within the timeframe that our rental assistance will be available, all we can do is the best we can. We try to approach each survivor in a very individualized way which includes taking those kinds of things into consideration and finding out what she wants to do – what kind of a plan she wants to make. If she wants services, we connect her with those services. If she doesn't want services, there are no services. If we can help her identify the resources that would be most helpful to her, we'll see a pretty high engagement in the activities required to access those resources. And if she really doesn't want to have much engagement with us, our task becomes just being very clear about what our program can do and for how long we can help. And continuing to touch base about that during the entire time she's in the program.

Imposing compliance requirements and punishments or threats for non-compliance can be re-traumatizing for participants. I was on a panel focusing on voluntary services models and talking about how important this is for domestic violence survivors and somebody came up to me after the session and said, "You know, this kind of approach would just be better for people in general." I said, "Yes." I heard some detractors in a workshop session say that the "carrot and stick" approach is really important. Well, treating people that way is pretty institutionalized, but it's wrong; I believe that our thinking on that really needs to be shaken up.

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(#42) One of our main programs focuses on healing from intergenerational historical trauma, grief, and loss. So that people understand who they are, and can reconnect with their culture, in whatever way they feel able to at this time. For example, we look at the genocide in the boarding school era going back seven generations -- how people were taken from their community and how they were punished for using their language or for sharing stories of history and culture. Or how their hair was cut, how their clothing was changed, and all that. The cultural cleansing that occurred, as people in boarding schools were taught nontraditional ways of running a household. And if they were not compliant, there was so much violence --rape, beating, near-death experiences. There were situations where children were set upon other children. So we look at how inter-tribal racism has emerged through that; how traditions and cultural practices were lost -- not their values, but their practices. How they lost a lot of the teachings about peaceful communication, ways of teaching their own children. We look at how the introduction of drugs and alcohol impacted Native Americans, and how given their different body composition and metabolism, it was much more toxic to them. And how the violence, particularly sexual and domestic violence, has become more prevalent over the generations.

Some programs have access to clinicians that work on mental health issues or substance abuse, or some of the clinical aspects of trauma. Others use lay providers that might be good case managers or advocates, and if clients need clinical support, they try to leverage them from the community. Here, we have so many resources available. Mental health providers - some people will choose to access tribal resources and the

counselors and therapists that are here. I don't know how much expertise they have in the dynamics and the multilayered impact of domestic violence. And I think very few of them are really competent in processing sexual abuse trauma. We have a lot of medical and mental health agencies that, with the tribal healthcare available to them, they can contract out to non-tribal areas if they want. And we do have therapists that have expertise in rape trauma syndrome and that sort of thing available.

I love that I can take my dog with me. If I have the dog there with me, he can be working with the kids—that's what he does—and I can have an honest conversation with the parent.

If I see something that is concerning to me, I'm really upfront. For me, honesty is critical: everything's got to be above board. We have this conversation before they come into the program, how I work with people, and that we understand that people go backwards and forwards. Because of trauma, we see a lot of different types of behaviors and reactions that are trauma-based, and we get it, and we encourage them to put everything on the table. And we work with them to build the trust to do that.

"When I was here last time, this is what I saw...." I'm not saying they're a bad parent. It's helping them understand historically how this came to them. And usually people say, "I don't want that for my kids." So then we look at how we change it. That's self-identified whether it's them or someone else coming into their home presenting with the behaviors that might be harmful to the children. I think it's the way you approach it. Not in a shaming, blaming way; so, looking at the abuse as the cause and not looking at the parent as the cause.

If I start by explaining that, "with historical trauma, we often see these behavior patterns," and then explain how "I can see that what I'm seeing here is trauma-based," then I'm not saying to the parent, "You shouldn't do this because X." It totally changes the way they receive the information. Because then they understand that this behavior is something that came to them, and not something they chose to do. That's huge in terms of shame-and-blame trauma.

Some people don't want to deal with their trauma in that way. They don't want to formally sit down. The tribe has just brought in rapid eye movement treatment<sup>39</sup> and we also open the doors to treatment such as equine therapy, and there are some ladies who are all masters in [Reiki](#) and energy work around trauma. So really providing different options other than having to repeatedly talk about what happened to you.

Maybe you're stuck in the trauma and the emotion of it and you can't get to that lateral processing. So looking at other options for processing your trauma, I think, is super important. I think clinical is a piece of it, but I think having a lot of other options available has been really helpful to clients. I have a dog that's a certified good canine companion that can come into homes with me and work with clients. And he is one of the most powerful healing tools for a lot of people in their household, especially the kids. He's safe. He's like a giant teddy bear, and they can talk to him all they like. There's no judgment or feedback. We connect people with art therapy, with just a lot of different resources beyond traditional mental health therapy.

Another thing that's really helpful in people processing their trauma is going through the **ceremony of receiving a Native name**, if they were never given one.<sup>40</sup> We often see enormous shifts once they've received their name and that sense of identity. We built a **sweat lodge**<sup>41</sup> in the backyard of one of our employees that we use as part of the healing from trauma, and the ceremonies that go with that. And we connect people with

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<sup>39</sup> Rapid Eye Movement Therapy refers to EMDR, cited in an earlier footnote and described in the preceding narrative.

<sup>40</sup> See, for example, Lisa VanBibber's article, "[What Is Your Spirit Name](#);" and Elisabeth P. Waugaman's article, "[Names and Identity: The Native American Naming Tradition](#)."

<sup>41</sup> See, for example, Barefoot Bob Hardison's [post about the Native American Sweatlodge](#)

resources in the community to do ***cleansings of the household***,<sup>42</sup> if they are staying in the same household as where they were abused. So the trauma, under their belief system, is dealt with in different ways.

We can work with the adult caregivers to come up with a safe exit plan that's not re-traumatizing to the kids. We have culturally based family-centered programming that we can do as groups. We have our Families of Traditions program that we run every summer and the whole family can go through that. And if they want to have one of our home visits as a family meeting, we can look at processing some of that trauma. People can do their own trauma timelines, identify what's present for them, and look at shared values: "What does safety mean? What does respect mean? What is harmful? What is helpful?" And we can do that as a family. It depends where the caregiver is at and what contact they want us to have.

I have a different role with a community mental health agency, where I see their case plans for sexual assault victims. They're written like, "She will reduce her sexual activity. She will do this, she will do that." They come across as very victim-blaming. If someone believes that what they're doing is their fault, then they're going to feel bad about it, and it's no different with any of the clients that I work with. If a case plan is set up in a way that implies that they did something wrong in the first place, they're not going to be successful. We need to make sure that everything is coming through a trauma-based approach, looking at how what happened in their life led to this, looking at where they want to go, and making sure that we approach it in a way that feels safe for them. Safety is just so paramount. And never shaming and blaming them.

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(#43) Across the board with all the programs our agency offers, we try to make sure that, not only are we culturally sensitive but that we also use a trauma-informed approach. I think you have to assume that everyone who comes to you has experienced trauma and shape everything that you do based on that. You have to realize where they're coming from, and that they're just trying to survive. Everyone may have different survival skills and those skills may sometimes mean doing something that you personally wouldn't choose to do. Well, you don't really know, because you're not in their shoes, and you haven't experienced what they've experienced.

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***(Interview with LGBTQ-Focused Providers on LGBTQ-Specific Aspects of Being Trauma-Informed)***

The first step in helping LGBTQ survivors to heal from their trauma is being welcoming and affirming to them, and there are some easy, concrete steps that programs can take to be welcoming. On an environmental level, they can have affirming posters and signs, maybe safe-zone stickers that visually show that LGBTQ people are welcomed; those can also be on brochures and websites. Also making sure that organizational personnel policies and program rules address discrimination around gender identity, gender presentation, and sexual identity; and making sure there are anti-harassment policies, and that staff address breaches in these policies consistently and immediately.

Another important step is making sure forms are inclusive, so participants can identify their gender identity and sexual orientation, and can include their preferred name and pronouns. The LGBT Resource Center at the University of Wisconsin - Milwaukee maintains a [webpage resource on gender pronouns](#) [LGBTRC at UW-M, 2016] that may be helpful. Some of our colleagues at a local rape crisis center now put their preferred pronouns on their email signatures, which surfaces the issue, and invites the reader to share their own gender identity.

A lot of this looks like what our community did with shelters – the work that The Network La Red did in [Open Minds Open Doors](#) (Quinn/The Network-La Red, 2010) and the work that the National Gay and Lesbian Task Force and the National Coalition for the Homeless did in [Transitioning Our Shelters: Making Homeless Shelters](#)

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<sup>42</sup> See, for example, the article about "[Smudging and the Four Sacred Medicines](#)" on the Dancing to Eagle Spirit website.

[Safe for Transgender People \(Mottet & Ohle, 2003\)](#). The guidance in those publications was for shelters, but it is equally applicable to transitional living programs.

Part of being welcoming is giving a participant the opportunity to say who they are. Staff might wonder, "Isn't it enough for us as providers to know that someone was a victim of abuse and trauma? Do we need to ask about their gender identity and sexual orientation?" I think it's so very important that we ask the question. If we don't ask, it's like "don't ask, don't tell" -- it could send a message that maybe it's not okay to be out in this program. And that can make people feel like our program is not a safe place for them to be.

I would encourage staff to make a habit of both modeling the gender pronouns they prefer, and asking survivors about the pronouns they would prefer that staff use in referring to them. In LGBTQ spaces, we often do that at the beginning of meetings, "Hi, I'm Chris; my preferred gender pronouns are she, her, and hers." In short, ask. And recognize that we will all make mistakes. Apologize and move on. The aforementioned [LGBT Resource Center fact sheet on pronouns](#) has some helpful hints about how to have those discussions.

It's hugely important to the effectiveness of groups or trauma support or advocacy support in the program. How can they talk about abuse, if they can't talk about the person who was abusing them? How can they talk about the details of their experience, if they can't name the gender of that person? We know that for men abused by men, there's a whole piece about masculinity. And for women abused by women, there's so much in our society that women aren't violent, women aren't abusive, so this really didn't happen to you. You can't unpack those things if you can't talk about it.

The act of asking is so important; whether we get the answer is less important. It is important to know, but we always want to create space for people who choose not to disclose. If someone chooses not to tell us, or to wordsmith their story in a way that's not explicit, we need to make room for that. While we need to create space for that conversation, there will be some survivors who won't be able to have it with us. We might have conversations about the person who abused them, but their need to remain hidden is another kind of abuse they have suffered at the hands of the larger community, and for now, the best we can do is create safety.

We don't want to pry information out of people, but asking is important. And how you ask is important. We normalize it. We ask about sexuality and gender orientation in the same way that we ask about every other piece of demographic information -- routinely and matter-of-factly. And at the beginning of the conversation, before we ask a single question, we say "You don't have to answer any questions you don't want to answer."

And if a survivor is not comfortable with their sexuality or gender identity, we need to meet them where they're at. We need to use the language that they use about themselves. If they've talked about behaviors that might be considered bisexual, but they're not comfortable identifying as bisexual, and instead refer to themselves as straight, then we should use that same label, and if that's "straight," then that's what we use. It's about supporting them around their identity and being open to how they want to identify themselves.

It's important not to push any individual person or their boundaries. The nature of abuse is that someone hasn't respected your boundaries. And I think our proactive responsibility is to create affirming environments, which might help them feel more accepting of themselves. That may be posters and materials and brochures and intake questions, and all the ways we do that.

It's also about the environment that we create; so in our support group meetings, if someone says something racist, we'll confront that -- we'll do it gently but we won't let it go unremarked upon. And the same should be true of homo-, bi-, and transphobia. We should not be tolerating those kinds of comments or attitudes any more than we'd tolerate someone's racism or xenophobia.

Where staff are in safe situations, we can model for participants that, "I'm part of the LGBTQ community and happy to be who I am in the world." And my colleagues can say, "We're really happy to have her on our team." Personally, when I've been able to be out with survivors, I feel like it's been very appreciated. It could be by just having a rainbow sticker on my water bottle; and I've found that people would come out to me all the time because they'd see that -- and I don't think they would have told me otherwise. I think it's fantastic if

a staff person feels comfortable being out – it can be so helpful to survivors who identify in similar ways. But while staff should be allowed to be out, they should never be forced to be out.

I often say that "trauma-informed care" is just "human-informed care" and there are some things human beings need and have in common, no matter what. But there is a specificity of oppression that must also be addressed. There are certain things that LGBTQ persons suffer more of and experience differently because of how they are treated in the community. If you're LGBTQ and a survivor of domestic violence, statistically you're more likely than your straight cisgender<sup>43</sup> counterparts to have a history of childhood sexual abuse, to have been subject to hate crimes or police brutality -- so there may be lots of different kinds of trauma in your life. With young LGBTQ people in particular -- across their lifespan, they, and especially the TQ and bisexual folks, are more likely to suffer more and different kinds of violence and trauma at the hands of lots of people.

Many of the culturally specific LGBTQ organizations don't just deal with DV and sexual assault – because the way that violence and abuse collide in the lives of LGBTQ folks, they're far more likely to be subject to the cascading effects that one kind of violence or abuse might open in someone's life: that one kind of abuse precipitates additional abusers and other forms of violence. LGBTQ survivors are far more often subject to poly-victimization and more likely to encounter barriers to help and healing. And they are far more likely to be carrying the weight of historical trauma. At the same time, though, LGBTQ communities carry enormous strengths and have developed effective survival and coping strategies precisely because of those historical traumas.

Even something as simple as the concept of "family of choice" means different things to a straight person than it does to an LGBTQ person. If you're LGBTQ, "family of choice" is a necessary survival strategy; we create community in strong and profound ways, and very intentionally – otherwise we are alone and isolated. We don't grow up in queer families. So the trauma and the healing that needs to happen are both the same and different for LGBTQ survivors as compared with cisgender survivors whose abuse happened in a heterosexual relationship.

While aspects of the trauma may be the same, addressing the aspects of that trauma that are specific to their experience as LGBTQ survivors is extremely important.

So many survivors have experienced external shaming around their gender identity and sexual orientation, and their abuser may have used this against them, or perhaps their friends and family may have used this against them, and blamed the abuse on them. A huge part of the work we do is taking that apart and helping survivors realize that the violence and abuse is not about their identify – it's not because they are gay or trans; it's about their partner using violence to assert power and control. So many of the tactics that abusers use are rooted in the LGBTQ experience. Like, "it's us against the world," or "I'm telling you're not gay enough" or "I'm telling you're not trans enough" or "I'm not going to let you be connected to your queer community." So much of unpacking and healing from the abuse is dealing with the specific issues that arose and that are particular to the LGBTQ experience, and that are compounded by the shame that becomes internalized, even though it's coming from external sources of homophobia, biphobia, and transphobia.

### ***Trauma-Informed Care: Questions to Consider***

1. What challenges limit the ability of programs/organizations to integrate trauma-informed practices across the following domains ... and what strategies can providers take to overcome those challenges, including:
  - Supporting staff development in trauma and trauma-informed care, reinforcing trauma-informed practices in supervision, and preventing/addressing vicarious trauma

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<sup>43</sup> A "cisgender" person's assigned gender at birth matches the gender they feel themselves to be, i.e., they identify as a man and their birth certificate says they're male, they identify as a woman and their birth certificate says they're female.

- Providing a safe and supportive environment that minimizes trauma-related triggers/reminders and emphasizes control, respect, trust, and empowerment
  - Appropriately assessing trauma and its impacts and providing access to trauma-specific services
  - Involving consumers in policy development and program design
  - Updating agency policies and procedures to be more trauma informed
2. To what extent do program operating constraints -- housing configuration (e.g., scattered-site versus clustered or congregate; provider-owned versus provider-leased versus participant-leased), staffing patterns, program time limits, funders' performance expectations, geography (e.g., dense urban versus rural) -- impact the ability of programs/organizations to address the following domains outlined in Sullivan & Goodman's Trauma-Informed Practice (TIP) Scales ... and what strategies can a provider take to overcome these challenges:
    - Affording participants opportunities for choice and control
    - Providing participants with information about trauma and coping strategies
    - Creating opportunities for survivors to develop mutually supportive relationships with their peers
    - Recognizing and valuing the strengths that participants bring from their family, culture, relationships, and life experiences
    - Understanding and being inclusive with regard to participant identity, based on culture, race, religion, sexual orientation, gender identity, socioeconomic status, immigration status, etc.
    - Supporting survivors in their parenting and relationships with their children
  3. How is the ability of the program to deliver trauma informed services impacted by the environment in which the program operates, including the availability and accessibility of appropriate complementary and supplementary services, the availability of appropriate and affordable housing, the availability of transportation, the availability of employment, the availability of health coverage, the availability of childcare, etc. ... and what can a program do to overcome any such challenges to implementing a trauma-informed approach?
  4. How might a trauma-informed approach be reflected in a program's participant selection criteria and the criteria used to decide on extending the stays of current participants, if the duration of assistance varies with the needs and circumstances of program participants?

## 4. How Families and Children Are Helped to Heal from the Trauma

### (a) Exposure of Children to Family Violence

***Children with early and prolonged exposure to domestic violence may experience profound and enduring impacts, potentially affecting multiple aspects of brain function, including cognitive and learning skills, memory, behavior and emotion regulation, and social development.***

Data from the second National Survey of Children's Exposure to Violence (NatSCEV II), sponsored by the U.S. Department of Justice (DOJ) and the Centers for Disease Control, indicates that approximately 7% or 1 in 15 children and youth (age 1 month to 17 years) witnessed one parent assault another parent or partner in the past year, and for youth ages 14-17, the mean lifetime rate of witnessing one parent assault another parent or partner was 25% ([Finkelhor et al., 2015](#)). Witnessing such violence is traumatic and has negative effects on children and youth ([Scheerenga & Zeanah, 2001](#); [Kilpatrick & Williams, 1997](#); [Sternberg et al., 2006](#); [Moynan et al., 2010](#); [Miller, Howell, and Graham-Bermann, 2014](#)).

Increasingly, the term "**exposure**" to domestic violence is understood to encompass the range of experiences associated with domestic violence that goes beyond "witnessing" --including seeing, hearing, and being directly involved in events, and experiencing the aftermath of violence ([Evans, Davies, & DiLillo, 2008](#)). The continuum of exposure to domestic violence includes arguments and yelling, controlling and threatening

behaviors, deprivation and punishment, destruction of property, physical and sexual assaults and threats of homicide or suicide, use of weapons, and even serious injuries or fatalities ([McAlister Groves, 2012](#)).

Sources of trauma for children in OVW-funded transitional housing not only include their high levels of exposure to domestic violence, but also the stressors of fleeing from that violence, separation from family and friends (including separation from the abusive parent, with whom the child may have had a positive relationship), loss of home and personal possessions, displacement from familiar routines, exposure to their parent's traumatic stress and its behavioral concomitants, and adjustment to a new living situation.

## **(b) Effects of Trauma on Children**

The adverse effects on children of exposure to domestic violence, like other types of violent trauma, vary by age and stage of development; they vary with the duration and intensity of the violence to which the child is exposed; and they also vary based on the child's exposure to other sources of violence, stress, and trauma. Resiliency and mitigation of those adverse impacts vary with the child's access to meaningful support, and especially, their receipt of support from a parent or other primary caregiver.

### ***(i) Variation of Impacts by Developmental Stage***

Young, pre-school-age children exposed to domestic violence may struggle with elevated levels of fear and anxiety, difficulty separating from caregivers, regression to an earlier developmental stage (e.g., losing speech and toileting skills), sleep and eating disturbances, and/or frequent illnesses ([NCTSN, 2008](#); [APA Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents, 2008](#); [Howell et al., 2016](#)). They may have difficulties regulating emotions and related behavioral issues, as well as difficulty developing social connections, which can adversely impact relationships with peers and adults ([Hungerford et al., 2012](#); [Miller et al., 2012](#); [Minze et al., 2010](#)). And they are at increased risk of developing mental health problems, memory and attention problems, learning disabilities, language impairments, and other neurocognitive problems. ([Perkins & Bermann, 2012](#), [Zero to Six Collaborative Group, 2010](#), [Osofsky, 1999](#)).

Elementary school-age children may experience nightmares, difficulties concentrating and learning at school, physical complaints, behavioral issues such as aggression towards adults or peers, and attempts to process what happened by reenacting aspects of the traumatic event in their play ([NCTSN, 2008a](#)).

Adolescents may exhibit behaviors such as withdrawal from family, peers, and activities; avoiding reminders of the event; more intense mood swings; and poor school performance. Teenagers engage in more risk-taking behaviors such as alcohol or drug use ([NCTSN, 2008b](#)), risky sexual behaviors, fights, or self-harm as ways to manage feelings related to the trauma ([NCTSN, 2007](#); [NCTSN, 2007a, p.104](#); [Danielson et al., 2006](#)).

Children and youth exposed to domestic violence may experience particularly intense worry about their safety or the safety of a parent or caregiver and become distressed by reminders of the violence, such as loud voices, arguing, or aggressive behaviors ([NCTSN, 2010](#)). They may believe the abuse was their fault, may have conflicting feelings about parents and their parents' ability to care for them, and may fear talking to others about what they have experienced, which can lead to increased isolation and negative coping ([NCTSN, 2008c](#)).

### ***(ii) Impacts Intensify with Longer-Term Exposure***

As traumatic experiences accumulate -- that is, as the intensity and duration of the exposure to violence increase -- the physiological and psychological impacts becomes more significant and challenges to daily functioning become more profound ([Cook et al., 2005](#)). Early and prolonged exposure to domestic violence has profound effects across all stages of development ([Howell et al., 2016](#); [Moylan et al., 2010](#); [Graham-Bermann & Perkins, 2010](#); [Davies, Evans, & DiLillo, 2008](#)).

Exposure to chronic, interpersonal trauma from an early age can alter how a child's brain develops and organizes itself, focusing on survival at the expense of developing higher level skills related to learning, memory, self-regulation, and coping ([Tsavoussis et al., 2014](#); [National Scientific Council on the Developing](#)

[Child, 2005](#); [Putnam, 2006](#); [Perry et al., 1996](#); [Perry, 2001](#); [Cohen et al, 2002](#); Saxe, Ellis, & Kaplow, 2006).

The impact of chronic trauma can manifest as: increased medical and mental health problems; learning difficulties; difficulty planning and anticipating; problems with boundaries; difficulties with peers; self-destructive or self-injurious behaviors; oppositional behavior; difficulty managing rules and limits; learning difficulties and poor academic performance; and low self-esteem, shame, and guilt ([Cook et al., 2005](#); [D'Andrea et al., 2012](#); [Fairbank & Fairbank, 2009](#)).

There is evidence that child maltreatment, including exposure to domestic violence, can lead to changes in brain size and structure in children and youth experiencing PTSD symptoms ([De Bellis & Kuchibhatla, 2006](#); [Carrion et al., 2009](#); [Tomoda et al., 2012](#)), and disruption of the body's stress response system and related hormones ([Tarullo & Gunnar, 2006](#)).

These impacts place youth at greater risk for adverse developmental, emotional, functional, and academic outcomes ([Berliner, 2006](#); [Cook et al., 2005](#); [Fairbank & Fairbank, 2009](#); Hopson & Lee, 2011; [van der Kolk et al., 2005](#)). School-age children, who are likely to have had longer-term exposure to domestic violence, suffer from high rates of PTSD, depression, and anxiety and are at greater risk for becoming perpetrators of violence as adults ([Ehrensaft et al., 2003](#); [Kitzmann et al., 2003](#); [Renner & Slack, 2006](#); [Wolfe et al., 2003](#)). These children are also at greater risk than their peers of suffering with health problems such as asthma, gastrointestinal problems, headaches, and flu ([Graham-Bermann & Seng, 2005](#)).

Adolescents exposed to domestic violence in childhood are at higher risk for internalizing behaviors such as withdrawal, anxiety, and depression and externalizing behaviors including aggression and delinquency ([Moylan et al., 2010](#); [Howell et al., 2016](#)). Significant levels of aggressive behavior are common as well as other high-risk behaviors and increased risk for victimization by peers. Adolescents exposed to domestic violence are more likely to have post-traumatic stress disorder and major depression ([Howell et al., 2016](#)).

Research, such as the aforementioned [ACES study](#) have shown that without intervention, early exposure to adverse experiences, can have profound effects into adulthood, and that as the number and extent of those adverse childhood experiences increases, so does the risk for problems in adulthood, including high-risk behaviors like smoking, drug abuse, and unprotected sex; mental illness; chronic physical illnesses such as heart disease, obesity, autoimmune disorders, and cancer; and heightened risk of early death ([Felitti & Anda, 2010](#); [Felitti et al., 1998](#)). This awareness of the potential for enduring impacts over the lifespan is a powerful argument for efforts to prevent and address childhood trauma, rather than waiting until problems or symptoms pose even greater challenges for the child in school or later life.<sup>44</sup>

### ***(iii) Resiliency and Sources of Variability in the Impact on Children of Exposure to Domestic Violence***

Though children experience intense responses immediately following a violent event, they aren't necessarily "traumatized" by the experience. Children and adolescents are remarkably resilient ([Masten, 2001](#); [Masten 2014](#)), and the majority of youth who experience a traumatic event, especially a one-time event, are able to bounce back to their previous level of functioning. (See also [Masten, 2010](#))

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<sup>44</sup> Pages 5-11 of [Child Welfare Information Gateway \(2011\)](#), entitled ***Supporting Brain Development in Traumatized Children and Youth***, contains a chart describing "Ages and Stages," providing general guidance about the "normal" skills, abilities, and behaviors a child might be expected to acquire as they grow. For each stage of development (0-3 months, 4-7 months, 8-12 months, by 2 years, by 3 years, by 4 years, by 5 years, by 7 years, by 10 years, by 14 years, by 18 years), the chart describes what it calls "developmentally appropriate behavior" and "causes for concern," and suggests "parenting strategies" and "[parental behaviors that might be] causes for concern."

How children respond to a traumatic event is influenced by environmental factors such as the nature of the event,<sup>45</sup> level of support, and parental responses, as well as individual factors that include age, gender, cultural background, history of exposure, and level of internal resources and skills for coping. **In all cases, how adults respond is critical to preventing longer-term issues and complications**, and to determining whether and what kind of additional support and intervention may be necessary ([APA Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents, 2008](#); [Meichenbaum, 2009](#); [McAlister-Groves, 2012](#); [Masten & Gewirtz, 2006](#); [Howell et al., 2010](#); [Graham-Bermann et al., 2009](#)).

[Holt, Buckley, & Whelan \(2008\)](#) note that "each child is unique and their reaction will vary according to age, gender, personality, socio-economic status, role within the family, the frequency, nature and length of exposure to violence, with the impact moderated or mitigated by a further set of considerations, such as relationship with parents and siblings and available supports (Hester et al., 2000; Kashani & Allan, 1998; [Salcido Carter et al., 1999](#))." Their review of literature identified that

*"Other factors influencing outcomes include the intensity, severity, co-occurring and different forms of violence to which children are exposed. . . . [Lemmey et al. \(2001\)](#) and [Levendosky and Graham-Bermann \(1998\)](#) found that an increase in physical violence against the mother was correlated with enhanced internalizing behavioral problems in the child. [Kitzmann et al.'s \(2003\)](#) meta-analysis of 118 studies highlighted that children experienced a greater impact when they witnessed physical violence between their parents than when other abusive behaviors occurred (e.g., verbal aggression)." (pp. 804-805)*

#### **(iv) Importance of Parent-Child Relationship in Mitigating the Impact of Trauma**

For the purposes of this discussion, which is about what programs can do to help, perhaps the most significant mitigating factor with respect to the impact on children of exposure to domestic violence is the role of the non-abusive partner in safeguarding the children from the negative effects of that exposure.

To that point, [Holt, Buckley, & Whelan \(2008\)](#) report that,

*"A secure attachment to a non-violent parent or other significant [caregiver] has been cited consistently in the literature as an important protective factor in mitigating trauma and distress ([Graham-Bermann, DeVoe, Mattis, Lynch, & Thomas, 2006](#); Mullender et al., 2002), with much of the research highlighting the considerable role that the maternal parenting role plays in the overall adjustment of children, across their developmental stages ([Levendosky & Graham-Bermann, 1998](#), [Levendosky & Graham-Bermann, 2001](#); Mullender et al., 2002; [Osofsky, 1999](#); [Radford & Hester, 2006](#)).*

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<sup>45</sup> In trying to reconcile the findings on resiliency by researchers like Masten with other researchers' findings identifying serious adverse impacts from exposure to violence, it is important to note the **high level of co-occurrence of child abuse and witnessing domestic violence** ([Kelleher et al., 2006](#); [Herrenkohl et al., 2008](#)), and the fact that, as [Ewen \(2007\)](#) cites,

*"The way in which research is conducted may influence research findings. Populations of children chosen for study often come from the criminal justice or shelter systems. These children may disproportionately represent children who have been exposed to the most severe forms of IPV. Only one-third of the almost 100 studies documenting the harmful effects of IPV exposure have differentiated between children who were physically abused and those who weren't, leading to questions regarding the validity of the remaining two-thirds of the studies (Edelson, 2004). Experts on children and IPV caution against assumptions that IPV exposure constitutes maltreatment or warrants child protective services (CPS) intervention in all cases ([Hughes, Graham-Bermann, & Gruber, 2001](#))."'*

Similarly, [Holt, Buckley, & Whelan \(2008, p.798\)](#) observe that

*"Exposure to domestic violence is not a "homogeneous uni-dimensional phenomenon" ([Jouriles et al., 1998, p. 178](#)), whose impact can be neatly examined in isolation from the potential impact of other stressors or traumas in a child's life. With the co-occurrence of domestic violence and other forms of abuse and adversity clearly established in the literature, **failure to differentiate abused children who also witness violence from those who witness domestic violence only, may inaccurately attribute a child's difficulties to the impact of witnessing**, without considering the impact that being a direct victim of abuse may have on outcomes for the child ([Connelly et al., 2006](#); [Edleson, 1999](#))."'*

Indeed [Osofsky \(1999\)](#) concluded from her review of the literature that the relationship with a parent or another familiar and caring adult is the exposed child's greatest protective resource.

That is, **a strong relationship with a caring parent can be one of the most important protective factors for children exposed to trauma and can have a valuable buffering effect in how a child responds to the stress of witnessing violence.** ([National Scientific Council on the Developing Child, 2004](#)); Brom, Pat-Horenczyk, & Ford, 2009; [Masten & Coastwoth, 1998](#)).

If the caregiving parent is prevented by the abusive partner from offering her support to the child, or if her capacity to provide support is depleted as a result of chronic victimization, the child's vulnerability to trauma and its concomitants dramatically increases. Thus, for example, high rates of parental PTSD are related to higher rates of child PTSD (Brom, Pat-Horenczyk, & Ford, 2009). To the extent that a transitional housing program can furnish a safe, nurturing environment in which the survivor can begin to heal, and offer the kind of support that can help restore her mental and emotional health and reserves, it rebuilds the survivor's capacity to offer the support that the child desperately needs.<sup>46</sup>

As will be discussed, however, it may be beneficial to explore other interventions that can help address the damage done to the child's wellbeing, even if symptoms of that damage are not yet raising red flags. The increased awareness of trauma's potentially multifaceted and enduring impacts over the lifespan argues for best efforts to prevent and proactively address childhood trauma, rather than waiting until manifestations of those impacts threaten the child's ability to lead a healthy, successful life.

#### **(v) Threats to the Survivor's Ability to Retain Custody of the Children**

As described by [Beeble, Bybee, & Sullivan \(2007\)](#), one of the ways that abusive (ex-)partners try to exercise power and control is by threatening and exploiting the survivor's relationship with her children (e.g., threatening her ability to retain custody, using prolonged custody battles to keep track of her, using the children as informants about her activities and whereabouts, using visitation as a means of continuing psychological abuse, and even threatening to harm the children if the survivor doesn't do what he wants).

To the extent that the presence and continued support and affection of the mother is one of the most potent forces counteracting the effect of exposure to violence, **an adverse outcome in a custody battle is not only a source of additional trauma for the battered woman, it is also a risk factor for the child.**

Two arguments which have been used to **remove children from the custody of the domestic violence victim** have been that (a) she has **failed in her duty to protect the child from exposure to the violence**, and (b) that she has engaged in **parental alienation**, that is, attempting to alienate the child from the abusive parent.

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<sup>46</sup> However, as traumatic experiences accumulate, so do the risks for a negative impact on the child and the adult victim. If as a result of cumulative trauma, a parent is unable to be adequately responsive and sensitive to her child's needs, the child may not receive the support needed to sustain their resilience; the child may withdraw and become less responsive as well ([Osofsky, 1999](#)). High rates of parental PTSD are related to higher rates of child PTSD (Brom, Pat-Horenczyk, & Ford, 2009). Depression, which commonly co-occurs with PTSD, is one of the strongest predictors of compromised parenting and child maladjustment ([Center on the Developing Child, 2009](#); [Bassuk & Beardslee, 2014](#); National Research Council & Institute of Medicine, 2009; [Shonkoff & Meisels, 2000](#)).

Experiences of domestic violence are particularly toxic for children because they can disrupt early attachment relationships between caregiver and child that are critical to the child's healthy development and resilience ([Zeanah et al., 1999](#); [Levendosky et al., 2011](#)). The effects of insecure attachment on social and emotional functioning in very young children include difficulties regulating emotions, separating from parents, and intense distress ([Lundy & Grossman, 2005](#)). In turn, mothers who have experienced domestic violence are more likely to perceive their children as having a difficult temperament, which can further strain the parent-child bond ([Casaneueva et al., 2010](#)). As children develop within a context of continued exposure to domestic violence, they learn that the world is an unsafe place and adults cannot protect them from harm. They are exposed to negative images related to expressing anger and problem solving that reinforce violence as a means of coping with future challenges ([McAlister-Groves, 2012](#)).

Although these arguments have been discredited, as described below, they still appear to exert undue weight in court cases involving custody and visitation in which abuse has been alleged. Thus, the [womenslaw.org](http://womenslaw.org) [webpage describing preparation for a final protection order hearing in civil court](#), advises survivors that, "If you have children, you may want to talk to a domestic violence advocate or a lawyer in your state about how to present any evidence about what the abuser has done to the children. You want to be sure not to present this information in a way that may implicate you in some way (i.e., you don't want to be accused of failing to protect your children from abuse) and so asking a lawyer for advice on this topic is often best."

**(A) "Failure to Protect" Laws**

As described in [Harris \(2010\)](#),

*"Today, statutes in all fifty states and the District of Columbia require courts to consider domestic violence committed by one parent against the other in resolving a custody or visitation dispute between parents. A significant number of states also have statutes or case law that require courts to consider the occurrence of violence in a child's household or proposed household in resolving such disputes, regardless of who commits the violence or at whom it is directed. The latter type of law is aimed, not at a parent who commits domestic violence, but at a parent, often a victim, who fails to protect a child from being exposed to the violence. . . .*

*The first [set of statutes] ... weight the custody decision against the parent who was violent, on the theory that the parent presents a variety of dangers to the child, including the risk that the child will be harmed by being exposed to the violence. The second [set of statutes] turn this claim of harm around and use it as a reason to deny custody to victims of domestic violence" (p.170)*

*"By the early 1980s, juvenile courts were regularly holding that a parent who does not extricate her children from a household in which the children are being abused by another adult can be found neglectful, and, if the problem is not corrected, that her parental rights can be terminated. By the 1990s, courts were applying this theory to victims of domestic violence who "allowed" their children to be exposed to domestic violence by not leaving their batterers. Beginning in the late 1990s, states began to amend their juvenile codes to include exposing a child to domestic violence as an explicit basis for an adjudication of child abuse or neglect. This trend was controversial, however. Critics argued that the practice unfairly blamed victims of domestic violence for their own victimization, failed to hold batterers accountable, harmed children's interests by removing them from their mothers unnecessarily, and deterred women who wanted to leave their batterers from seeking assistance.*

*In 1999, the National Council of Juvenile and Family Court judges adopted a statement of best practices in child welfare cases involving domestic violence, familiarly called the Greenbook,<sup>47</sup> that adopted the critics'*

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<sup>47</sup> As described on homepage of the [Greenbook website](#),

*"In 1999, the National Council of Juvenile and Family Court Judges published [Effective Interventions in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice \(NCJFCJ, 1994\)](#) This publication, commonly referred to as "[the Greenbook](#)" due to its green cover, is helping child welfare, domestic violence service providers and family courts work together more effectively to serve families experiencing violence. Since the Greenbook's release, dozens of communities around the country have used it to improve their policies and practices and developed enhanced coordination among courts and social service agencies to better serve families in need.*

*From 2000-2007, the United States Departments of Health and Human Services and Justice funded [six demonstration sites](#) across the country. The demonstration sites joined battered women's organizations, child protection agencies, the courts, and other partners in implementing the Greenbook's recommendations. NCJFCJ, Family Violence Prevention Fund and the American Public Humane Association provided technical assistance to the sites. Every local site was evaluated individually, and a [comprehensive national evaluation](#) was conducted at the completion of the initiative. . . . Many lessons were learned and products such as training curriculums, community assessment tools and multimedia materials were developed and collected to assist others in doing this work. These items are available on this website. Please visit "[Tools and Resources](#)" and the individual demonstration sites for site specific products."*

*perspective [i.e., that preserving children's relationships with their primary (non-abusive) caretakers best serves the children's interests].*

*The Greenbook, in turn, was the foundation for groundbreaking litigation that challenged the way child welfare/domestic violence cases were routinely handled in New York City, [whereby] ... as a matter of policy the New York City Administration for Children's Services (ACS) routinely charged mothers with neglect in juvenile court solely on the basis that they were domestic violence victims and then removed their children to foster care, rather than offering them services on a voluntary basis. The plaintiffs argued that these practices were unnecessary to protect [the] children and violated the mothers' and children's substantive and procedural due process rights. . . .*

*The federal trial judge found that ... the ACS practices violated procedural and substantive due process. The judge relied on the expert testimony and cited the Greenbook extensively. The principles from the Greenbook that he highlighted included: (1) Mothers should not be accused of neglect for being victims of domestic violence. . . . When [child protective services] files a petition, it should allege and be able to support the contention that the child has suffered harm and that the mother cannot adequately protect the child with assistance from [protective services]. (2) Batterers should be held accountable. (3) Children should be protected by offering battered mothers appropriate services and protection. . . . [Case plans] should focus on, among other things, 'securing safe housing—in the adult and child victims' own residence whenever possible or with her family or friends, in subsidized housing, in shelter, or in transitional or permanent housing [and] providing voluntary advocacy services for battered women within the child protection system. (4) Separation of battered mothers and children should be the alternative of last resort.' (pp. 184-185)*

[Lansner \(2008\)](#), written by a member of the legal team that represented the plaintiff, cited the New York Court of Appeals' "strongly-worded unanimous decision [that] domestic violence victims who are beaten in the presence of their children are not per se neglectful parents," and described the implications for the many other jurisdictions who continue to support "failure to protect" statutes:

*"'Failure to protect' cases rest upon a tacit assumption that somehow battered mothers consent to being beaten, assaulted, and injured in the presence of their children. CPS also may presume that a battered mother who does not enter a domestic violence shelter or otherwise relocate is failing to exercise a minimum degree of care. However, relocating is frequently not in the best interests of the child. Even in cases where relocating is in the child's best interests, there is a critical shortage of domestic violence shelters. Further, many women who try to relocate cannot find permanent housing, and there is 'no guarantee that there may be adequate resources available to meet the needs of her children.'*

*CPS and courts also frequently consider, as a litmus test for neglect, whether a battered mother successfully ended the relationship. As the District Court found, "the process of extrication from a violent relationship often takes time. . . . Moreover, separation does not equal safety. Leaving is not an appropriate safety plan for many mothers because it actually may increase danger to the mothers and children. As the District Court found, 'even if a battered mother wants to free herself from the abusive relationship immediately, this is not always a viable option. The most dangerous time appears to be immediately after she leaves the batterer.' The media is replete with examples of cases in which a battered mother was killed after she left or because she left."*

[Ewen \(2007\)](#) cautions that, "The threat of removing a child from a mother can be used to manipulate the mother into leaving an abusive situation prematurely, possibly without a safety plan in place. Leaving an abusive partner without a plan increases the risk of stalking, injury, and homicide ([Kopels & Sheridan, 2002](#))," and that "fear of CPS involvement may decrease disclosure of violence and reduce the number of women seeking assistance from mandated reporters, further endangering children ([Weithorn, 2001](#))."

Notwithstanding the realities about the difficulties attendant to safely leaving an abusive relationship and establishing a stable home, [Harris \(2010\)](#) observes that

*"Experts advise and juvenile courts require child welfare agencies to offer battered mothers services and protection to help them escape from violent situations and live safely with their children. If a mother refuses these services or, if even with services she is unable to create a safe home for the children, a court can and likely will order the children removed, of course. Even then, though, the agency will have a continuing obligation to arrange visitation between the mother and children and to continue to offer appropriate services to the mother to try to help her solve the problems and regain custody. These obligations are consistent with child welfare agencies' general duty under federal and state law to make reasonable efforts to prevent the need to remove children from their homes of their admittedly abusive or neglectful parents and, if children are removed, to make reasonable efforts to reunite the family. In a domestic relations case, no one has a duty to offer such assistance to a mother who lives in a violent household. If the mother cannot pull herself out of the situation alone, she may not only lose custody but may be allowed only supervised visitation away from her household. It is, therefore, all the more critical that the court's decision about whether to change custody be well-founded, since as a practical matter, if the battered mother loses custody, she may never regain it. (p.192)*

**(B) "Parental Alienation" Claims<sup>48</sup>**

[Meier \(2013\)](#), written by the director of the Domestic Violence Legal Empowerment and Appeals Project<sup>49</sup> (DVLEAP), explains that Parental Alienation Syndrome (PAS) and Parental Alienation (PA) are often-invoked contentions by the father (alleged perpetrator of abuse) that the mother (alleged victim of abuse) has caused the child to be alienated from the father, in order to deprive the father of his rights for custody or visitation.

*"Alienation claims have become ubiquitous in custody cases where domestic violence or child abuse is alleged, as grounds to reject mothers' requests to limit paternal access to their children. . . .*

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<sup>48</sup> See also the following publications:

- Meier, J.S. (2009). *A historical perspective on parental alienation syndrome and parental alienation*. Journal of Child Custody. 6:232-257. DOI 10.1080/15379410903084681. Retrieved May 15, 2018, from <https://drive.google.com/file/d/191BEZoaiPa9TEp44AU2yxzIP-Y70tGXu/view>
- DVLEAP. (2013). *Scientific and Professional Rejections of Parental Alienation Syndrome*. Retrieved May 15, 2018, from <https://drive.google.com/file/d/1EQeiqbHHPpVLD5J93dLg67yQLeJdWJsH/view>

<sup>49</sup> The Domestic Violence Legal Empowerment and Appeals Project (DVLEAP) received a two-year funding award from the Office on Violence Against Women to implement a **Custody and Abuse Project** that would focus on strategies for "improv[ing] the family court system's ability to protect children in custody cases involving domestic violence or child abuse." Although that project has ended, DVLEAP maintains a [Custody resources webpage](#) containing links to the numerous resources developed by the project, including (a) resources on the misuse of "Parental Alienation Syndrome;" (b) Resources for attorneys and advocates representing protective parents; and (c) research summaries. The DVLEAP [Case Digests webpage](#) and its [Briefs and Court Opinions webpage](#) provide information about generally relevant cases and cases in which DVLEAP was specifically involved, respectively. A [Training Materials webpage](#) provides links to PowerPoint presentations and other training resources for advocates and lawyers involved in domestic violence cases. A [Publications webpage](#) provides links to relevant papers, including some of the publications listed on the Custody Resources webpage. As described on the now-defunct Custody and Abuse Project webpage,

*"In partnership with the [Leadership Council on Child Abuse and Interpersonal Violence](#), [DVLEAP provides] education on critical issues that often determine case outcomes, such as the misuse of flawed parental alienation theories and failure to consider evidence of abuse. One particularly powerful aspect of the Project's work is the development of a unique database of cases that have "Turned Around." These are cases in which the initial custody order placed a child (or children) in dangerous contact with an abusive parent and a subsequent order protected the child. Analysis of these cases is providing valuable understanding of how and why custody evaluations so frequently fail to identify or predict actual risk to children who are victims of family violence. . . . Additional valuable research by DVLEAP includes a national analysis of published alienation and abuse cases with respect to gender and allegations of abuse. Preliminary results affirm that parental alienation claims by fathers increase their chances of reversing custody from the mother to themselves, but the same is not true for mothers who accuse fathers of alienation. Preliminary results also indicate that when mothers allege child abuse, fathers' custody rates increase significantly."*

*"Beginning in the early 1980's, attention to a purported "parental alienation syndrome" exploded as the result of the dedicated efforts of Richard Gardner, a psychiatrist loosely affiliated with Columbia Medical School, who ran a clinical practice that focused on counseling divorcing parents.*

*Based solely on his interpretation of data gathered from his clinical practice, Gardner posited that child sexual abuse allegations were rampant in custody litigation, and that 90% of children in custody litigation suffered from a disorder, which he called "Parental Alienation Syndrome (PAS)." He described PAS as a "syndrome" whereby vengeful mothers employed child abuse allegations as a powerful weapon to punish ex-husbands and ensure custody to themselves (Gardner, 1992a; Gardner, 1992b). He further theorized that such mothers enlisted the children in their "campaign of denigration" and "vilification" of the father, that they often "brainwashed" or "programmed" the children into believing untrue claims of abuse by the father, and that the children then fabricated and contributed their own stories (Gardner, 1992b, p. 162, 193; 2002, pp. 94-95). He claimed – based solely on his own interpretation of his own clinical experience – that the majority of child sexual abuse claims in custody litigation are false (Gardner, 1991), although he suggested that some mothers' vendettas were the product of pathology rather than intentional malice (Gardner, 1987, 1992b). In short, Gardner claimed that when children reject their father and they or their mother makes abuse allegations, this behavior is most likely the product of PAS rather than actual experiences of abuse. PAS theory is thus premised on the assumption that child abuse claimants' believability and trustworthiness is highly suspect." (pp. 1-2)*

[Davis et al. \(2011\)](#), a U.S. Department of Justice grant-funded publication entitled, *Custody Evaluations When There Are Allegations of Domestic Violence: Practices, Beliefs, and Recommendations of Professional Evaluators*, explains how a related construct, known as the "friendly parent," can similarly result in the victim of abuse being denied custody in favor of the abusive partner, when the court's decision making is guided by the belief that the best arrangement is one in which the child can maintain relationships with both parents:

*"In concert with the belief that it is best for children to have strong relationships with both parents, the seemingly more benign but conceptually related construct of the 'friendly parent' is sometimes incorporated into statutes and case law as one of the factors to be considered under the child's best interest. Under the 'friendly parent' construct, along with other considerations, custody should be awarded to the parent more likely to support the other parent's role in the child's life. When applied to domestic violence cases, in which a victimized parent may have legitimate safety reasons for wishing to limit the former partner's access to the children, a preference for the friendly parent reduces the probability of the victim being granted custody and increases the probability of the abuser being granted custody (Zorza, 1992). These provisions are widespread and routinely applied across the United States with only a small number of states exempting domestic violence cases from the provision ([Dore, 2004](#))." (p.15)*

[Meier \(2013\)](#) writes that,

*"PAS has been rejected as invalid by scientific and professional authorities. The dominant consensus in the scientific community is that there is no scientific evidence of a clinical "syndrome" concerning "parental alienation." Leading researchers, including some who treat "alienation" itself as a real problem, concur, "The scientific status of PAS is, to be blunt, nil" ([Emery, Otto, & O'Donohue, 2005](#), p. 10; see also [Gould, 2006](#); [Johnston & Kelly, 2004b](#); [Myers, Berliner, Briere, Hendrix, Jenny, and Reid, 2002](#); [Smith and Coukos, 1997](#); [Wood, 1994](#)). The Presidential Task Force of the American Psychological Association on Violence in the Family stated as early as 1996 that "[a]lthough there are no data to support the phenomenon called parental alienation syndrome, in which mothers are blamed for interfering with their children's attachment to their fathers, the term is still used by some evaluators and Courts to discount children's fears in hostile and psychologically abusive situations" (p. 40). Dr. Paul Fink, past President of the American Psychiatric Association, describes PAS as "junk science" ([Talan, 2003](#), line 9). . . .*

*Echoing the scientific consensus, a leading judicial body, the National Council of Juvenile and Family Court Judges (NCJFCJ), has published guidelines for custody courts stating: "[t]he discredited 'diagnosis' of 'PAS'*

(or allegation of 'parental alienation'), quite apart from its scientific invalidity, inappropriately asks the court to assume that the children's behaviors and attitudes toward the parent who claims to be 'alienated' have no grounding in reality. It also diverts attention away from the behaviors of the abusive parent, who may have directly influenced the children's responses by acting in violent, disrespectful, intimidating, humiliating and/or discrediting ways toward the children themselves, or the children's other parent (Dalton, Drozd, & Wong, 2006, p. 24). The American Prosecutors' Research Institute and National District Attorneys' Association have also rejected PAS ([Ragland & Field, 2003](#)).

[Yet,] most family courts accept PAS contained in an opinion offered by an evaluator or Guardian Ad Litem (GAL) (legal representative for the child) without ever questioning its scientific validity or admissibility.<sup>50</sup> Where it has been formally challenged on appeal, appellate courts have also avoided directly ruling on the issue. . . . As a result there are as of the date of this writing only three trial-level published opinions actually analyzing and ruling on the legal admissibility of PAS. Each opinion has concluded it lacked sufficient scientific validity to meet admissibility standards. . . . Four trial level decisions have ruled it was admissible, but the appeal of each decision resulted in no ruling on the PAS issue. No published decision exists for several of the purportedly favorable trial court opinions ([Hoult, 2006](#)).

While the robust critiques and rejections of PAS as a 'syndrome' have reduced the use of this label in court and in the research literature, it has continued to garner popular and political recognition. For example, the American Psychological Association and state and local bar associations continued to sponsor workshops on PAS during the first decade of the century. **Since approximately 2005, roughly fifteen governors have issued proclamations concerning the purported problem of PAS** at the urging of a relatively small group of PAS proponents ([Parental Alienation Awareness Organization, n.d.](#)).

The many critiques of Gardner's PAS have resulted in a shift among leading researchers and scholars of custody evaluation from support for PAS to support for a reformulation of PAS. Instead, they speak of 'parental alienation' or 'the alienated child' as a valid concept that describes a real phenomenon experienced by "a minority" of children in the context of divorce and custody disputes (Johnston, 2005, p. 761; [Johnston & Kelly, 2004b](#), p. 78; see also [Drozd & Olesen, 2004](#)).

What is the difference between PAS and PA? The primary shift appears to be away from Gardner's focus on the purportedly alienating parent and toward a more realistic assessment of the multiple sources of children's hostility or fear of a parent, including behavior by both parents and the child's own vulnerabilities (Johnston, 2005; [Johnston & Kelly, 2004b](#); Kelly & Johnston, 2001). [Johnston and Kelly \(2004b\)](#) state, In contrast to PAS theory that views the indoctrinating parent as the principal player in the child's alienation, this study [their own] found that children's rejection of a parent had multiple determinants.... Johnston also differentiates her approach from Gardner's by rejecting his draconian 'remedies,' including custody switching to the 'hated' parent. Characterizing Gardner's prescriptions as 'a license for tyranny,' [Johnston](#)

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<sup>50</sup> See, for example, [Davis et al. \(2011\)](#), the November 2010 report on **Custody Evaluations When There Are Allegations of Domestic Violence: Practices, Beliefs, and Recommendations of Professional Evaluators**, in which the authors state, "Another theory that, although widely discredited, continues to play a role in custody disputes is that of the 'Parental Alienation Syndrome' (PAS), a construct created by a psychiatrist who claimed an affiliation with Columbia University (Gardner, 1991; Williams, 2001). Gardner framed PAS as pathological behavior of a parent who deliberately manipulates the children to 'poison' them against the other parent, so that the children would resist contact with that parent. Gardner proposed that the children needed to be protected from the alienating parent and custody should instead be awarded to the alienated parent. Mothers who had been abused by the fathers of their children or whose children had been abused by their fathers and who sought to protect the children by limiting or avoid visitation were accused of PAS and, in some cases, lost custody to the abusive fathers ([Hoult, 2006](#)). Parental Alienation Syndrome was discredited and is generally not accepted in courts throughout the United States ([Hoult, 2006](#)). Nonetheless, the term 'parental alienation' is used frequently in regard to children and divorcing parents, is still frequently referenced in custody disputes; the 'alienated child' is a subject of concern to the courts and custody evaluators." (p.15)

*and Kelly (2004b, p. 85) call instead for individualized assessments of both the children and the parents' parenting, maintaining focus on the children's needs rather than the parents' rights.*

*In theory, the goal is a more realistic and healthy relationship with both parents, rather than reconciliation with the hated parent as the only desirable goal (Johnston, 2005). Unfortunately, the common practice in court is far less nuanced and individualized (see below). The notion that some children are alienated from a parent is both a less scientific and more factual assertion. It is thus easier to raise "alienation" in court without triggering a battle over the admissibility of scientific evidence (Gardner, 2002). However, debate continues to rage in research and advocacy circles over the extent to which parental alienation is something that can be measured, is caused by a parent, and/or has truly harmful effects, or whether it is simply a new less objectionable name for the invalidated PAS. To the extent that PA is widely used almost identically to PAS in court, it may not matter in practice what the theoretical differences are."*

### **(C) Resources Addressing Challenges to DV Survivors' Retention of Child Custody**

Addressing challenges to child custody by the victims of domestic violence takes a coordinated community response.

- As noted earlier, DVLEAP maintains a [Custody resources webpage](#) containing links to the numerous resources developed by its Custody and Abuse project, including (a) resources on the misuse of "Parental Alienation Syndrome;" (b) Resources for attorneys and advocates representing protective parents; and (c) research summaries. The DVLEAP [Case Digests webpage](#) and its [Briefs and Court Opinions webpage](#) provide information about generally relevant cases and cases in which DVLEAP was specifically involved, respectively. A [Training Materials webpage](#) provides links to training resources for advocates and lawyers involved in domestic violence cases. A [Publications webpage](#) provides links to relevant papers, including some of the publications listed on the Custody Resources webpage.
- The [National Child Custody Project](#), a project of the [Battered Women's Justice Project](#), "provide[s] training and technical assistance to courts, legal and dispute resolution professionals, advocates and others working to resolve child custody disputes in ways that account for the nature, context and implications of domestic violence for parents and children." The project webpage provides free access to over two dozen webinars and other resources.

Other related resources include:

- [Applying the Safe and Together Model to Custody and Visitation Cases](#) - An October 2011 [Battered Women's Justice Project webpage](#) provides a link<sup>51</sup> to a recorded webinar by [Mandel & Reilly \(2011\)](#) describing how "the [Safe and Together model](#) is being implemented in a number of states and jurisdictions (Connecticut, Ohio, Colorado, Florida, Kansas City, MO) to improve case practice and cross system collaboration in child welfare cases involving domestic violence. Challenging the double standards that often punish battered mothers and provide advantages to fathers who batterer, the model emphasizes the importance of a clear assessment of the behaviors batterers engage in to harm children and the day to day efforts battered mothers use to promote the safety and wellbeing of their children. In this webinar David Mandel [the originator of the Safe and Together model] and Bridget Reilly provide an overview of the Safe and Together model and its implications for custody and visitation cases."
- [What Can We Learn from Turned-Around Custody Cases](#) - An April 2014 [Battered Women's Justice Project webpage](#) provides a link to a recorded presentation ([Silberg & Dallam, 2014](#)) describing the results of a case analysis of 27 custody cases involving the abuse of children. In these cases, a judge initially ordered the children into unsupervised contact with an abusive parent and then a later judicial decision protected the children from abuse. This sample is illustrative of failures common in family court

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<sup>51</sup> As with most BWJP webpages, there are links to other, related resources.

where signs of child abuse are ignored and theories which blame the mother, such as accusations of parental alienation are relied upon. The case analysis shows that it is often the court-ordered custody evaluators who recommend access to the unsafe parent and experts in child abuse and domestic violence who correct the information for the court. This webinar presents recommendations derived from this case analysis about how to approach allegations of abuse in contested custody cases so that children are more consistently protected.

- [Davis \(2011\)](#) reviews three studies about custody evaluators' beliefs about domestic violence and the participants in custody cases involving allegations of abuse, and how those beliefs inform their recommendations to the court about parenting and custody. She find that,

*"Taken together, these studies suggest that custody evaluators' beliefs are more strongly associated with [what they believe the] custody outcomes [should be] than what is actually going on in the real life of the family. Family court practitioners hold a lot of beliefs about domestic violence. Some of the most common beliefs have to do with: (1) **false allegations** [i.e., that mothers falsely allege abuse]; (2) **parental alienation** [i.e., that scheming mothers position their children against the father]; (3) **friendly parenting** [i.e., that parents should facilitate their partners access to the children, for the children's benefit]; and (4) **failure to protect** [i.e., that as the primary caregiver, it is primarily the mother's duty to protect the children from exposure to domestic violence]. . . .*

*In these ways, many of the most commonly held beliefs about domestic abuse are actually beliefs about victim-mothers. In fact, it is difficult to identify any beliefs about domestic violence that relate to perpetrators at all. While some people might believe that perpetrators are madmen or sociopaths, or that they cannot control their anger, in our experience, most people do not think much or talk about the person who is actually responsible for abuse at all. Instead, their attention is persistently diverted away from the abuse, even though abuse itself might well be the central issue in the case.*

*If, as the three recent studies seem to suggest, evaluators' beliefs are associated with outcomes – and if, as we observe, many of the most commonly held beliefs are negative beliefs about battered mothers – then it is no wonder that outcomes are so often disconnected from the real life experiences of battered mothers and their children."*

### **(c) Resources on Serving Children Exposed to Trauma (and Supporting Their Parents)**

#### ***(i) Resources Describing Approaches and Interventions for Supporting Children***

- (A) Futures without Violence: [Promising Futures: Best Practices for Serving Children, Youth, and Parents Experiencing Domestic Violence website](#) and accompanying publication: [Comprehensive Review of Interventions for Children Exposed to Domestic Violence - Chamberlain \(2014\)](#)

The Best Practices website offers information about the [impacts of domestic violence on children](#), the importance of [acknowledging and supporting mothers in their parenting role](#) and strategies and resources for providing that support, and the importance of [supporting children and adolescents](#) and strategies and resources for providing that support.

Futures Without Violence asserts that "All advocates should be advocates for children, just as all advocates are women's advocates," makes the case for the [paradigm shift](#) it says is necessary to make that a reality, and suggests a [review of program practices](#) to explore how efforts can support a more balanced approach to advocacy with children and mothers both as individuals and together as families.

A [Communities in Action webpage](#) features eight examples from across the country of approaches to working with children and families.<sup>52</sup>

With funding from the U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Futures Without Violence conducted a national scan of interventions for Children Exposed to Domestic Violence (CEDV) to create a "***web-based repository of information about interventions for Children Exposed to Domestic Violence and related resources.***" That resource is the [Interventions for Children and Youth webpage](#) of Promising Futures' [Best Practices website](#). The information from that national scan of interventions is presented in [Comprehensive Review of Interventions for Children Exposed to Domestic Violence](#), a downloadable publication written by Linda Chamberlain, for Futures Without Violence. The [online version of the Database of Interventions for Children and Youth](#) is searchable by a variety of parameters, including language, type/source of trauma, demographics, whether a caregiver will be involved (and their role), setting for the intervention, duration of intervention, group versus individual approach, etc. There are separate resource listings for [working with children with disabilities](#) and [working in Indian Country](#).

- (B) Futures without Violence: [Promising Futures: 16 Trauma-Informed, Evidence-Based Recommendations for Advocates Working with Children Exposed to Intimate Partner Violence](#) - DeBoard-Lucas et al. (2013)

(from the Introduction:) "It has been well documented that exposure to IPV is a potent traumatic stressor for children, often adversely affecting their physical and emotional health. However, caring adults can help children heal and thrive. The recommendations that follow were created to help guide IPV advocates in their daily work with mothers and families. The recommendations are drawn from a review of core components of evidence-based therapeutic intervention models for children exposed to IPV including Child Parent Psychotherapy, Trauma-Focused Cognitive Behavioral Therapy, and the Kid's Club. Information about these evidence based models and other research on services for children and youth can be found on the [Promising Futures: Best Practices for Serving Children, Youth, and Parents Experiencing Domestic Violence website](#)."

Each of the following recommendations is followed in the publication with contextual information, citations, and or links for further information: (1) Understand that children of all ages, from infancy through adolescence, are vulnerable to the adverse impact of IPV exposure. (2) Establish a respectful and trusting relationship with the child's mother. (3) Let mothers and children know that it is okay to talk about what has happened if the child would like to engage in this type of discussion. (4) Tell children that violence is not their fault; if children say that the violence is their fault or that they should have stopped it, tell them directly that they are not responsible for violence and that it is not their job to intervene (or coach their mothers to do so). (5) Foster children's self-esteem by showing and telling them that they are lovable, competent and important. (6) Help children know what to expect. (7) Model and encourage good friendship skills. (8) Use emotion words to help children understand how others might feel during disagreements. (9) Recognize that when children are disruptive, they are generally feeling out of control and may not have the ability to use other strategies to express themselves. (10) Incorporate the family's culture into interventions, and support mothers and children to explore the values, norms, and cultural meanings that impact their choices and give them strength. (11) Actively teach and model alternatives to violence. (12) Involve mothers in conversations with their children

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<sup>52</sup> For analyses of some of the challenges to building effective collaborations between domestic violence advocates and child protective services, see Jennifer Inman's [CPS: Closing the Distance Between Domestic Violence Advocacy and Child Protective Services](#) (for the Washington State Coalition Against Domestic Violence; 2003, updated 2008) and Linda Spears' [Building Bridges Between Domestic Violence Organizations and Child Protective Services](#) (for the National Resource Center on Domestic Violence, the Child Welfare League of America, Inc., and the National Council of Juvenile and Family Court Judges; 2000).

about the children's views of the abuse. (13) Discuss child development<sup>53</sup> with mothers. (14) Help mothers teach their children how to label their emotions. (15) Address mothers parenting stress. (16) Work with mothers to help them extend both their own and their child's social support network.

(C) **The [National Child Traumatic Stress Network \(NCTSN\) website](#)**

- **Types of Traumatic Stress**: Information and resources effects, assessment, treatment, etc.) on different types of trauma that can affect children and youth: [complex trauma](#), [domestic violence](#), [early childhood trauma](#), [physical abuse](#), [refugee trauma](#), [sexual abuse](#), [traumatic grief](#), etc.
- **Treatments that Work** (for Traumatized Youth and Families) A webpage with links to information about a broad range of treatment modalities for working with children, youth, and families that have experienced trauma, including links to information about the competencies required to implement the various treatments, and about cultural uses and adaptations.

[Note: The original version of this report described De Arellano, et al. (2008) "**Trauma-informed interventions: Clinical and research evidence and culture-specific information project**" as a companion downloadable publication providing comparable information for an abridged set of treatments. The publication is no longer available on the National Child Traumatic Stress Network at [http://www.nctsn.org/sites/default/files/assets/pdfs/CCG\\_Book.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/CCG_Book.pdf). However, a copy of the paper's Conclusion section, enumerating the principles that culturally competent trauma-informed therapies for children should include is [available online](#), and links to the lead author's related publications can be found on his [Researchgate profile page](#).]

- **Other Resources**:
  - for [trauma screening and trauma-informed mental health screenings](#);
  - for [addressing co-occurring trauma and substance abuse in families](#), more generally (e.g., substance abuse by the perpetrator of IPV, impact on children of prenatal exposure to substances, and caregiver substance abuse and trauma) and working with [youth with co-occurring trauma and substance use problems](#)
  - for addressing the [cultural specifics of trauma](#), including the importance of linguistic competence, special topics on working with Latin American families exposed to trauma, working with pregnant immigrant Latinas, four-part series on cultural and linguistic competence, three-part series on historical trauma, supporting LGBTQ youth in disclosing abuse, preventing youth suicide in Indian Country
  - addressing [trauma in special populations](#): families with a child or parent who is deaf or hard of hearing, and in families with a child with intellectual or developmental disabilities

(D) Futures without Violence: **[Building Promising Futures: Guidelines for Enhancing Response of Domestic Violence Programs to Children and Youth](#)** - Lyon, Perilla, & Menard (2016)

(from the Introduction:) "This discussion paper presents guidelines for consideration to improve the services to and success of children exposed to domestic violence. There is increasing evidence—both research based and practice-based—of the strong relationship between the health and well-being of children and that of their protective parents or caretakers where family and/or domestic violence occur. Many domestic violence (DV) programs across the country have made great strides in focusing more attention on children and youth over the last 15 years, including those supported in 2005-2008 with

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<sup>53</sup> See the earlier footnote for Pages 5-11 of [Child Welfare Information Gateway \(2011\)](#), entitled ***Supporting Brain Development in Traumatized Children and Youth***, containing a chart describing the ages and stages of development.

funds generated by the Family Violence. However, others may require additional support and guidance to fully embrace and implement comprehensive and integrated approaches to working with children affected by violence within their families. ***Separate responses to mothers' and children's safety and well-being often place them at odds with one another.***<sup>54</sup> ***In contrast, an integrated approach to intervening with the family as a whole results in better outcomes for children, their mothers, and the whole family.*** These comprehensive solutions more accurately reflect the lived realities of families affected by the violence."

The authors propose (and elaborate on) the following "Key Considerations," and then provide guidance on infrastructure and logistical considerations (overall approach, programming, staffing, training, partnerships) for starting/developing/enhancing programming with a more unified focus on parents and children:

- "Recognize children as more than just "secondary" victims.
- Involve children, youth and parents in program design.
- Recognize cultural relevance as an essential characteristic of successful programming.
- Recognize that people from different cultural backgrounds may have vastly different experiences, including multiple types of oppression that can affect access to resources, support, and, ultimately resilience.
- Ensure that programming is developmentally appropriate.
- Invest in advocates working with children and youth.
- Work to provide a network of support for children and youth staff.
- Focus on enhancing well-being in addition to safety.
- Incorporate positive and supportive responses to challenging behaviors.
- Integrate response to childhood exposure to domestic violence into all programming.
- Include awareness of the potential for sexual abuse.
- Provide program planning and infrastructure that support stable, durable programming for children and youth."

In the companion publication on ***Developing Outcome Measures for Domestic Violence Programs' Work with Children and Youth*** ([Lyon, Perilla, & Menard, 2016a](#)), the authors emphasize the importance of developing a small number of metrics that (a) can apply to a range of services; (b) are meaningful even if there is a limited amount or period of contact; (c) are associated with evidence of improved wellbeing for children; (d) apply across cultures; (e) apply across all children, that is, regardless of age, developmental stage, gender, type and extent of abuse, etc.; and (f) can be implemented with sensitivity to ethical issues, that is, so that children and mothers feel safe and comfortable responding, feel that they have a choice about responding, and understand that their answers will be confidential. The publication describes the process of developing themes from the literature and from the experience of advocates in the field.

Key concepts that guided their work were (a) the evidence of resilience; (b) children's reactions to exposure to violence and abuse vary, especially at different stages of development; (c) "research consistently finds that parenting skills and positive parent-child interactions show strong evidence of

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<sup>54</sup> The authors note that, "Efforts to jointly address violence against women and children have not been considered widely and, in some instances, the two have been regarded as opposing camps in competition with one another for funding and relevance." (p.3) At the same time, "Studies have found that when both mother and children are given adequate support, about half of the children exposed to violence at home were found to be "resilient" in functioning and coping, showing no evidence of Post-Traumatic Stress Disorder (PTSD)." (p.5)

helping to protect the wellbeing of children who are exposed to domestic violence;" and (d) "the ability of [children and adolescents to identify and] regulate their emotions is associated with improved outcomes" in multiple domains. Some of the protective factors that other research has indicated promotes resilience and enhances wellbeing are (i) parental competencies, (ii) parental or caregiver wellbeing, (iii) positive peers, (iv) children's and adolescents' skills (self-regulation, problem-solving and relationship skills) and characteristics (sense of purpose and sense of optimism)." (The authors note that positive school environment was also a protective factor, but is beyond the scope of most programs.)

[Lyon, Perilla, & Menard \(2016a\)](#) suggested the following possible outcome measures, indicating that the first two in each list may be most compatible with "interventions and supports that DV programs early in the process of program development can use with families, even when there has been limited contact:"

**Note:** The proposed metrics are designed to be helpful to both outreach and non-residential programs, as well as shelters and transitional housing (TH) programs. TH programs will have a more continuous opportunity to work with children and youth, and a longer term opportunity to observe changes in the status of parents and their children. The longer term of engagement likely means that programs will see improvements and setbacks as participants respond to the challenges they face.

***For parents/caretakers:***

- ***I have a better understanding of the impact that domestic abuse/violence can have on my children***
- ***I have more tools and information to plan for my children's safety***
- I have a better understanding of my child's developmental needs
- I feel more hopeful about my relationship with my children
- I feel more confident as a parent
- I feel better prepared to handle my concerns about my children
- I feel more supported as a parent
- I have a better understanding of the impact that domestic abuse/violence has had on my relationship
- with my children
- My children can express their feelings better
- I am more comfortable talking with my children about things that matter

***For children/adolescents (over age 8):***

- ***I know more ways to get help when I am scared or upset***
- ***I have a better understanding of the troubles in my family***
- I better understand that troubles in my family are not my fault
- I believe that adults care about me
- I believe that people at this program can help me and my mother
- My parent/caretaker(s) and I are more comfortable talking about things that matter
- I am better able to talk about my feelings
- I know more ways to calm down when I am upset
- I know more ways to resolve conflicts I may have with other people
- I have a better understanding of healthy relationships

- (E) [Evidence-Based Practices for Children Exposed to Violence: A Selection from Federal Databases](#) published by the U.S. Department of Justice and the U.S. Department of Health and Human Services. ([US DOJ/HHS, 2011](#)).

As described in the introductory page of the document, "This package of information summarizes findings and evidence from federal reviews of research studies and program evaluations to help

localities address childhood exposure to violence and improve outcomes for children, families, and communities. . . . Subject matter experts at the Department of Justice and the Department of Health and Human Services collaborated in preparing this information based on reviews of existing federal databases of evidence-based programs, [including] SAMHSAs National Registry of Evidence-Based Programs and Practices, SAMHSAs National Child Traumatic Stress Network, OJJDPs Model Programs Guide, and OJJDPs Children Exposed to Violence Evidence-Based Guide."

The matrix of approximately 50 interventions for children exposed to trauma provides an intervention description, and indicates the age range targeted, the outcome indicator (how success would be measured), the targeted improvement (e.g., greater resilience, reduced trauma symptoms, reduced incidence of problem behaviors), and the source of the information about the intervention.

(F) [\*\*VAWNet Special Collection: Enhanced Services to Children and Youth Exposed to Domestic Violence: Promising Practices & Lessons Learned.\*\*](#) (NRCDV, 2012).

The website provides lessons learned and related resources -- including manuals, protocols, and other tools -- developed by nine FVPSA-funded 3-year demonstration projects (in California, Colorado, Washington, D.C., Michigan, New York, Oklahoma, Oregon, Pennsylvania and Virginia) "to enhance services to children and youth who have been exposed to domestic violence." As described in the executive summary of the final report on the overall initiative, ***Enhanced Services to Children and Youth Exposed to Domestic Violence: Promising Practices Lessons Learned*** (Menard et al., 2012), the demonstration projects were funded to:

- "Develop and enhance assessment and intervention strategies for children and youth exposed to domestic violence and their parents;
- Train domestic violence program staff and community partners on the effects of being exposed to violence on children and youth and intervention strategies; and
- Develop or enhance community-based interventions specific to issues of domestic violence in order to meet the needs of children and youth impacted by such violence."

***(ii) Resources Describing Approaches for Supporting Parents (and Their Children)***

(A) National Center on Domestic Violence, Trauma and Mental Health: [\*\*Guide for Engaging & Supporting Parents Affected by Domestic Violence: Enhancing Parenting Capacity & Strengthening Parent-Child Bonds\*\*](#) - Blumenfeld (2015)

Given the fundamental importance of relationship-based support, this publication: (a) offers narrative guidance and perspectives useful to establishing a helping, empathic, and affirming relationship with parents who have experienced domestic violence; (b) helps the advocate think through what it means to offer strengths-based, trauma-informed, family-centered support to a parent who likely experienced the deep frustration of parenting amidst violence that she felt powerless to stop or protect her children from, felt sabotaged in her efforts to address her children's needs, and was perhaps humiliated in front of them; (c) and offers tips for sustaining a positive approach: for listening, being attuned to non-verbal cues, putting aside personal frustrations and judgments, sharing observations and being observant to how the survivor reacts, and initiating and engaging with a survivor in potentially difficult conversations.

Strategies discussed are (a) empathic inquiry, (b) mindful awareness and self-regulation; (c) being with the survivor, and helping them "hold and contain" strong feelings that may seem overwhelming or frightening; (d) engaging collaboratively with the parent in difficult conversations; (e) affirming and supporting and helping the parent strengthen her attunement and responsiveness to her children; and (f) helping her build her capacity for reflective parenting.

(B) National Center on Domestic Violence, Trauma and Mental Health: [Supporting Children, Parents, and Caregivers Impacted by DV webpage](#)

Resources listed on this page include the following:

- [Tips for Supporting Children and Youth Exposed to Domestic Violence: What You Might See and What You Can Do](#) (tips for staff)
- [Resources for Grounding, Emotional Regulation & Relaxation for Children and Their Parents](#) (Physical and creative activities)
- [Fingerhold Practice for Managing Emotions & Stress](#) and [Fingerhold Practice for Managing Emotions & Stress – Diagram](#) (tactile approaches to relieving trauma)

(C) National Child Traumatic Stress Network: [Resources for Parents and Caregivers webpage](#)

As described in the "Welcome" tab of the webpage, information provided (in language intended to be accessible to parents) includes the following:

- Definitions of trauma, traumatic events, and traumatic stress
- Answers to commonly asked questions about child traumatic stress
- Signs and symptoms of child traumatic stress
- Suggestions for ways to cope with child traumatic stress
- Advice on how and where to find help
- Information on evidence-based treatments (scientifically proven practices) that can assist families in helping children recover from child traumatic stress
- Links to resources to help children and families better understand what they are feeling when they (or someone close to them) has experienced a traumatic event
- Support to help children cope with their traumatic experiences

See also: National Child Traumatic Stress Network (2009) [Caring for Kids: What Parents Need to Know About Sexual Abuse](#) - from the webpage: "From dealing with the shock of disclosure to coping with the emotional impact of navigating the legal system, these resources will help you and your child move past the pain, and realize that it is possible to transcend trauma. In addition to helping you to recognize child sexual abuse and cope with its aftermath, this toolkit provides ... information on understanding sexual development in children and on how to talk to children about sexual issues and body safety, as well as information for teens on acquaintance rape and how to reduce their risk of victimization."

(D) Ann Jennings, Abt Associates. [Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services. An Update of the 2004 Report Draft](#). (Jennings, 2007)

This report, prepared for SAMHSA's Center for Mental Health Services and the National Association of State Mental Health Program Directors, describes close to 100 trauma-informed and trauma-specific treatment models (addressing various combinations of trauma, PTSD, mental illness, depression, and substance use and abuse) for adults, children, and children and caregivers. There are models for working in groups and individually, models for managing addiction, managing pain, trauma-informed parenting, dealing with grief, supporting empowerment, and more.

The model descriptions address the purpose and focus of the model, the population it is intended to serve, how it is delivered (approach, duration, etc.) and by whom it is intended to be delivered, available training and manualization, the status/outcome of any research that has been conducted on the efficacy of the model, and contact information as of the date of publication.

In addition to promoting a useful lay understanding of the treatment model, the report is valuable, too, for the historical perspective that Jennings has incorporated into her introductory sections, where she

explains the importance of addressing childhood, adolescent, and adult trauma, detailing the link between traumatic experiences and mental illness and substance abuse, and explaining how awareness of trauma and efforts to address it were absent from standard mental health and substance abuse treatment until the early 2000s, and how, over time, trauma-specific and trauma-informed care/services have gained increasing prominence as components of health and behavioral health care -- although, as documented in other materials cited in this report, much work remains on that front.

In introducing her report, Dr. Jennings explains,

*"All of the models described in this document are designed for persons receiving or at risk for receiving public mental health and/or substance abuse services who have been traumatized by interpersonal violence and abuse and other adverse experiences during their childhood and/or adolescence. Many of the models were designed specifically to address the kinds of complex traumatic stress issues and problems common in the lives of children and adults seen in public service sector settings today. These individuals often have severe and persistent mental health and/or substance abuse problems and are frequently the highest users of the system's most costly inpatient, crisis, and residential services." (p.10)*

Although as Jennings documents, a huge proportion of these children and adults have experienced childhood, adolescent, and adult trauma, their diagnoses and misdiagnoses historically were about mental illness or substance abuse, with little formal recognition about the trauma that may have caused or exacerbated their conditions.

*"The traumatic experiences of adults, adolescents and children with the most serious mental health problems are interpersonal in nature, intentional, prolonged and repeated, occur in childhood and adolescence, and may extend over years of a person's life. They include sexual abuse or incest, physical abuse, severe neglect, and serious emotional and psychological abuse. They may also include the witnessing of violence, repeated abandonments, and sudden and traumatic losses. They frequently include several different kinds of traumatic or adverse experiences resulting in cumulative traumas that have neurological impacts and lead to health risk behaviors or symptoms adopted as attempts to ease the pain. These in turn can result in severe sometimes chronic dysfunctions over the lifespan including disease, disability, and serious social and mental health problems. (Felitti, 1998, Jennings, 2006)." (p.11)*

*"Individuals with histories of violence, abuse, and neglect from childhood onward make up the majority of clients served by public mental health and substance abuse service systems:*

- *51-98% of public mental health clients with severe mental illness, including schizophrenia and bipolar disorder, have been exposed to childhood physical and/or sexual abuse. Most have multiple experiences of trauma. (Goodman et al, 1997, Mueser et al, 1998; Cusack et al, 2003)*
- *75% of women and men in substance abuse treatment report abuse and trauma histories (SAMHSA/CSAT, 2000)*
- *97% of homeless women with mental illness experienced severe physical and/or sexual abuse, 87% experienced this abuse both as children and as adults (Goodman, Dutton et al., 1997)*
- *Nearly 8 out of 10 female offenders with a mental illness reports having been physically or sexually abused (Smith, 1998)<sup>55</sup>*

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<sup>55</sup> The reference cited is Dr. Brenda Smith's "An End to Silence: Women Prisoners' Handbook on Identifying and Addressing Sexual Misconduct," published in 1998 by the National Women's Law Center, and no longer available online. The [3<sup>rd</sup> edition of that resource](#), published in 2014 by the [National PREA Resource Center](#), with grant funding from the U.S. Department of Justice, Bureau of Justice Assistance, was authored by staff from the [Project on Addressing Prison Rape](#) at the American University Washington College of Law, Brenda Smith, Director. PREA refers to the Prison Rape Elimination Act of 2003 and the [U.S. Department of Justice Standards promulgated in 2012](#).

- *93% of psychiatrically hospitalized adolescents had histories of physical and/or sexual and emotional trauma. 32% met criteria for PTSD. (Lipschitz et al, 1999)*
- *In Massachusetts, 82% of all children and adolescents in continuing care inpatient and intensive residential treatment have trauma histories. (NETI, 2003).*
- *Teenagers with alcohol and drug problems are 6 to 12 times more likely to have a history of being physically abused and 18 to 21 times more likely to have been sexually abused than those without alcohol and drug problems (Clark et al., 1997)*
- *Among juvenile girls identified by the courts as delinquent, more than 75% have been sexually abused. (Calhoun et al, 1993)*
- *[Yet,] 3 years of data from New York State Office of Mental Health showed that only 1 in 200 adult inpatients and only 1 in 10 child/adolescent inpatients carried either a primary or secondary diagnosis of PTSD. (NYS-OMH, 2001; Tucker, 2002)" (p.12)*

Although, of course, there is much greater understanding now of the importance of addressing trauma, the resources to accomplish that have not yet caught up with the need. And, as described in some of the other websites and documents listed in this section, there is still work to do in building our understanding of, and preparedness to address, the role of trauma in shaping the challenges that confront victims/survivors of domestic and sexual violence.

- (E) International Society for Traumatic Stress Studies: [\*\*\*Effective Treatments for PTSD \(Second Edition\): Practice Guidelines from the International Society for Traumatic Stress Studies\*\*\*](#). (2008). Edited by Edna B. Foa, Terence M. Keane, Matthew J. Friedman, and Judith A. Cohen. Guildford Press. New York ([Foa et al., 2008](#))

As described on the ISTSS website, ***Effective Treatments for PTSD*** provides treatment "guidelines based on an extensive review of the clinical and research literature prepared by experts in each field and intended to assist clinicians who provide treatment for adults, adolescents and children with PTSD. Because clinicians with diverse professional backgrounds provide mental health treatment for PTSD, the Guidelines were developed with interdisciplinary input. Psychologists, psychiatrists, social workers, creative arts therapists, marital therapists and others actively contributed to and participated in the development process. Accordingly, the guidelines are suitable for the diversity of clinicians who treat PTSD." According to the website, the ISTSS began a process of updating the guidelines in 2015. In the meantime, the following are current guidelines, some addressing trauma in adults, and some addressing trauma in children:

- [Guideline 1](#): Psychological Debriefing for Adults
- [Guideline 2](#): Acute Interventions for Children and Adolescents
- [Guideline 3](#): Early Cognitive-Behavioral Interventions for Adults
- [Guideline 4](#): Cognitive-Behavioral Therapy for Adults
- [Guideline 5](#): Cognitive-Behavioral Therapy for Children and Adolescents
- [Guideline 6](#): Psychopharmacotherapy for Adults
- [Guideline 7](#): Psychopharmacotherapy for Children and Adolescents
- [Guideline 8](#): Eye Movement Desensitization and Reprocessing
- [Guideline 9](#): Group Therapy
- [Guideline 10](#): School-Based Treatment for Children and Adolescents
- [Guideline 11](#): Psychodynamic Therapy for Adults
- [Guideline 12](#): Psychodynamic Therapy for Child Trauma
- [Guideline 13](#): Psychosocial Rehabilitation
- [Guideline 14](#): Hypnosis
- [Guideline 15](#): Couple and Family Therapy for Adults

- [Guideline 16](#): Creative Therapies for Adults
- [Guideline 17](#): Creative Arts Therapies for Children
- [Guideline 18](#): Treatment of PTSD and Comorbid Disorders

The webpage also contains a link to the [ISTSS Expert Consensus Guidelines for Complex PTSD in Adults](#), which were developed in 2011

- (F) Bigfoot, D.S. & Schmidt, S.R. (2010). [Honoring Children, Mending the Circle: Cultural Adaptation of Trauma-Focused Cognitive-Behavioral Therapy for American Indian and Alaska Native Children](#).

After briefly contextualizing the disproportionate experience of trauma and violence in Indian Country, and describing the resulting distrust and reluctance to seek mental health services using treatments that have not been designed or adequately adapted to reflect traditional practices that support healing and wellbeing, the authors introduce the Indian Country Child Trauma Center (ICCTC), a joint project of the National Child Traumatic Stress Network and the University of Oklahoma Health Sciences Center on Child Abuse and Neglect. The article explains how the ICCTC has adapted Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) to address the impact of trauma on American Indian and Alaska Native children who indicate an identification or desire to identify with their indigenous roots. The authors explain the choice of TF-CBT as a starting point:

*"CBT principles are complementary to many traditional tribal healing and cultural practices. American Indian and Alaska Native traditional teachings typically rely on thoughts, feelings, and behaviors, and the interplay between these domains. Moreover, TF-CBT is consistent with core components of American Indian and Alaska Native traditional teaching and beliefs, such as the centrality of support provided by caregivers and family, attending to and listening to children, telling about experiences (e.g., through storytelling or ceremony), the relationships among emotions, beliefs and behaviors, and identifying and expressing emotions."*

The article explains the nature of some of the adaptations that went into the creation of Honoring Children - Mending the Circle (HC-MC), and how the approach remains flexible enough to accommodate the cultural differences among the over-650 federally recognized tribes and native villages, provides a case illustration, and indicates that refinement of treatment, training, and supervision/consultation support for HC-MC are ongoing.

#### **(d) Overview of Provider Efforts to Assess and Address Children's Trauma-Related Needs**

The [annual OVW solicitation for TH grant proposals](#) clearly states that,

*"Applicants may not use grant funds to provide direct services to children, including children who witness domestic violence or are survivors of child abuse, except where such services are an ancillary part of providing services to the child's parent who is a victim of sexual assault, domestic violence, dating violence or stalking, such as providing child care services while the victim receives services."* (p.10)

Thus, only TH providers with other sources of funding or the ability to leverage services from otherwise-funded in-house staff (or community-based providers) can provide or leverage direct services for children.

Quite a few providers interviewed for this project did not have such resources. Some providers have child-focused staff connected to their shelter, who are able to continue to make their services available when families move on to the transitional program, and that continuity can be very helpful. Other programs, including many that operate scattered-site TH programs, indicated that once a family leaves the shelter, program staff rarely see the children, especially when the logistics of travel are challenging.

In our interviews with providers that might have been able to offer or leverage services for children, there were two nearly universally shared perspectives: (a) that parents are the gatekeepers when it comes to

services for their children; and whether or not staff believe that a child needs or could benefit from services, the parent is the final decision-maker; and (b) that parents typically want what's best for their children, and are often willing to accept services for their children before they accept services for themselves.

The majority of providers we interviewed indicated that their programs do not conduct formal child assessments or use specific tools to assess for the impact of trauma on children and youth. These programs rely on staff observation or concerns raised by parents to identify children who may have more significant needs. Some staff explained that children of families that came from their agency's shelter (or another shelter) would have already been assessed by child-focused staff at that shelter, and could continue to participate in any specialized services that they were already enrolled in, as long as logistics allowed.

Many providers stated that they were only able to offer child care or children's activities while parents are in meetings, and rely on the school system for specialized supports. Nearly every program cited their good relationship with school personnel, either the McKinney Liaison or other staff. Some providers noted that local preschool or Head Start programs can assess for and address special needs, if requested. A few providers mentioned referring infants/toddlers for Early Intervention.

Pretty much every provider indicated that their TH program offers "DV 101" to adult participants, to enhance understanding of domestic violence and its impacts. In some interviews, staff specifically mentioned providing information about children's developmental stages, and how "normal" development might be impacted by exposure to trauma. With that information, they told us, parents could draw their own informed conclusions about whether their child needs services. A few staff noted that parents who feel overwhelmed by their other challenges may not be emotionally ready to accept the reality that their child has developmental needs that could be related to the violence they fled.

A number of providers reported that parents believe that their children were not impacted by, or were largely unaware of, the violence that took place between the program participant and her abusive partner. A couple of providers with more extensive in-house children's services noted that children often demonstrate greater awareness of that violence (e.g., through conversations or play or artwork) than their parents realized.

Several providers with in-house clinical capacity or children's services indicated that they take steps to nurture a trusting relationship between the parent and their children's services provider, to facilitate any necessary discussions about behaviors that may indicate a problem that would benefit from specialized attention. One provider mentioned their effort to "normalize" the idea that children have been effected by trauma, just as their parents have, so that parents will not feel guilty or ashamed if their child has a trauma-related condition.

Several staff mentioned that some parents are reluctant to refer children for off-site mental health services, out of concern that the child will be labeled with a diagnosis that creates a long term stigma; a few providers with in-house clinical staff noted that because those in-house positions are grant-funded, they don't have to bill insurance or Medicaid for services, and therefore do not need to specify a diagnosis. Travel logistics, waitlists, and/or insurance requirements can also be a barrier to follow-through for some children's services.

A few staff in programs operated by agencies that offer more substantial on-site child services, including therapeutic daycare or clinical child services described their ability to do in-house assessments and developmental screening and to offer interventions like art therapy, play therapy, Cognitive Behavioral Therapy (CBT) for children and youth, Trauma-Focused Cognitive Behavioral Therapy, or specialized interventions such as the Families of Tradition program for Native children and the [Darkness to Light](#), addressing child sexual abuse.

A few such staff reported incorporating formal measures as part of their child assessment process. Tools mentioned during interviews with providers included a brief trauma screen, the Trauma Symptom Checklist for Young Children, the Trauma Symptom Checklist for Children, a tool called the Child and Adolescent Behavior Assessment, and a trauma experiences questionnaire developed by a local mental health partner.

**Recommendation:** Given all that is known about the potential adverse impacts of early childhood exposure to violence and trauma, and about the benefit of addressing that trauma as soon as possible, it seems unduly risky to wait -- as a number of program staff told us they do -- until a child enters kindergarten, so that the local school department can assess for developmental delays or other effects of that exposure to violence. In fact, not all school departments have the resources to identify and appropriately respond to such needs; and if staff there believe that a child in a TH program will only be in their district for a few months, assessing and developing an IEP ([Individualized Education Program](#)) for that child may not be their highest priority.

Perhaps the OVW could explore, in cooperation with the Family and Youth Services Bureau of the US Department of Health and Human Services, sponsoring staff training on strategies for appropriately engaging parents of pre-school-age children in discussions about the potential impacts of untreated trauma and about the options and potential benefits and drawbacks to the parent requesting a child assessment through the local [Medicaid Early and Periodic Screening, Diagnostic and Treatment \(EPSDT\) program](#), or through the local [Early Intervention, Early Head Start](#), or [Head Start](#) programs, depending on the child's age and access to such programs. With [income eligibility for Medicaid/CHIP coverage](#) ranging (depending on the State) from 140% to over 300% of the federal poverty limit (FPL), many, if not most of the children of TH program participants are likely to be eligible.

Few of the providers we interviewed described any staff involvement in the process of developing an IEP for a school-aged child. More often, providers told us that they leave that to the parent to work out with the school. A number of providers told us about parents that are apprehensive about stigmatizing their children by requesting special education services. Given how advocating for their child could be extremely intimidating for a parent in a TH program (as it is for many mainstream parents), and given that parents who are unfamiliar with special education may not have enough data to make an informed choice about whether or not to pursue an IEP for their child, it may be helpful for the OVW to sponsor provider staff training about IEPs: why they may be helpful, how they are developed and monitored, how to minimize any stigma, and how to discuss the topic with parents. It may also be helpful to assure staff that supporting a parent in navigating the process of advocating with the school on behalf of their child is not a violation of the OVW's limitations on providing services for children.

A number of providers spoke about providing safety planning for the children, especially with older children; depending on the age of the children, staff may meet separately with each child in addition to meeting jointly with the parents, or they may do safety planning only as a joint parent/child activity.

Several providers spoke about the value of services for the parent and child together, based on the importance of the parent-child bond. Interventions mentioned that address the parent-child relationship included Child-Parent Psychotherapy (CPP), Preschool PTSD Treatment, Trauma-Focused Cognitive Behavioral Therapy and Parent Child Interaction Therapy (PCIT). There were only a small handful of programs that offer this level of service.

Programs with access to child advocates or clinicians clearly receive other funding. A number of the providers whose programs depend on the OVW transitional housing grant noted that the focus on adults in transitional housing programs limits the options for providing child services, and questioned whether child services were allowed. With only that very limited funding, even if they were allowed to use the grant to pay for children's services, they simply wouldn't have enough money to cover their housing-related costs and a case manager.

Several providers stated that they wished they could afford to hire child-focused staff (or additional child-focused staff, in the case of a few agencies that already had some in-house capacity). One provider noted that programs that serve families have more children than adults in the program.

#### **(e) Provider Comments about Efforts to Assess and Address Children's Trauma-Related Needs**

***Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.***

(#01) Our children's services are available to anybody experiencing domestic violence, even if they haven't

ever been in shelter or transitional housing, even if they are still living with the abuser. We refer to the children as child witnesses. There's education about healthy relationships to children exposed to DV whether they've been abused or witnessed the abuse in their homes. We talk about what a healthy relationship would look like, we do safety planning with the kids, because they can't control whether or not they are going to go back into that abusive relationship. We talk about how they can handle it, how can they keep themselves safe, and who they can talk to.

Usually if there's something affecting their performance in school, it's assessed by the school. Occasionally, but not often, we have been invited to participate in the discussion about IEPs for kids at school. Most of our involvement with the McKinney Liaison is about transportation between the school and the shelter.

If we see something we think parents might want to address, we inform them and offer to refer them to a community resource that's better suited to addressing the issue, like the schools, or Head Start, if it's a young child, or a local children's counseling organization. Usually parents want the help for their children, so we do the referral with the parent, not separate from the parent. And they disclose what they want to disclose, so there's no confidentiality issue. We just provide education about the resources and support and help in linking parents to the resources; we're not mental health providers, and we don't provide mental health counseling to victims or witnesses of violence.

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(#02) We have a strong relationship with a regional non-profit that serves as a one-stop center for addressing incidents of sexual assault, so a child only has to tell their story once, because all the people who need to be at the table -- district attorney, police, etc. -- are there and can observe the assessment.

In our program we have three Child Trauma Clinicians who provide the ongoing care. While shelter is not the best environment for children -- and can even be traumatizing for some children -- for some children, being in the shelter can be the first time they've felt safe, not had chaos, had someone to tell their story to, had three meals and gotten to school on time. In our program, being in shelter is the first time that many of these children have had an assessment and treatment; it is a safe place, where they are listened to and free from violence. Children for whom shelter has been that kind of safe place may be sad or fearful to leave shelter; transitional housing allows us to continue to provide case management for the parent and children, and to make sure that the transition for the child is as good as it can be.

Our staff provide counseling onsite; we only refer a child for off-site services if there is a huge waiting list; children in shelter get high priority, and are never referred out. They can get as much follow-up as needed, and we also continue to work with the parents. All of the services that are available to children in our shelter continue to be available to families in our transitional housing. In fact, these services are open to families in the community, as well.

Our shelter advocates work very closely with the schools. We have a really good relationship with the school-based adjustment counselors, and with non-profits that can supplement our services. We work with the YWCA and local summer camps to ensure that every child goes to camp, with scholarships, or using a family fund that we have. For many children, it's the first time that they've gone to camp. Again, all of these services are available both to children in shelter and in our transitional housing.

We are the only East Coast program with a [Window Between Worlds](#) program (an art therapy program for victims of violence) in English, in Spanish, and for children. We sent our staff, including the child advocate, to a week-long training in order to offer the program. Unfortunately, our funding was cut which may mean that we don't have a child advocate available for the same number of hours. We lost that child advocate because we can't compete with the pay and benefits offered by a state agency. We'll try to find replacement funding, because we believe that spending money on helping children now saves money and prevents problems later.

You have to make sure that professionals who are experts in child trauma are available to interview the children immediately upon their arrival in shelter or entry into a program. Children are traumatized at all

different levels. Parents don't always understand their children's trauma. The statistics tell us that parents think that children only know what's going on 20% of the time in a household where domestic violence is occurring, whereas children tell us that they know what's going on 80% of the time. Programs need to make sure the children get assessed as soon as they get into the program, and then get the counseling they need.

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(#03) We don't assess participants' children for developmental delays or the impact of trauma. If the need for an assessment is identified in the shelter or by the parent, we help make a referral to counselors in the community. We make referrals to and work together with one of the local hospitals that has a healing and trauma unit with counselors that specialize in trauma and children's issues. It's the shelter identifying the needs, or the parents saying, this is what I'm seeing; can you assist?

We work with the school -- regular staff, McKinney Liaison, or special needs program -- when asked by the parent. We don't want to overstep our boundaries with the parents. We encourage parents to do it on their own, and if they need help, we step in. In two cases, abusers have found a woman through the schools. There's a way you can work with the schools where it's kept confidential. That's an issue -- that abusers can find the women through the school.

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(#04) Implementing the family case management model with a single direct service staff person is a real challenge. I wear many hats -- it's just me providing therapy, case management, life skills, etc. Ideally there'd be a separate provider to do activities, a group, and counseling for the children, and someone else for adults.

Typically, when a mom comes in she's been referred through our outreach program or shelter, so they've been through the initial assessments, one with the mom, one with the children, and initial safety plan. When they come to me, I do an intake, an assessment with mom, and I meet with the children and do assessments with them plus another safety plan. We meet as a family to safety plan for their new apartment and for any child visitation with the other parent/abuser.

We've had quite a few families struggling with developmental delays. One mom had two young girls diagnosed with autism, so we helped link her with services in the county for speech and occupational therapy, and helped with the SSI application. They were accepted for Habitat for Humanity and the kids are doing great, so that was a success. Currently we have a family with a three year old with some delays, so I've recommended an assessment through a local children's behavioral health program that provides free screenings, clinical assessments, Early Intervention services, and system navigation support to parents of children with behavioral and mental health issues. It's basically working with other agencies and the school to get kids the services they need. We have a good relationship with the homeless liaison in our school district, and we talk with her every time we get a new family, so she knows who the kids are and can provide the resources they need at school. We coordinate transportation with our school district. We also provide some direct assistance for after school programs, if needed. If they're getting therapy services through school or another agency we'll leave it, and I'll focus on DV-related matters with them, but if they need more trauma-focused therapy I'll provide it.

We encourage parents to be as involved as possible with the school. If we identify that their kids have issues with attendance and grades we'll talk to mom about options, causes, solutions, and help her advocate for her kids, attend a parent-teacher conference. We offer support with homework, and we try to model behavior for parents. Our agency also has a program that works with young boys to try to ensure that they don't perpetuate the kind of violence they witnessed.

To ensure that the family's confidentiality is respected, we require that parents sign a release at the beginning indicating who we have permission to discuss their situation with. For example, if mom identifies school transportation as an issue, we'd have to get her permission to talk to liaison. We have a strong relationship with the liaison, but I can't give names without permission, so we're as confidential as any other DV program.

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(#05) Maybe the school contacts us to say that, "Johnny is having difficulties, and we understand that he lives in your apartment complex; can you have one of your Connectors meet with him and his family to see about addressing his needs." Our apartment complexes house all kinds of families, so Johnny's family might be in the transitional housing program, or might have kept their apartment after completing our program, or might just be a non-program tenant. Some of our staff are housed in the complex and offer site-based services; because they are housed there, they develop relationships with the families. We have other service providers that we partner with. Because they know we're in these complexes, if they're working with someone that happens to live there or close by, there's a reciprocal referral process.

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(#06) We have an intern – she's actually a veteran social worker working on her specialist certification for play therapy, and she comes in and works with some of the children. While the work that she does is great, what we find is better is when we have a person designated to engage with the entire family, because they can address the family dynamic, not just what's going on with the child. Working with a child will provide minimal, short-term benefits, but for sustained, long-term success, you have to engage the entire family unit.

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(#07) We had a child in the program who identified as LGBTQ and who was struggling in school with bullying. I worked with mom to find local resources, and connected him with an LGBTQ group at the college.

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(#08) My primary focus is keeping the kid safe and allowing them to have as normal a childhood as possible. There's not just one single aspect of a child's well-being that a program needs to address. We try to provide wraparound services. We have children's groups at the same time that the women's group has its meetings. We know enough providers in the community so we can talk to that mom and make appropriate suggestions for services and about activities that are available for kids. If there's a referral, the mother can come here to make the connection with them while we're sitting with her, so she doesn't feel alone. We do one-on-one personal contacts, supporting them with whatever they need.

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(#09) I've noticed that a lot of our participants' children seem to have speech delays; they're three years and still not very verbal. Quite a few have had behavior issues once they've moved into stable housing, and the moms don't know how to handle it. Maybe because they feel safe enough to express themselves. They know life isn't going back to how they thought it would be. When we see something like that, we refer the child to our agency's children's program or to other community resources, because staff funded under our OVV transitional housing grant are not supposed to provide direct service to children. If the referral doesn't need to come directly from us, if the mom just needs to call the provider, I give them the info and follow up with them to see if they've done it. I empower the mom to make the kid's appointment herself.

The problem is sometimes with participant follow-up. The Health Department has a waiting list that is months long. One client had transportation issues. The doctor wanted an 8AM appointment, but the bus didn't run until 9AM. Some providers don't understand that not everyone has reliable transportation. As far as school-related issues go, the homeless liaison is familiar with our transitional program and emergency shelter. We've worked with him for a long time; he's a good advocate for us in school system. We've never been involved in developing an IEP for a child with special needs.

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(#10) In a years' time, our shelter and transitional program see far more children than adults. So we have MOUs with counselors that specifically focus on children. We have a very strong working relationship with the public schools -- the Title 1 program -- that can provide services to our school-age children. We have an MOU

with a local community mental health center that operates a lot of afterschool programs. Our children's program is just as strong as our adult services. Our transitional case manager is a licensed social worker.

Ultimately, participation in services is voluntary. If staff observe that a child appears to have a need that could benefit from services, and if the parent hasn't already raised the issue, the case manager will certainly bring it up and offer information and some possible options. But it's up to the client. Or our case manager may see something that, as a parent herself, she may not agree with. But it's the client who's raising her children, and not our staff person. If our case manager believes that resources or a referral would benefit the children, the only thing she can do is present the information in a way that the client will be receptive.

If, for example, a parent had a child with special needs, and we knew that Early Intervention or that a pre-K class would be very helpful with that child, but Mom said, "No, I don't want it," then we can't make her accept the referral. We would certainly encourage her. But if she's not putting her child in danger, then we have to back off and that's Mom's decision. But we haven't had a case like that.

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(#11) We don't do any child-specific assessments. We do have a child advocate in our shelters, but her primary responsibilities are really more around providing respite to mom. She will do an intake with moms, but it's more about, "Tell us about your kids and what we need to know while we help watch them." And we do everything we can to give mom a break and some time off to get stronger so that she can step back in.

So those really aren't assessments. We do have, in our shelters, children's therapists that come in and meet with moms and meet with kids; they're catching things that really need to be addressed. And then those services are always in place for any of our transitional housing participants, as well, if they haven't already gotten that started when they were in shelter. Therapy for kids who've experienced domestic violence is free here, so we're able to engage a lot of our women.

While the family is in shelter, our program works with the McKinney Vento liaison at the local school to ensure that the needs of school-age children are being addressed; but once they go into the transitional program, they are considered residents of whatever town they're in, and we no longer work with the liaison.

Staff provide women with as much information as possible. Every resource we find, we share. Our transitional coordinator is always bringing the women fliers about programs and free events. And then it's up to the women what they want to participate in. We try to help with transportation to make sure they can get places they would like to go. Transportation can be the biggest barrier. We live in a really rural area; there are some central towns where there's a bus system and transportation is not a big deal. But once you hit the southern county, the bus system is not much use for anything; it takes two hours to cover a 20 minute distance.

Another obstacle is faced by women with multiple children. If you have four children of varying ages, it's really hard to find programming for all of them. Or you have a neat program for two kids, but not for the other two; it's a lot to juggle. And you're not going to take a long ride on a bus with four children to go do something for an hour. It's just exhausting.

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(#12) We have a youth advocate, a youth coordinator, and a play therapist on staff. The youth advocate does the children's assessment with parental permission. They also go on the home visits. (Our program advocate does the assessment on the adults.) We work very closely with the school's Title X McKinney program, which serves homeless children. However, we don't play a role in IEPs for children having trouble in school. That's between the parent and the school. We can -- through another grant -- pay for school physicals, tutoring, eyeglasses, and speech therapy. Our youth department is very much on top of things in the community for youth. And we make sure we hand out flyers to the parents, so they know about those things.

The waiting list for subsidized childcare is another barrier, but we have another grant that enables us to pay for emergency childcare services for any of our transitional housing participants or shelter residents. We've

built a relationship with children's services, so that they try and move the kids up the list – if it's a shelter referral. But we haven't been able to do that with other childcare centers.

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(#13) Children's services are an integral part of our family support services. When a family gets on our wait list for transitional or permanent housing, they get assessed as to what the family might need; a case manager and clinician work as a team with the families to make sure that the child's needs are taken care of in the classroom as well as at home. They do that with all the homeless families we serve, whether there's been domestic violence or not. And if they're working with a family with school-age children, they visit the school and work with the McKinney Liaison. We have great relationships with some of the public schools; in fact, our clinicians run groups for children in the schools.

Our agency operates an accredited children's center serving infants, toddlers, pre-school-age children, and school-age children up to age 12 from homeless families. Staff at the center provide early education care; before- and after-school care; summer camp; nutritional services (breakfast, lunch, and snacks); and clinical services, including developmental screenings, mental health services, and referral of children with special needs to county programs. We understand that homelessness influences all aspects of child development, and that the stress of transition can impact academic performance as well as social competence; so our children's center works to provide a safe, stable environment for children to develop the skills necessary to succeed in school and with their peers.

If a parent indicates that they are not interested in connecting their child with the kinds of resources our staff believe they need, we let them know we're not going anywhere. We try to show that we really care about the children. If we need to, we make a referral to CPS. There's not just one way to approach it. Each situation is different.

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(#14) If I were to see that a child needs some type of assistance, I'd let the counselor know so it could be brought up with mom, so she could make a referral to whatever program she felt was suitable for the child. Most of the children have had medical care; it's usually the moms that haven't been seen by a doctor in a while. I think they don't see it as much of a priority, but when it comes to the children, the doctors are probably pushing them more about making appointments. Usually in order for the kids to go to school, they need to have checkups and their immunization records up to date.

Pre-school-age children who need specialized services are usually already are connected to services by the time they get to our transitional program. For example, we served a family with a very small child who wasn't speaking and another family with an 8 year old child who had behavior issues, but they were already receiving services from outside agencies. The school district is pretty good about doing IEPs, independent education plans; when the children register, the school completes a very lengthy questionnaire that really helps them determine if the child needed extra assistance. I don't really get involved in special education matters, unless someone wants me to work with the child, maybe using materials they have from the school or reading with the child once a week for an hour or something. I'm more than willing.

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(#15) We don't have a child advocate. We do have a children's group that operates at the same time as our women's groups do, and sometimes things come out there, but we do not have funds for a child advocate. We provide childcare for the children, and sometimes things come up there, but we don't have funds for a child advocate who can do assessments. If we identify any issues, we can connect the families to the school system, where they assess for special needs, the preschool, where they do their own mandated developmental testing, or the non-profit that administers the Early Intervention program, which does home visits, offers parenting classes, and provides caregiver respite for parents with developmentally disabled children. That agency has been a real valuable partner, because they have several different resources that our

participants can tap into, including assistance with childcare costs. And of course, we also have Head Start for schooling issues. For pre-teen/teenage children, there are a handful of very good programs that offer counseling, mentoring, etc.

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(#16) Often, when children come to shelter, they haven't felt safe in their home. So they act out a bit at the shelter because they're finally feeling comfortable, and so, we'll access services from there, whether it be counseling or art therapy, or getting the child enrolled in a daycare program, whatever the child may need. By observing the child in the shelter, we get a sense of what they will need as their family moves into the transitional program. So it's a natural progression for our child advocate to continue to work with the kids in the transitional, acting as a middle person to help the child and mom get what they need. Our child advocate networks with a lot of organizations, so she is the point person for referrals and resources. She works hand-in-hand with the McKinney liaison; she's very sensitive to the needs of our clients and busing and everything else. Having a child advocate who works specifically with the kids in the shelter and the transitional program makes a difference in the services the kids get.

When we started, we just had the shelter and we didn't have a child advocate; so there was no one there specifically for the kids. I think it's really important to have someone specifically for the children. We say it's the kids' case manager, but the kids don't know that. They just see her and they're happy it's playtime, -- she's really great with kids -- and they're able to talk to her. I think it's critical to give kids the opportunity to say what's on their mind because there's a lot going on with them too and just witnessing the abuse was very difficult for a child, so it's good to have someone neutral they feel they can talk to, and who can act as a middle person for the mom if they have something really important they need to say but are afraid to say it -- to work with the advocate to say how are we going to tell mom this?

If the child advocate felt that a child needed something, they would meet as a team with the case manager and the mom to talk about what's best for the child and the available options. Sometimes, the mom may not follow through on some of the referrals, and an issue isn't resolved. But depending on the situation, it's up to the mom to follow through. We can only encourage, unless of course there's abuse, and then we're mandated to report it. Otherwise, and I know that staff struggle with this, the mom gets to make those decisions. All we can do is hope she takes the advice we offer.

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(#17) I definitely think it's important for a program that serves families to have a separate staff that focuses on the children. Sometimes, in focusing on the adult victim and what they dealt with, I think we miss how the DV affects the children. The emotional effects of DV are, I think, just as great as the physical. Even if a child has been in a situation where they witnessed domestic violence, but weren't physically involved. I believe that when women are in situations where they are the victim, it can greatly affect what happens in the household.

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(#18) The majority of services that children receive are through referrals to our community partners. For children five years of age or less, there are programs available that can provide free counseling, assessment, and therapy. We make the connection and the referral, and the agency that's going to provide those services assesses the eligibility of the client. If the child is five years of age or older, we refer them to a different counseling service that has the funding to serve those particular clients for free, for the most part. We mention the resource to the mom and strongly suggest that the child be assessed by a therapist; that's part of the mom's case plan: it's up to her whether to follow through.

If we observe behavioral issues that we associate with witnessing domestic violence, we'll have a therapist come to the transitional shelter. If the mom doesn't want to get the child into therapy, we'll have a therapist come and spend one-on-one time with her and/or the child and provide services that way. Ultimately, though, it's the mom's decision.

(#19) All the families that go to the supportive housing program first stay in our safe house, the emergency shelter for survivors. While there, especially if the child displays some unusual behaviors, we can connect them with a behavioral health services provider or the Early Intervention program, where their trauma-related symptoms can be identified and begin to be addressed. Once the family has transitioned to more stable housing, we can implement a more long-term plan. We have an in-house program through which licensed creative art therapists meet regularly over a six-month period with the mom and children to try to reduce the children's trauma symptoms. We also have in-house therapists and can make referrals to community partners to continue services.

We have an assessment tool that we use, but it is informed by the mom's concerns and her reporting. We use a strength based intervention to try to address all of the mom's concerns. If we have other concerns, we can talk to the mom about them. But ultimately it's her decision to seek services or not, unless there is a reportable matter. As an example, we served one family in which the mom was concerned about the behaviors of one of her children, and she was looking for help. The creative art therapist confirmed that the child was displaying trauma symptoms from the domestic violence.

I haven't really encountered an occasion where a mom doesn't want services for her child once a recommendation has been made by the case manager or by one of the art therapists or by a clinical supervisor. In fact, it's the opposite. But we really give them their own time. When they first come into the Safe House, that might not be the first thing they're worried about; they may have just gotten a restraining order, or they're worried about custody, or they just left their home. We try to work with their immediate needs and give them time. If we do make a recommendation, for example, if we see that a child is having a hard time eating or sleeping and we explain our concerns to mom, we would ultimately let mom make the decision about services, unless this is a duty-to-report type of situation.

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(#20) We do assessments of the children as part of the intake process, and continue to reassess the needs as they continue throughout the program. It's the same for below school age and school age children for us because we do it on a case-by-case basis. The majority of children receiving counseling in our transitional program are school-aged, but we do have some below-school-age children who are who are also receiving counseling. As part of the intake process we have our children's counselor meet with the children to get to know them and to find out exactly what their needs are. And we work closely with the mother to get her understanding of their needs. That way, we can support the children individually and as a family unit, as well.

We don't provide therapy on site, but we do provide counseling, particularly focusing on the impact of trauma and witnessing violence. If, in collaboration with the mother, we assess that it would be necessary or helpful for a child to receive outside therapy or Early Intervention services, we refer them for more in depth support. If staff see a behavior that the parent doesn't see -- whether because the parent doesn't know what's developmentally appropriate, or because she just wants to believe that her child is thriving -- our clinical director (who is a Licensed Marriage and Family Therapist) can guide the parent in their understanding of whether or not the behavior is developmentally appropriate.

We really want to support the mothers, but we sometimes may see signs that the children need extra support, and that may go against what we see the mothers doing. So trying for balance and to be an advocate for the whole family, and not just the mother or just the children is a challenge.

But it's ultimately the parent's decision. We had a child who was dissociative, and the mother felt very strongly that the child was really well adjusted, and everything was going well. So we sat down with her and said, "We've noticed these behaviors, and it's a bit concerning to us and would you like therapy referrals?" Again, it was the mom's decision. Having worked with families for a long time, we've seen that if a parent isn't supportive of the child going to therapy, it's hard for the therapy to be successful. So we work with the parent

to help raise their consciousness about how the child is being affected. Sometimes it's helping the parent work through their guilt about what the child was exposed to.

If staff believe that a child's experience of violence has contributed to some developmental or educational delay, so that the child might benefit from an IEP, we get our clinical director's feedback and her help with how to talk with the parent about it. And again it really is driven by whether the parent wants that support or not. Our children's counselor is able to accompany the parent to the child's IEP meeting and provide support and advocacy, but it's always based on whether the parent is open to that. Our involvement is always guided by whether it's something they want or don't want.

We would have liked to use OVW money to hire a children's therapist so that we could actually do more for children with significant needs, to fully assess their needs, and provide that additional comprehensive support. But the OVW transitional housing grant only funds adult-focused services, so we couldn't pay for a children's therapist. I think our approach is working out well, but of course we could always use more staff to provide even better services. For example, one of the challenges we experience is that external counseling and therapy agencies are often backed up, so even if we make a referral, it can take up to two or three months for a child to begin counseling or therapy with them. We work on having good relationships with them, and sometimes that does help to expedite things.

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(#21) All families in the transitional housing program have access to the licensed daycare program which is based at our emergency shelter. We have children's therapist, who can do child and mother-child therapy with the families if they are interested in that. With parental permission, the program staff or the children's therapist or the daycare staff will do an assessment of a child and then recommend services and referrals. We created a partnership with Health Care for the Homeless, which provides an on-site pediatric nurse practitioner a couple of times a week. If the women feel wary about talking to us -- because they associate social workers with Child Protective Services -- they may be more willing to talk to a medical professional about their concerns, and then we can get them connected through that clinic. We get a 99% agreement rate to assess the children, because most of them tend to focus concerns on the child and may not realize that it may be an issue with the family or related to the trauma that they've experienced.

Because a lot of the families have come from the emergency shelter, by the time they're in the transitional program, they've already been connected to the local school system's McKinney liaison, and have either gotten transportation to their home school or been transferred to a new school. Once they're in school, the children's therapist and/or the service coordinator advocates as issues come up and as needed, to help the parent navigate the school system and get the services they need. Our licensed daycare also operates a developmental preschool program, and we encourage the women in shelter to drop their kids off in that program while they conduct their business, giving the staff an opportunity to assess the children's skills and notice if there are any developmental issues that need to be addressed. Most of the women are very open to getting services for their children. The ones that aren't, we spend a lot of time educating and explaining that, "we're not trying to label your child; we just want to make sure they get the services they need," tying it back to the trauma, giving them some developmental information and strategies to help with their expectations.

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(#22) While survivors are in our support groups, we provide child care. If the children are zero to five, their activities involve a lot of interacting and playing and learning how to play with others. With the older children, we also work on safety planning and healing, and they can work with advocates, for example, if they're having problems in school. If it's the child's birthday, we have a resource that helps provide the cake and the gifts.

Most of our families come from our shelter and have already been engaged in the children's program. Once they go into the transitional housing program, the children can still engage with the children's program. There's also a licensed therapist that can work at no charge with the family or individually with head of household or with the children.

(#23) We could really use more staff to work with the children, even though we have a good number of staff working with the transitional housing. We have 130 children on the property now, and I have only one part-time child advocate. I'd say that the number one challenge for this program is more staff to work with the children. Every mom here has an advocate. The children do have some resources, but what we see is that you can provide therapy to the children, but if you're not working with that family unit -- mom and the child and how they interact -- you're not really meeting that holistic need. We want to implement more services as far as the parent-child interaction and how they work together as a family and how they communicate.

The person who does the children's program is also the one doing the overall family intake, so during that intake process, he not only assesses the applicant's needs, but also each family member's needs, so we can put services in place to address those needs. With children under age five, our assessment is conversational. For the children over the age of five, we use a tool called the Child and Adolescent Behavior Assessment that is programmed into Alice. With this assessment, he first asks mom the questions to hear her perspectives, and then he meets with the children and they answer the same questions, so he gets both perspectives.

If there's an issue related to a school-age child's education, we reach out to the McKinney liaison. Although our shelter uses the liaison more than our transitional housing, we have certainly utilized him a couple of times. We see our role as talking with the parents about their children's needs. If a mom identifies that a child is having any needs in school that are not being addressed, our advocates will assist mom in going to school and talking about, "Is an IEP an option? Is there an assessment option?" We're very fortunate that the school seems to identify that as early as we do. If the school develops the IEP and there aren't any problems, then we don't get involved. If there's not an IEP being developed or even talked about in school, then we will go in as an advocate and support mom in having those conversations.

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(#24) We don't provide direct service to children, but we've been able to outsource to different community partners, child therapists, and make referrals for parents struggling with some of those issues. We also work with Title I school services, which pretty much takes care of the transportation needs for children attending public school. Assessment is one of the things we outsource to other providers. If we recognize a behavior, we'll share our concerns with the parents and offer support, tell them about services that are available, and ask if they would like help in accessing those services.

So far, that approach has been well received, because it's non-judgmental, and not pointing a finger; it's just saying, "We're noticing these things that may need additional support; would you like that support?" We can assist them with bus tokens to get to and from appointments, and we've even transported and accompanied them, to make sure the transition to another provider is done in a way that the survivor feels supported.

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(#25) In addition to participating in case management, oftentimes parents participate in counseling services, and at times, their children join the sessions. It's up to the parent whether to participate and whether to incorporate the children in the therapy. Our agency has a substance abuse program and a huge mental health program, and children from the transitional housing program can also participate in other groups led by our counselors. Assessments of the children are not a routine matter; they are only done on an as needed basis, and as decided by the parent.

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(#26) Assistance starts when the family is in the shelter. The shelter-based counselor will assess mom, will offer mom one-on-one counseling, and at mom's request, and with our encouragement, will also assess the children and offer the children one-on-one counseling, and/or joint sessions for mom and kids. Especially when the kids are older -- say 10 to 13 years old -- there's a lot of things they need to say to each other that they need somebody there to facilitate. So they'll do individual sessions for the children. And just like the rest

of our services, once we've assisted someone in their transition to housing, as long as they're living in our catchment area, their child is still eligible for individual counseling sessions through our program. We also assist with enrolling children into school, as do all shelters. We also make sure that moms and children have access to medical care. We have partnerships with a couple of local doctors in our local hospital to make sure that if a child hasn't had a physical, or they're behind on their shots, they can get that all taken care of, so that's one less thing they have to worry about when they're out on their own.

Often, when children come into the shelter, they already have an IEP. And if that's the case, we work with the school to make sure the child is getting the services they're supposed to get. We haven't had a lot of problems with parents who don't want counselors to speak to their children; we find it's the other way around: many parents, once they're in shelter and see the assistance we can offer, want more services as opposed to fewer.

Many of our parents might have an open child protective services (CPS) case, and that's a very frightening thing for a parent. Often, if there's a CPS case open, it's because the child was present during an incident of domestic violence. So the child advocate will help them navigate and support them through that service. It's rare that a parent will turn down an offer of assistance if we say we have services that might be beneficial, or if we tell her the school is not giving her child everything the child is entitled to, and we offer to help her navigate through that. Most parents will appreciate an offer of help, especially an offer to help their child get something that the child is entitled to. They may not approach the school on their own, they may not trust on their own, but with that empowerment and that assistance, most of our moms are pretty receptive. But we don't force anybody into anything; if they don't want it they don't have to take it.

Whether a parent takes advantage of our assistance goes back to their relationship with the counselors and the case managers in the shelter. We use an empowerment model, and we work from a compassionate trauma informed perspective. We know that being homeless is its own trauma. And we know that people for all different reasons are not necessarily going to automatically trust the school system, or automatically trust us, or take advantage of everything. So we offer bilingual services in our shelter, and we try to be culturally competent as well, because it's not just about speaking a language it's also about understanding the culture.

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(#27) I think children's services are really important. A lot of programs focus, very understandably, on the head of household as the main victim. But I think the kids in the family are such bellwethers for how it's going – how the day-to-day is really going. It's important to provide support to mom around the kids. We have a lot of kids who don't go to the doctor regularly, or are behind in school. We have an eight-year-old in one of our programs whose mom never sent her to school, because she wasn't allowed to. So not just helping mom figure out how to navigate the school district, but also working with the child, to figure out how it's going to be as an eight-year-old in kindergarten. Trying to give kids a chance to be themselves -- to run around and play, because that's what kids do. It's important to have children's services that can allow for that. And to have a trained professional who can observe what's going on with the kids, and see how that measures up to what's going on with mom.

That's a service that most funders don't want to pay for – because those are not the outcomes we're measuring for. How did Johnny do in school this year is not really how we're going to end homelessness or end violence. But how they did in school is going to be a real indicator for the stress level that mom's experiencing -- and her sense of whether she made the right decision in leaving. A lot of our parents take a huge amount of pride when their kids start to thrive again, and you can tell that it's boosting their self-esteem again – that they did the right thing in leaving, or that they made good decisions. As opposed to when their kids are struggling, and they're thinking, "Maybe I should just go back."

I think the type of services you need depends on the age of the children. We operate a daycare program, which is great, because a lot of the moms in our program have little kids. When this batch of clients leaves, we could get a group with more pre-teens and teens, and then it would be important to have an after-school program, with homework help or opportunities for kids to do normal stuff, while still getting to talk about

some of the other stuff going on with them. Teen support groups are pretty helpful, but that takes a lot of relationship building. Teenagers don't always want to talk with adults. I think it really depends on the age of the kids in the program, what would be the most valuable services.

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(#28) We have a children's counselor through the shelter that can meet with any of the children -- zero to five or school-age -- upon request by the parent, and they will do a psychosocial with the child and assess trauma impacts, etc. But it's got to be requested by the parent. We don't just go in and do the assessment. Our services are voluntary, so that kind of assessment would be triggered by the parent seeing some behavior connected with, say, past sexual abuse, or witnessing domestic violence, or anything that the child is dealing with, even transitioning into a new home.

I'd say that the biggest barrier to follow-through with service referrals is transportation. A lot of times, the parents' schedules are so full already -- with CPS appointments or other agency appointments and trying to juggle one or two jobs -- that trying to fit in counseling for their kids kind of takes them over the edge. A lot of them just can't find the time to be consistent with the counseling; we like to see them once a week or every two weeks, and sometimes that doesn't happen because of scheduling for the parents. Sometimes we will meet them at their house, if it's safe. We don't like to do that, because that's their space, but if we have to, we will; or else we'll try to meet them on a weekend day, if Monday through Friday doesn't work for them.

If a parent wants help advocating for their child in school, the children's counselor can work with them on that. Sometimes people don't ask for help, sometimes they do. If a parent isn't wanting certain services for their children, there's usually a reason. So we just provide information and ask them why they don't want their child to participate in certain services offered by the school. If that's still their answer, we respect it, because they know their child better than we do, and probably have something else lined up that's working.

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(#29) We believe that domestic violence is generational and it's important to reach the children because they don't have a voice. And so our policy has always been that mom has an advocate and so do the children. It's important to teach children that domestic violence isn't okay, so they also go through a full assessment and then, in our permanent housing program, we have family plans where the therapist and the advocate and the child advocate work together in helping mom and child accomplish their goals for the family.

So one thing we do with the child is safety planning. If mom decides to go back, does the child have a safety plan? Do they know how to call 911, can they go to a neighbor's house? Because a lot of children, first thing they want to do is protect mom and they get hurt either directly or indirectly. We also educate the child about what violence is, and about emotional abuse, physical abuse, and sexual abuse. We also ask the child what they want to accomplish at the shelter.

Our advocates can work with the school, help mom enroll the child, go to meetings with mom if that's what she needs, to assess any behavioral issues that may come up. When the family enters the shelter, not only do they do an intake or needs assessment and a case management plan with their advocate, they also meet with a child advocate to assess if mom thinks her child needs any resources. We ask questions like have you seen any behavioral issues that you want to address? How do you discipline? What's your parenting style? So, we also do that with the mom and work with her as well and the schools. That work continues once they shift into the transitional program.

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(#30) It's absolutely important to have a clinician on staff. We've had an amazing clinician; some of the ladies take advantage of her services and some don't. It's important for not only the moms but for the kids too; the kids have experienced trauma just as the moms have, and they have so many needs. The kids may understand it in a totally different way, or they may not understand it at all, but I think it's important to sit and talk with them about what they've seen, how they feel about what they've seen, and remind them that it isn't their

fault -- so they can become healthy young children. The kids have been in the room, seeing that violence, seeing things they should never have to see. They've been in the next room and heard things they should never have to hear. It's important to make sure they get a chance to work through the trauma they've experienced and to deal with the issues and what they're feeling. It's important and it's oftentimes forgotten.

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(#31) We have a child specialist who conducts children's assessments; we use the same instrument for children in the shelter, the transitional living program, and our outpatient services. The assessment covers all the demographic information, and identifies the most current DV incident, why they entered the program, their goals, what symptoms of trauma they've noticed. It includes a brief trauma screen. And we ask about discipline: how they handled discipline and how their partner handled discipline. And then we do clinical assessments for measures related to PTSD, and we get a parent report as well as speaking to the child if they're old enough. We use the trauma symptom checklist for young children where parents fill it out, and the trauma symptom checklist for older children that they can fill out themselves. For zero to five, the assessment focuses on parenting, bonding, safety, nutrition, things like that.

We offer [Parent Child Interaction Therapy \(PCIT\)](#) for families with children age 2-7, which supports mom in gaining the communication and disciplining skills that will strengthen the parent/child relationship, and increase mom and the child's enjoyment of each other.

With school age children, in my role as case manager, I work with the McKinney liaison and help them get their uniforms and backpacks, bus routes, and things like that. The McKinney liaison is excellent. Typically, we don't get involved when the school is developing an IEP for a child. However, if, say, a mom with a child on the Autism spectrum wants to do an IEP, I am aware enough to help her make choices, to help her understand that, "You're not at the mercy of the school; these are your decisions. They can be helpful; but don't just accept what they've said, if you're not finding it's addressing your child's issues." So I'm in more of a supportive role, empowering the mom to be involved.

A huge part of empowering women is helping them understand how their trauma has affected their parenting, so that they don't have to feel like they're bad. Through PCIT, they can learn simple skills that help them connect better with their kids, where connection has been difficult because of the trauma or anxiety or depression. I think it's a huge part of developing their self-esteem too, if they do that PCIT and they improve on their parenting, and they feel stronger as a woman -- which is what we want. We're not huge like New York, but we have more services available than in some other smaller towns. We feel very fortunate to have what we have: especially children's counsellors who have been trained in different therapies to help with children of all ages, and an understanding of domestic violence and trauma.

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(#32) We do a lot of children's services, and that's an area where we also do a lot of partnering with other programs. Twice a week, we have a children's group. And our staff member who works with kids builds the relationships with the school and with other community resources, and then brings those back to the advocates so that they can make appropriate referrals and know who to talk to. The clinical director supports the advocates to make sure that when they're working with the adult participant that they're also making sure to include the needs of the children.

Before she came on board, we didn't realize how much we had been missing around that; we were thinking that, "we can just do this with the whole family." We had one case file for "the family." When we brought on the children's expert, who is now our clinical director, she helped to educate us that the children are individuals with their own needs. We were so focused on being low barrier, trauma-informed, and organized around voluntary participation in services, and all the challenges that we were working through with our primary participants, the survivor. It wasn't until she came on board that we realized that there's so much to

do, to carve out that specific area for kids, especially policy wise, like how to respond more appropriately to child abuse and child protection issues. It was a learning curve for us.

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(#33) We serve families, but we don't offer counseling services to children. Children and other dependents are usually secondary clients, you could say, because they benefit from the rental assistance we provide. But we don't really see them one-on-one. We do, however, partner with other agencies that address children's needs. A lot of clients are either already seeking counseling or may want to get their housing situation under control and then focus on mental health. So if they want their children to receive counseling services, we link them with counseling agencies or domestic violence agencies that offer counseling to children. Although we always encourage counseling services for both the primary participant and their children, it feels like the mothers are more likely to have their children receive services and less likely to focus on the services that they, themselves, need. Mothers usually put their children's needs before their own. One of the barriers for participants accessing counseling for themselves is lack of time: if they work in the day, and then they have to be at home to watch their kids when they come home from school, they won't go to counseling.

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(#34) We have children's therapists on staff, and if a mother gives permission, they'll meet with the child. However, the child has to be verbal -- at least age two or three -- for the therapist to meet with them, and they'll do an assessment and provide individual therapy or joint mother/child therapy. We also have children's advocates on staff, who work with children from age zero on up; they're trained to notice any glaring developmental delays. We have good relationships with the school districts here. The two school districts that we work with the most are really awesome in following through with McKinney-Vento requirements. We're lucky; it hasn't always been that way. We did some work, but right now it's functioning very well. Teachers come in and meet the families, and they'll do developmental screenings and such. Several families have been hooked up with special education services for children with developmental needs. As I said, we're very fortunate to have great relationships with the area schools, so we're able to make sure that children get enrolled quickly, and get their IEP. We also have a person on staff whose whole job is to help with that, and to provide advocacy support for kids with special needs so they get what they need at school.

Usually that's all done while the family is in our emergency shelter, prior to coming into transitional housing, but if someone were to move into one of our scattered-sites, if they needed that kind of assistance, we could arrange it. I have gotten parents hooked up with teachers coming to their home. We also help families with completing and following up on their application for benefits like WIC, SNAP, and Medicaid, including going with the parents to the actual government offices, if necessary. And figuring out where to get healthcare for the children and signing them up.

One of our strengths is that we offer both therapeutic services and non-therapeutic groups run by our children's advocate. So we have built relationships with parents who were maybe initially reluctant to get any services for their child. By them attending our non-therapeutic groups and seeing the kids doing fun activities, the parents develop more trust in the children's advocate, who can then say "I see this" or "I can go with you" or "Do you want to try it one time?" So the parent is still in charge, but maybe accepting some of our advice or assistance.

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(#35) At the beginning, when a child is going to join one of the children groups, the parent will write down any concerns about their child that would be helpful for us to know about. We don't do actual children's assessments here. We don't have that kind of expertise. But we'll work really closely and help them get to resources. So if they express concern or we notice something with a toddler, we refer them to a program in town that will do developmental assessments and then provide services. If they have a concern or we notice something they might want to have their physician check, we can help with that. We also support them in the schools: we don't do the actual assessments, but if the child has an IEP, we do what we can to support them.

With the children's services, there aren't any barriers: the parents are willing to go to wherever we refer them. Most people with kids are anxious to find help; at least that's been our experience.

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(#36) We have a staff person who provides services to the moms and kids in transitional housing. When a mom and her children come into shelter she'll meet with them and talk about any issues that mom might have around her kids and help mom navigate through that. She also works a lot with our state's child protective services (CPS) agency, because a lot of the folks we see have open cases. She does a lot of work on individual CPS cases, but also a lot of system work and a lot of training with that agency on creating a more trauma-informed approach to services. She's been working with our local mental health agency and some of the other organizations that provide services to families in our community. So, it's on an individual level and it's also on a systems level that she works.

Although doing a child assessment is the ideal, it's not always formal. It depends on the family, if the mom wants those services. Our staff are available to sit down and ask, "What are your kids' needs?" Participants often come from outside communities, so it's about whether the kids are in school and arranging transportation to their home school. Lots of issues might come up that moms are dealing with, and so that's our family services coordinator's role. If we have any concerns, we talk with mom, work on building a relationship so that there's trust, and so we can say, "somebody can come in and talk to you about that." Because often, they're afraid or it's an unknown. We have a lot of conversations with mom around those kinds of things. We make referrals to Early Intervention all the time. We try to make it as easy as possible. Our Coordinator would certainly work with families in transitional housing on that kind of referral.

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(#37) (Not a current OVW grantee) We have a child advocate but he is primarily based at the shelter. It would have been good to have someone for the transitional living program but I think it would be more difficult for them because there would be a lot of travel back and forth between apartments. They would need to come into people's homes and sort of observe. It's not like they have an office and they're in the background; they would have to insert themselves into people's homes and say, "I'm here; show me how you play with your child." It's not like our child advocate is completely divorced from the children in the TLP, he does interact with them when there are group activities. He does see what's going on. Parents can reach out to him if they need support around IEPs at schools or if they have questions, even though he's not specifically assigned to work with the TLP participants. But he knows who the children are and he knows where there are issues.

It's the issues that more relate to participants' parenting struggles that he can't address, because he isn't in their homes. That's where we try to consult with other agencies, to help with parenting struggles. Being a parent is a big, big challenge, and we see people struggle with it in many ways. It's hard to change people's patterns. You can offer some suggestions, but it can be difficult to get someone to look at their parenting style from a different perspective, especially if their approach to parenting is deeply ingrained. And it's a TLP, so unless the parent identifies it as an issue, we're not going to know because we don't have the kind of staff oversight as in the shelter, where we would see things.

We don't always see the children. If the family is lucky enough to have another source of daycare or a family member to watch their child while they come meet with us, we won't necessarily see the child. If we see something, we'll ask questions: "It looks like your child is struggling, do you need help with this?" But unless the parent indicates the need, we won't intervene. It has to be client initiated. Right now there's a woman who's told us she's got a lot of anger issues with her child, so we're trying to get someone from an external agency to do in-house therapy with her.

We'll offer a referral to Early Intervention if a child is under age three, or a mom is pregnant, but it's the mom's decision whether they want to partake or not. And if Early Intervention is involved, it could be that mom and Early Intervention are working on an issue, but it's not something that she needs help with from us, so it might not come to our attention.

With special education, the parent is absolutely the gatekeeper. We'll talk with them and explain the situation as best we can, to help them make an informed decision. We'll encourage them to speak with our child advocate, who is a wiz at these things and is very good at explaining to the parents why services might be a good idea. But at the end of the day, it is totally up to the parent on whether they go with an IEP or refuse it.

When you're struggling with homelessness and domestic violence, the last thing you want to be told is also that your child is not perfect. So we sometimes have parents that resist or are angry when we broach the subject, and they can be adamant that nothing is wrong. But they're with us for a period of time, and sometimes something changes, and they have to acknowledge it, because things are not progressing well.

In time, most parents do buy in. With some of the parents in our shelter, we don't ever get to see that. In the TLP, we get to see that more, because they're with us longer, and at some point, the parents are more ready to face reality and say okay, my child is struggling with something. But we've also had clients who were with us for multiple years, maybe in our PSH or follow-up services, and we've seen the shift, as they become more informed about the situation, what it means for their child, what services are available, what they can push back on, and we watch them become their child's biggest champion, push back when a service isn't included, or argue why something needs to be addressed. It's fulfilling for us when that happens, but we have to understand that it's their child, not ours. And we have to relinquish control and power and let the parents take care of their kids, and sometimes that's really hard.

Some parents have a lot of shame and disappointment in having a child with special needs. And they may feel guilty about leaving their partner and leaving everything behind. When they find out their child is struggling on top of everything else, they tend to blame themselves for their child's imperfections, and it could be something that really breaks their back because it's like, "Now this on top of everything? I can't take this."

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(#38) Our core children's advocacy program does an individual assessment with each child living in our onsite program that's old enough to speak. The assessment is done when they come into our shelter, to get a sense of their experiences and any needs they may have. We offer age-appropriate counseling groups to help with social support for all school-age children who live onsite. Most other counseling is generally provided at the parent's request; however, teenagers and pre-teens -- starting somewhere around age 12 -- can self-refer for counseling on their own, without parental consent. Different programs use different assessments. One of our parent support programs focuses on child development, in partnership with a local non-profit. The parent specialist that leads that program does a lot of standardized child development assessments and then shares the results with the parents, and works to link the parent with appropriate resources or community-based referrals. Another of our parenting programs does separate assessments with the parent and the child, and tries to tailor a plan to support the parent in providing the best possible support to that child. Sometimes parents have high expectations that their child should be able to behave like a little adult, so we need to do informal education around normal child development stages, to help set age-appropriate expectations.

A lot of our parents have tried very hard to shield their children from knowledge about the abuse that was happening in the home, and they may not realize exactly how much their children know about what was going on. And in addition to any trauma, there's also just the disruption of life-as-usual -- changing living situations, going into a shelter, leaving home. It's not uncommon for kids to be struggling with having accidents -- bed-wetting, delayed potty training -- or different behavioral issues or separation anxiety or other acting out. So parents can find it supportive to speak with somebody who's nonjudgmental, just providing information about the different impacts of trauma and how to heal from trauma and how to support your child's healing from trauma -- and how to gauge your expectations accordingly.

Framing is important. We've found that many parents think that being in counseling means that something is wrong with them. But they're very interested in any type of parent support. If we can offer a parenting class or make available a parent coach, or provide in-home supports that will help their child, or help them help their child, that will often be very welcomed.

We try to have a range of services to maximize our opportunity to have contact with different members of the family. For some people, counseling doesn't feel very culturally relevant, or there's a stigma attached to it, and so some parents don't want you looking at their child. But whereas counseling may seem like a scary thing, afterschool activities may be fine. So our children's advocates do a lot of therapeutic play and after-school activities and groups with the children, while the parents are attending life-skill classes or other groups. Those are opportunities to have supportive contact and intervention with children in a way that's comfortable for the parent. And we do family nights, group activities with children, and parenting support programming.

We also have an onsite charter school, K-12, an after-school, and a summer program of activities. We run counseling groups (by age cohort) for all children in the school or in those activities -- so participation isn't because a child has been singled out as having a problem or because they acted out or because we think there's something's wrong. These groups are offered as a source of social support for everybody, and they're another point of access.

Although we do different assessments and offer a range of therapeutic activities, we really try not to send the message that you have to be assessed or diagnosed in order to access services. There shouldn't be a sense that something must be wrong if you're getting help. The services are open to anybody who wants them, and there are different tools to help us better help you, but it's not a screen-you-in, screen-you-out situation.

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(#39) Our transitional housing is very adult focused. There's definitely a service gap when it comes to children. The child's needs get assessed if the mom says there is a need and wants it addressed, and that's when they would get referred to our children's therapy program.

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(#40) We don't have anyone on staff that focuses on the children, I'm sorry to say, and I think that's a huge gap. We don't have a children's advocate. We receive funds to do teen work because that's the big thing these days. But we don't receive funds to do children's work. We do children's groups -- childcare -- like when we're running dinner meetings; we have lots of play space indoors and outdoors to accommodate children. But at this point, we do very little supportive counseling with children. We used to do that work, but funding trends change. We still do some work with families whose children have been sexually abused, for example, going with moms to court, to forensic interviews and exams, but primarily, our work is with the parent.

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(#41) We don't have any services specifically focused on the children. The way that we support children is through supporting mom. If mom was having problems with parenting, we would refer out for help, but we could definitely talk with her about it. When I'm in a participant's home, I don't give my suggestions about disciplining or parenting. I just support them in working through their frustration and then ask them what I can do to help. If a moms says, "I want to learn alternatives to timeouts because my kids are not doing timeouts," I'll research some things and print them out for the mom, but I'm not in the role of telling her how to be a mom. I just try to find out what kind of mom she wants to be and what values she has with her kids, and then try to find a way that works. But I don't work specifically with the kids.

If I noticed a developmental delay, or behavioral issue, or something -- but I don't think I would -- I wouldn't be afraid to communicate that with her, but then ultimately, it would be, "what do you want to do about this," and "how can I help you do this?" I know some moms have been in denial about how it's affected the kids and I will point that out in a kind way, and try to validate and normalize that, and then we just move on to working with the school district. I've done that before, to try and get an IEP with them, but mom is in the driver's seat; I'm just helping her do some of those things.

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(#42) Our counseling program, which can serve our transitional clients, has funding from other sources including the state and the county, and from other VAWA and VOCA grants that we get from the state's

criminal justice agency. So some of our transitional clients who are involved with Child Protective Services have met with that agency's domestic violence liaisons. And, on the flip side, sometimes one of the DV liaisons has a child abuse case which involves a caregiver who experienced domestic violence, and they might refer that family to us for transitional housing.

We have a parenting group, but we also speak individually with parents about their needs for services. We provide counseling to support healing from the trauma of domestic violence; we talk with parents more generally about the effects of DV on children; we talk about whether they're seeing any signs in their kids that cause concern or worry; and we inform them about our children's counseling program.

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(#43) There are a couple of different ways that we work with children. If a mother chooses, the child can engage with the art therapist on staff, who works with children who've been traumatized. We talk to mothers about education and the impact that trauma can have on children; we talk about some of the behaviors they might be seeing that are a result of that trauma -- how it can interfere with functioning and development, and what can be done to try to address some of those things, so they're able to move forward. And we offer to connect them with on-going support and resources if the child could benefit from something more comprehensive and long-term than art therapy.

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(#44) (Not a current OVW grantee) We have children's advocates on staff, some of whom work with the residential clients, and some of whom work with the children of families that don't need shelter, but who still need counseling or therapy. If we feel that a family in the transitional needs a referral, we offer to make it; or if they're already working with somebody when they come into our program, that continues. Our small transitional program has served a few parents who were in denial that the abuse had affected the children, but I don't think any parents were flat out reluctant to engage their children in services. So, we provide education around DV and its effects, how it might affect the children and maybe some warning signs, like acting out in school. We have a pretty good relationship with the local school system, and there are a lot of resources in that system that we can help clients tap into. If a client wasn't willing to work with the children's advocate one-on-one, we would consult and try to get some worksheets or grounding techniques or find some other way to have a conversation with the client to give them the information they would have gotten had they met one-on-one with the advocate.

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(#45) There are different counseling agencies across the state. Sometimes it is a little bit of a challenge to ensure that if they're providing services to a family with children, they understand domestic violence. That's why we started to do more work reaching out to counselors and social work service providers, so they understand the domestic violence piece. But being able to offer these services is a challenge because of the lack of resources in our rural areas. Our state has implemented a Juvenile Justice Initiative whose whole focus is on keeping juveniles out of the correctional facilities, and as we know, many of the children of victims of domestic violence end up in the juvenile system because they're running away, or they're getting into fights, or whatever. We're involved in the discussion, because we want to make sure that if they're going to develop services in the rural parts of the state, where there aren't services, the providers have to understand domestic violence and how to respond to it. Sometimes the children in a family that has experienced domestic violence don't receive any assistance until they've found themselves in the juvenile justice system.

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(#46) We have an amazing child advocate. The children just love her and look forward to the activities she leads, from the time they are in the shelter until the time their families move on from transitional housing. The assessment process happens during the time that the children spend with her, and then she can make appropriate referrals.

Originally, our children's advocate's services were entirely child-focused, but we realized that it was really important to engage the parents -- giving them the opportunity to take back the decision-making power that they need as parents -- and she invited and encouraged them to participate in and observe those activities, and she really earned their trust and confidence in the program and in our staff. In turn, building that relationship made it possible for her to discuss the kinds of things she might be seeing, and to help parents understand that they were not to blame if their child had a developmental delay or other setbacks due to witnessing or experiencing the violence, that it was the perpetrator, and that by working together now to address those issues, they could prevent more significant problems and setbacks later.

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(#47) Working with parents is about meeting them where they are, helping them understand how the traumas they've experienced in their lives affect how they parent their kids, and helping them understand what their kids have been through. Generally, the women that seek our assistance want services for their kids. There was one mom whose child was in trouble, really floundering in school, but mom wasn't bringing him in regularly. We talked to mom, but she wasn't bringing him in. When you work in a voluntary service program, you have to learn to live with pain: mom wasn't changing. There's nothing we could do. We remind each other that if nothing else, they're safe tonight. It's not everything, but compared to living in danger, or living in their car, or in a homeless shelter, it's a lot. A clean, safe, healthy environment for children is a lot. You have to take comfort in that. For the first six months they're here, they may not be ready to acknowledge the effect the trauma has had on their children. But maybe a year later, they are. We go with that.

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(#48) Our shelter has a full time child advocate who spends about 60 or 70% of their time physically in the shelter so a lot of the kids receive services, parent driven, that way. One of the intake questions in the OVW-funded transitional program, is "Are there any concerns for the children? Are there any services now or in the future you think your child may need?" We tell the parent that our child advocate can meet with the parent and the child, meet with the child separately, and we describe the services she can provide. Since many of the people in the transitional program are from shelter, most likely, the children have already had some interaction with the child advocate. If we see something that suggests a problem, we bring it to the attention of the parent, explain that the observed behavior is typical for children who have been affected by domestic violence, and recommend support for the child. That support could start with our child advocate or with a referral to one of the local mental health agencies that work with children, if the issue seems more clinical. There are only rare times when parents have been really opposed to such intervention.

We're mandated reporters, so we're very clear with our clients that if there are some negative consequences, we would have to make a report to child protective services. We're very supportive of the non-offending parent and we're very good at naming their strengths when we make our reports but there are instances that require us to make them. I recently worked with a woman who was resistant to working with our agency's child advocate in relation to some of the issues that her minor child was having. Consequently, it did bring some negative things into their life. I was able to support her in addressing those things; I just worked with her and tried to explain that "They're young enough and they deserve to have this opportunity for healing and support as well. Ultimately, it's going to be a benefit to you, and your child is going to be in a better place and have time to heal from the things they witnessed." Ultimately it worked out.

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(#49) For the majority of participants, who are located within 30 miles of our facility, we have regular support groups, regular kids club, regular gatherings. Our children's advocate does things like pick up all the adolescents and take them to the river to river surf or do fun things. She may take them all out for ice cream and just visit. We enroll our kids in a program called "Heart to Horse," working with wild mustangs so they can get a sense of bonding with this really powerful animal, and that seems to be really empowering and amazingly effective. She does regular visits, and of course, assists mom with parenting issues but her main

responsibility is with these kids. She drives a van and knows how to have fun, whether it's shooting hoops at the community center or teaching skateboard tricks. She's pretty amazing.

There may be some moms who are reluctant at first, and I think there may be some who become even a little jealous that these kids squeal and get so excited to see the child advocate. But for the majority of them, not only does she occasionally give them some space and time to breathe, but they also learn to see the value.

These kids have had the behavior modeled that "Mom's not okay. She's stupid and we don't have to listen to her, and I'll scream and yell and slam the doors and kick her if I want to." They really identify with that power person and often when they enter our program, they're angry, they're hurt, they're confused, and they're duplicating the power behavior they've seen. Especially the boys; they're more aggressive than the girls, and will act out while the girls tend to be more depressed and withdrawn. It's often the little boys who get the attention when the little girls are in pain, too. It's just that the little girls aren't causing so much disruption.

We always do our best to assist mom in acknowledging and sharing her feelings. The kids don't have to have all of the information, but it's okay for mom to say "I'm really sad too. I'm hurting. I'm so sorry this happening but things are going to get better," rather than trying to be stalwart and strong and stoic. It's okay to start talking about emotions and let the children know that, yes, mom's human too and she understands.

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(#50) We gather assessment information about the children at intake. Some of the questions we ask the parent are, "Have you seen any changes in your child?" and "Do you have any behavior-related concerns?" After she's met with the intake worker within the next two or three days, our children's case manager will meet with mom and the children to gather more information about what the child witnessed and any experiences that have taken place as a result. One of the good things about our program set up is that their case manager is at the same site as the family, so if she sees something, she can intervene right then, or gather information about what's going on with the child because she sees them every day. Along with her own observations, the case manager has information from mom about the history, about what mom is noticing and, because she also works closely with the schools, about what the school is noticing.

If concerns arise, we have a network of resources, including a leading clinical program at the local university that we can help mom link to, in order to get counseling services or play therapy or other services to address behavioral or developmental issues. We also have an in-house children-in-crisis program for children in the shelter, in the transitional program, and referred from our community programs (court advocacy, etc.) who are old enough to speak about their DV experiences. Just as mom can go to her support group, the children can attend weekly sessions of their own age-specific groups to have an outlet for speaking about how they're feeling, and to learn about healthy relationships, safe ways to cope, etc.

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(#51) (Not a current OVW grantee) Technically speaking, the children are not our participants, but if, as part of the assessment process, the parents have identified that their child has special needs -- for example, if they have PTSD or they're struggling in school and will need an IEP -- we'll put it in the service plan, so that we can support them in getting services for the child. Because if their children aren't stable, the parents aren't going to be stable.

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(#52) (Not a current OVW grantee) Both our staff members have clinical backgrounds, Masters in Social Work, specializing in children, so they run age-appropriate children's activity groups in the evening. They also do an intake with the parents and an intake with the child, and if they noticed delays or difficulties with the children, they'd first talk to the mom and say, "We noticed this; would you like to get the child clinically assessed by a professional? We can get this done for free by the school district. If they find a developmental delay in a child under the age of four years, they have to provide Early Intervention services to remediate the situation." As far as I know, we haven't had a mother refuse, and I think that's because it's so much easier to convince

somebody to intervene early. “We’re noticing these things, they may be nothing, but let’s get your child assessed and get this course of treatment because hopefully if they can intervene now it will be no problem later.”

We have a good relationship with the school district, and work well with the McKinney liaison to address the things they can help with, like arranging transport. If the child has special educational needs, we’ll usually accompany the parent to meetings at the school, work with the counselor, advocate for the family, and be very involved. We have had cases where an older child enters our program with signs of being on the autism spectrum, where parents are just like, “Oh no, he’s fine.” But then inevitably, the school will get involved and push from that side, and so we work closely with the schools. We’ve been able to get a lot of good services for our children. With the counseling programs in the school, I’d say we have more luck getting services for the kids, particularly in the mental health area, than we do for the adults.

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(#53) We have a children's program, and we have some terrific people. When a mom comes in, the children and the mom meet with the children's program director and/or counselors. They do an assessment of the needs and include the mom or dad in that assessment and get their input and talk about what kind of resources might be available. Staff in our children's program have very good relationships with the local schools and the counselors in those schools.

We have many people working in our program that came to our program when they were children. There were a group of kids that were in our shelter in their early years; their moms came back and were part of advocacy and support groups for new survivors, and the children started a group called The Second Generation. They wrote their stories and little vignettes about domestic violence and about their experiences as kids growing up and experiencing it. They put on these skits and work closely with the kids who are in our programs now. That experience alone, seeing kids that were like them, that were there when they were younger, and that are talking about it, that are young adults, is one of the most powerful things. It has meant a lot to the kids in our program. And it's empowered the kids that came from those backgrounds too, to be able to be experts and to inspire and to understand their situation and be able to help other kids.

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(#54) We assess the children when they come into the shelter and then the counseling and the therapy continues once they get into our transitional housing. We also have therapeutic daycare and everybody is trained in [CBT \(Cognitive Behavioral Therapy\)](#) for children and youth. We have the therapeutic daycare that focuses on school readiness, but also with the back element of the domestic violence and the trauma that they might have been through. They have talks about feelings and things like that. So the daycare allows us continue the observation process.

We’ve served some parents that seemed unable or resistant to recognizing signs that their children might be having developmental or behavioral issues related to the violence they experienced. We just try to work with the parent to help them recognize that some of the behaviors of their child are not normal. We do that by educating the parent on DV trauma and the trauma that it causes for the children and some of the behaviors that might result, especially if the child was sexually assaulted. If we see some developmental issues, we may pull someone in from one of the local schools and they’ll do an assessment and talk with the parent as well.

Usually, because of the domestic violence these women have experienced, because of the very nature of the DV, they’re going to try to please us. They’re trying to please a lot of the time. Sometimes they’ll cooperate because of that or sometimes they get information from the other clients. If they’re in shelter, the other mothers are going to help educate them too. We usually see folks come around. Not in every case, but thank goodness, it’s the majority. Maybe once since I’ve been with the center we’ve actually had to take a different course of action. Normally the moms participate.

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(#55) When families come into the shelter, they meet our children's advocate and the staff member who provides our childcare, and if they go into transitional housing, the kids' needs continue to be met by those two staff. Our local services, particularly children's mental health services, are really lacking. It's a challenge to get help sometimes, even when you identify a child's service needs. Our child advocate will spend time going to meetings at school and try to partner with the mom. It's rare that moms are resistant when their children have issues that needed to be addressed. Usually, if there is an issue with the kids, mom is trying to figure out how to get that managed. If the mom is resistant, the best our staff can do is to keep providing information.

When it's needed, having someone on staff who's focused on the children is very important. Maybe they have different styles, but we serve a lot of really capable moms with children who are really resilient. When we do have a kid who's struggling, they need services and mom needs support. So there are weeks when our children's advocate says that "everybody seems to be doing well," and weeks when she's super busy.

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(#56) (Not a current OVW grantee) Our hope is to provide as many of the services as we possibly can in-house, and the primary reason for that is we want to make it as easy as possible for the families to access the services. If they can all be under one roof and we can all be working together as a team, then the person doing the financial literacy and the debt reduction can be talking with the case managers as can the people who are doing the employment training or the people who are doing the legal services. So we can have a unified approach to helping the family. In addition to our case managers, we have a psychotherapist, a credit counselor, an unemployment counselor, ESL teachers, child care staff, and our own after-school teen program, nursery, and pre-K program.

Some parents are going to be very, very cooperative in helping us understand the needs of their children and some parents are not going to be as cooperative for one reason or another. The schools here are phenomenal, but they have their own confidentiality policies and it's not always easy to get the assessment information. We just have to be attuned to observing everything, so that if we recognize something, we can step in. Two of the programs we started in the last two years were intended to address this. One is our pre-K program for children aged three to five, which we started because we saw that our children weren't ready for kindergarten, and a lot of that was because they came from home environments where they were exposed to trauma and violence and dysfunction, neglect, and problems. By working with the children in that program, and through our work with older children in an afterschool program we started for teens, not only do we see what's going on with those children, but we get to know the rest of the family better, too. And with better awareness about what's going on, we can offer more appropriate interventions.

Sometimes, there's still a stigma if your child needs mental health services; somehow it implies that you're a bad parent, especially in some poor communities and foreign-born communities. That used to be more common in the mainstream, too. I remember when I was younger that seeing a therapist meant that something was wrong with you. We get around that barrier because our therapist is a marvelous woman, warm and engaging and smart and she does groups on wellness. People meet her as the instructor on wellness, and so they already know her, and if they want to talk to somebody about the trauma in their life, they think, "I want to talk to Susie." We introduce them to the person who can help them in a way that is very gentle and non-stigmatizing. She's not Dr. Guilty; she's Susie. To get a child into counseling, it can sometimes take months of conversations before a parent says, "you know what? I think that's the right thing."

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(#57) I think it's critically important to have a child-focused staff person available to our TH program. In our program, that staff person is a male whose background is in child and family development, and that's added an interesting element for us. The children develop a great rapport with him. Families usually come through the shelter, so they establish a relationship with him while they're there. And because we invite TH program residents to join us for some shelter activities after they leave the shelter, there's still that connection.

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(#58) It's common for our shelter-based youth advocates, to continue to be a resource for the children after the families move into an off-campus transitional unit. One of the things we do for all of our weekly support groups, is that every time we have a group for adults, we have a group for kids. We break them out by age group, so depending on the number of kids and their age range, there may be as many as four support groups going on at any given time.

If children are of school age, we are very connected with their school. We lead a bullying prevention curriculum in a couple of schools, and we work with the homelessness prevention staff in the district. We're in a college town, and the community is large enough that we have a good pool of child therapists, and we have been really lucky to have teachers and skilled volunteers who worked with our program. We have teachers who volunteer and lead a daily preschool program at the shelter and kids come back for that. We also have a child therapist and art therapists that volunteer to lead activities with kids. Our volunteer pool is absolutely amazing. We have a child therapist who is doing a progressive study with kids between the ages of eight and eleven, and she comes in every week and does group work with them.

The parents we serve don't typically get too defensive about their children being diagnosed or receiving services that might be linked to the violence they experienced. We work a lot with individuals who are connected to the state's social services or Child Protection Services. We know that that system has strengths and also weaknesses. We always approach things from the perspective of the people we work with: we are their advocates. We are not there in a therapeutic capacity; we can connect them with therapeutic services, but we are really there as their advocates. It is not uncommon for a family to have multiple advocates because the kids might have some different needs than the mom. I'm not going to say that it never gets dicey ... because it does, especially if CPS is involved in the case.

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(#59) We have two separate programs for children. Most of what we'll be talking about today is our trauma informed programming focused on the children in residence that we know are coming to us with trauma. The staff are well trained on the impact of violence on children, what may be going on for those kids, and how to best support them. But we also have an early education center, preschool, and kindergarten that are open to the community, as well as serving some children who live on our campus and whose families receive State childcare assistance. That's a source of revenue to us. Although the staff use some curriculum on working with families who may have experienced trauma, that's not the focus of their programming.

For our residential program, we do a lot of intake assessments. We use a trauma experiences questionnaire developed by a local mental health partner that serves children, and one of the questions we ask mom is, "what has the child been exposed to?" Last year, only about 55% of the moms said that their children were exposed to domestic violence. But there's a whole second part of the questionnaire that addresses behaviors and trauma symptoms, and those are off the charts: problems sleeping, problems eating, problems getting along with peers, etc.

I used to oversee the children's team, so I have a lot of experience sitting with families, and it is often the case that mom will say that the child didn't know what was going on, they were in the next room, they were asleep ... and then you play out a safety plan in a dollhouse with the child, and they can tell you exactly what just happened in the other room.

We use the trauma experiences questionnaire as a tool for engagement and we have child advocates whose role is to build a relationship with the mom and the child, and to start that education for mom about what may be going on for the child. As mom's saying, "why are they bouncing off the walls?" We're saying, "Let's connect this back to what just happened." It's a lot of education, a lot of relationship building. Thankfully, that mental health partner I mentioned is right next door to us, and so we've done a lot with them in terms of getting families connected to services. They have parenting classes, and we have clinicians from their agency that come to our campus and do monthly Q&A's. So if mom wants to talk about her kid not sleeping, the therapist is able to do a little more education on that. We really try to infuse parenting support and parenting

education into our programming for families. We have ongoing parenting groups that talk a lot about child development, the impact of trauma, and all of that stuff.

There's a lot of fear, denial, and being in crisis mode that keeps parents from engaging in longer term mental health treatment, but we try to overcome that. Some of it is finding time for a therapeutic appointment doesn't fit into their framework right now. Some of it is the piece about, "I don't understand why my kid is not sleeping at 11:00 at night. I want help at 11:00 at night," instead of understanding that your therapy may prevent some of these behaviors that are so exasperating. Also, we serve a good number of refugees in our program; we have an Arabic speaking refugee advocate, and she's pretty well known in the community. The therapeutic counseling model is fairly new to them, or has a stigma attached to it, and so they don't really want to take kids to counseling because that's for crazy people.

Again, it takes a lot of education. And that's partly why we started doing these monthly Q&A's with the therapists because we want that to be relationship building for the parents and the therapists, so it's not so scary to walk into a therapist's office to talk about really hard things. But if you just want to talk about my kids not eating very well or fighting with their sister all the time, they can start the conversation there. We found those Q&A's to be very successful, and then the therapist can say, "I'm happy to follow up with you. Do you want to set up an appointment?"

It's completely up to the family if they want to all meet together or if they want some separate time. We do have an intake that we do just with the kids that's just questions about what scares them, what they've been through, and what their dreams are; all of those things. The child advocates will usually go over that with a parent, **with the child's permission**. Again I think it's about helping mom understand what the child witnessed.

We also do a family safety plan together, so that we're not just doing one with mom and child separately, and that often comes with a conversation about what's not worked in the past, and those are very hard conversations for our families, for our moms especially. Frankly, some are more open to it than others, and we just have to go with where they're at.

I think we have a good model, but we'd like more of it. We have child advocates, essentially children's case managers, but we don't have enough for size of the program; there are 50 to 60 children on their caseload on any given day. That's too many to be effective. They end up concentrating on the most acute issues. So we would like more child advocates. We really see their role as not only what I've just described in terms of education and engagement for mom, but really as mentor for the child, and to be their safety person while they're here, and to help them with coping skills. Working with children is definitely about relationship building and that's where I think we need more staff. I think our staff is getting very little time with those kids. We've grown in the last few years, and we haven't been able to add to that infrastructure. For instance, I used to be a child advocate and I had time to sit with the child and really spend time playing and assessing. I have a clinical degree and so I can provide more of that play therapy assessment before doing the physical assessment with the child. We just need more of that frankly. We're not doing enough of that.

Our child advocates weren't necessarily specialists when we hired them; they had experience working with children, and we give them lots of training here. We do a lot of training with the early education center, with our mental health partner, and in other ways, so we turn them into children's specialists or early education specialists. I think the majority of them just have bachelor's degrees in social work-related fields. I'd think an ideal model would be to also have a couple of clinicians onsite to focus on children's issues like coping skills, life skills training, and relationship building between mom and child; less focused on long-term treatment, and more focused on short-term engagement.

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(#60) We work with a couple of other organizations to offer services for the kids that live with us, but that is an area I feel like we need to do a better job with and offer more services ourselves. I feel like that is a real gap. We don't have the funding, of course, but, in the meantime, we work with two organizations that work

with children and so they're able to go to group activities or a daycare that specializes in working with kids who come from homes where there's been domestic violence or abuse.

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(#61) We're working to enhance the services to children exposed to violence; to replace some of the children's coping mechanisms, so that we're not repeating this violent dynamic; and to expand the trauma informed counseling services for victims. In all the years I've done this work, civil legal services was always our number one requested service, but I can tell you, hands down, in the last two years since we have expanded our counseling interventions and our trauma informed model for both children and adults, the trauma informed counseling is clearly our number one requested service.

We find that survivors really want to understand the trauma. They want to heal from the trauma. They want to change that dynamic in their lives and they definitely want to not see it repeat with their children, so we have increased the number of trauma counselors we have on hand; we have expanded our services to children to include trauma services for bilingual children as well as children with disabilities. We've tried to expand our capacity as much as possible, so we can respond to the wide range of survivors who walk in the door, and really target the gap in community resources.

We feel that our children's services are essential, and that among mainstream providers there's not a lot of understanding of trauma or of the unique needs of children exposed to violence. We do a lot of training in the community, but we believe that we can integrate it here -- that the survivors are coming here and they bring their children in, they already trust us and have that relationship with us, somebody is meeting with the survivor and identifying all the other issues, and all the partners are talking to one another -- and so we're looking at the family as a total unit. If the survivor has to go to several different places to get her services, the chances of that really happening are very limited.

It's worked extremely well. We provide really good services that participants feel are helping them and we make participation easy. I think the keys to doing voluntary services successfully is how you frame your services, and giving survivors what they need --meaningful services. We don't do mental health assessments. We call it trauma informed services. They don't get diagnoses. We don't bill to insurance, so we don't have to classify a mental health diagnosis to justify cost. When we're talking with a parent about her child, we just frame it that "your child has been exposed to trauma just as you have been, and it doesn't mean there's something wrong with you or your child. It just means that something traumatic happened to them that oftentimes can have long-term effects. So the more we can provide different strategies for coping and for dealing with the traumas, the more successful they will be in overcoming any effects from that trauma."

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(#62) The very first responsibility of the youth services position is the children who live in our housing. We certainly do the public outreach and education and we do the dating violence prevention work, but it's the children who live in our housing who come first. When I say housing, it's all our housing: the hotel/motel units and the different kinds of transitional housing. Their needs come first. We'll do about five or six one-on-one educational sessions with children, sometimes including the mother, sometimes not. Sometimes it's just giving the moms a break -- basic child care assistance -- if the mom has court or appointments or whatever.

When we have our women's support group, we also have a youth group that is a mix of structured activity, art projects, and some free time. Some of the women bring their children to these sessions, some prefer not to. I would say that our youth advocate has gotten to know all the children at varying levels. The key is having a really solid relationship with the people you're working with, so you build up enough trust and time together that you can openly talk about things. "What's going on in your life? What do you need? What are you worried about? How are your kids doing?" Some people are in denial about what's going on with their kids and how they've been impacted by what happened.

When people are removed from battering situations, they flourish in ways they never could while they were in those relationships, and they're much more open to trying to figure out "What do I need in my life to make sure everybody's doing well?" Over time, you can start to have those harder conversations, as long as they trust you, they don't feel a judgment from you, and they're the ones making decisions about their own lives and the lives of their children.

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(#63) We have three full-time clinicians and one part-time clinician. That's where our embedded clinical program comes into play, because our advocates work in concert with our clinicians all the time, and clients are very willing and open to working with the clinical staff to address the needs of their families. Our clinical team is trained in evidence-based treatment interventions that address the needs of children who've experienced domestic violence. In addition to such interventions provided directly for the children, we work with children and their parents together, and directly with the mothers to address both their own trauma and how they as parents/caregivers can support their child, given the trauma that each experienced. We also offer a four-part workshop for parents once or twice a year that addresses the impact of trauma specifically on their ability to be a parent; the workshops are very successful with clients, because it's a huge issue for them.

My experience is that our staff is successful in engaging participants in clinical interventions because from the get-go, we create a climate of mutual respect and a nonjudgmental environment. We don't wait for parents to find a way to tell us that they think there's a problem, or to share with us that their child is struggling. We set a precedent from the very beginning that "your child will probably struggle and that's a normal reaction to what they've experienced, and we're here to help you. Nobody sets out to experience domestic violence in their life, but when you do, there's a range of things you may feel, or behaviors you may engage in, or things you may experience that are all a totally normal reaction to this abnormal experience of domestic violence. We are here to help you with that."

We don't bill health insurance companies, and because of that, there's broad flexibility in the interventions our clinical program is able to provide. We're not locked into a certain number of sessions. The frequency with which we see clients isn't predetermined by an insurance provider. We don't have to go through the process of diagnosing according to the DSM-5. Of course our clinical staff uses their understanding of mental health diagnoses to inform our interventions with clients, but we don't have to label people in order to provide that intervention. For us, it's about really building a trusting relationship with them, normalizing what they've experienced and what they might expect going forward, based on those experiences, and providing gentle interventions that don't feel overly clinical or scary to clients.

Our clinical team is trained in child-parent psychotherapy, which is a SAMHSA evidence-based clinical intervention specifically for kids between birth and age six who have experienced trauma, including domestic violence or sexual abuse, and it's been a really effective model for working collaboratively with parents and children together to empower parents to feel like they can facilitate healing for their child, and provide their child with the things the child needs.

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(#64) Working with children who have witnessed violence is a very big issue for us because there are very few services in these rural areas. We have a person that comes in and works with the children, and we do some art therapy. Not all parents want their children in these services. We can also refer them to counseling programs within their schools, depending on what their parent wants and what kinds of services are available to the child. When the parents are resisting services for their children, we suspect that somebody's trying to hide something. And a lot of times, it's the fact that a child's been sexually abused and the mother's aware of it. Depending on what the service is and how a parent reacts usually is an indication that there's a skeleton in the closet, and we do what we can to try to flush it out so that the child gets the services that he or she needs; even if it results in social services having to step in. But the child needs to have a safe environment as well, especially if they're going to be going back to the family situation they left on the reservation. And a lot of

times because of overcrowded housing it's not a safe situation. The mother may be sober, but there may be three or four families living in one house. And there may be a lot of drinking and drugs going on. We want to make sure the children, if or when they're going to go back in, have a safe environment.

Especially with the escalation of methamphetamine use in our communities, we want to make sure that's not going on in the household. A lot of these problems are created through overcrowding -- a sober family not being able to live on their own and being forced to live in a house where there's drug and alcohol use. And that's very dangerous for their children. A lot of times we talk to the moms about getting the children into boarding school if they're going back. They don't want to take their children back into that kind of a situation, but because of the economic ties and control that the perpetrator has, if they go back, they have no choice.

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(#65) Our state just signed a contract with David Mandel to utilize his "[Safe and Together](#)" model in our child welfare services, and we're working at the same time with the local programs to really try to up our game in that arena. We have programs that do very well at providing integrated child and family services, but about 70% of them either don't do it at all or just scratch the surface -- not for lack of wanting to, but for lack of resources and expertise in how to do it. Which breaks my heart, because it's so needed. We say to transitional providers, "Please incorporate kids into everything you do;" but when you don't give them enough money to actually provide those services, it's a whole other ballgame."

Good children's care means having opportunities for kids to talk with each other and somebody looking at how the children are interacting and who can talk to the moms about what they see, but in our state's transitional programs, we're not requiring it. So no matter what we see with the kids, if mom doesn't see it or isn't ready to deal with it yet, it's a serious problem; and so we continue to be in constant conflict with CPS taking women away, or taking kids away from women.

There's always been, it seems to me, a split between women's advocates and kids' advocates. Good children's care means having opportunities for kids to talk with each other, and somebody looking at how the children are interacting and who can talk to the moms about what they see, but in our transitional housing programs, we don't require it. So no matter what we see with the kids, if mom doesn't see it or is not ready to deal with it yet, it's a serious problem. We really encourage programs to do it, but they can't force women to come to those things or to let their kids come.

Before the economy hit the skids here, we were talking about building in extra grant funding and incentives for programs with onsite children's work that engaged, and perhaps even offered the moms financial incentives for bringing their children to groups and participating themselves. We were trying to keep the voluntary services model intact, but build in extra dollars and incentives for programs that designed something so compelling that women would want to use it.

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(#66) Our work with children depends on what the adult client wants to occur -- if they want us to have contact with their children, and if they want programming for them. Our top priority for that work is making sure we have a safe household and a safe exit plan that's not frightening or re-traumatizing to the kids. Often, I use a make-believe example, "We're in a house and we're on our own; what would we do if there was a fire drill?" So finding alternatives that are not going to bring those triggers back in for their kids.

If they want, we can have one of our home visits as a family meeting to process some of the trauma. People can do their own trauma timelines, identify what's present for them, and talk about what safety and respect mean, what's harmful, and what's helpful. And we can do that as a family. And every summer, the tribe sponsors the culturally based Families of Traditions program that the whole family can go through.

Some want us to do prevention work because they have young kids and they don't want them to be sexually assaulted. They have that great fear about that because it's happened with other people they know, so I do prevention work with kids - looking at prevention of sexual violence or physical violence and how we can use

tools, like the through the [Darkness to Light](#) program. Some want one-to-one meetings with their kids, if they have 14-year-old girls who might be sexually active. We can do that or we can refer them to counseling. We have a girls group. It depends on what they're looking for.

For little ones, we have a play therapist that they can refer them to. A lot of times, it's just setting up mutual boundaries in their household, which often they've never done before. So all the family can have an understanding of what body boundaries are, what safe boundaries are in terms of communication, what nonviolent communication looks like, and sharing those skills with the whole family. Because if the caregiver is working on them, and then the kids have learned behaviors, we want to have simultaneous healing in their household. And we encourage that, we don't enforce it if people don't want us to do that. Most of the time, they want us to work with the kids as well. We do a lot of family work.

I think for the most part, when families come to our program, they are ready to move. So I ask everyone if the children have been exposed to violence, if they were in the room, if they might have heard something. I think the kids are one of the primary concerns of the people in our program; if they didn't have their kids, they wouldn't survive. I think one of their greatest concerns is that the same kind of abuse will happen to them.

We see a lot of different behaviors and reactions that are trauma-based, and we encourage the mom to put everything on the table. And we work with her to build the trust to do that. And the same with her kids; that's why I love that I can take my dog with me. Because building those safe relationships with the kids -- if I have the dog with me, he can be working with the kids—that's what he does—while I have a conversation with mom. "When I was here last time, this is what I saw," and maybe help her recognize that as abusive. I'm not saying that she's a bad parent; I'm helping her understand historically how this came to her. And usually she'll say, "I don't want that for my kids." So then we look at how we change it. So, we look at the abuse - and not mom - as the cause, by explaining how, "With historical trauma, often we see those patterns," and "I can see how what I'm seeing here is trauma-based." I'm not saying to the mother, "You shouldn't do this because..." And so, it totally changes the way she receives the information. Because then she understands that this is something that came to her, it's not something she chose to do. And I think that's huge in terms of shame-and-blame trauma. It's the same with sexual assault.

I have a second, different role in the community -- I work for a mental health agency -- and I see case plans for mental health therapists' sexual assault clients. And it's like, "They will reduce their behaviors of sexual activity. They will this, they will that." And these are all imposed issues on them, and they come across as very victim-blaming. So if someone believes that what they're doing is their fault, then they're going to feel bad about it and it's no different with any of the clients that I work with. If a case plan is set up in a way that implies that they did something wrong in the first place, they won't be successful. So we have to really make sure that everything comes through a trauma-based approach and looks at how what happened in their life led to this, and where do they want to go, and how do we approach that in a way that they feel safe? Feeling safe is just so paramount. And never putting the person's name in a negative tone.

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(#67) We don't have a separate intake for the children, but our needs assessment includes the entire household; either the case manager or the victim advocate performs that assessment for the adults and any children. One of our own agency's programs is Big Brothers/Big Sisters, so we can make referrals to them. And then we have other community places that you can refer people to, so we do have a Center for Children's and Family Services which has a CASA (Court-Appointed Special Advocate) branch, if that's needed. There are different programs within the school systems that some of the children may benefit from. We're partnered with most of the school systems in our service area, so we do have contacts with the liaisons, so if someone needs help with buying school supplies or school uniforms and things of that sort, we can get them in touch with the proper persons, the school board office, to help with that or we can provide assistance with those needs, as well. If a parent wants us to go with them to meet with school personnel, we'll go with them. We haven't had to do it a lot but there have been several parents who have wanted us to attend different

meetings and we'll be happy to go with them and help them advocate for their child. I know that some of the children we work with do have IEPs with their school. If a parent came to us and said they needed our help with the process, we could work with them on that, but we haven't had that come up a whole lot.

We offer a monthly support group for adults and a monthly support group for children at the same time that the adult group is meeting, so they don't have to figure out child care. We try to provide some food, snacks, or a meal at these meetings, because they're usually late, and if you have children, you're trying to figure out supper. The victim advocate usually runs the children's group and our counselor or case manager runs the adult group. There are different things that we cover in the children's groups to help them, depending on the ages of the children. The children are also eligible for counseling, so if the mom chooses to sign the children up for counseling due to their exposure to violence, the counselor can work with the children.

### ***Family and Children's Services: Questions to Consider***

1. Given the importance of addressing childhood trauma, and given the adverse consequences of waiting until a child reaches school-age to address developmental delays or behavioral issues related to or exacerbated by exposure to trauma, what can programs do -- if they don't have access to in-house children's advocates/counselors and/or clinical staff funded through other grant mechanisms -- to ensure that children of all ages have the opportunity to be assessed and receive appropriate services?
  - To what extent does the answer depend on the configuration of program housing (e.g., scattered-site versus congregate/clustered, the local availability of child-focused providers, other factors)?
2. Parents typically want what's best for their children, but may not have accurate information about the stages of child development and how their children's abilities and behaviors compare with "normal" development, or may not be ready to come to terms with the possibility that their child's development has been adversely impacted by exposure to violence -- or they simply may not trust clinicians or wish to stigmatize their children by having them "labeled" as having a developmental delay.
  - As noted in the narrative that preceded provider comments, Futures Without Violence asserts that program staff need to be both advocates for the child and the mother. What might that look like?
  - What are the barriers to families accessing services? What are the potential "risks" to parents related to accessing services for their children?
3. What formal and informal processes (e.g., structured interviews, informal observation, observation in art therapy or play groups, questions to parents, interviews with children, formal assessments, reliance on the public school system, reliance on Head Start, referral for Early Intervention, etc.) does the program use to assess for children's needs (all ages)?
4. How does the program work with parents to implement services that can address the effects trauma on children and youth?
  - What types of child-focused services and parenting-focused services do families see as most needed or useful? What types of child- or parenting-focused services do providers view as most needed?
  - If and when there are incompatibilities between what parents say they want and need and what program staff perceive as beneficial, how do staff handle these differences?
5. How does the program meet the needs of adolescents? How are these needs different from the needs of middle-school-age children?
6. What does cultural competence mean when it comes to serving young children, middle-school-age children, and adolescents?
7. In a survivor centered, trauma-informed environment, how should program staff reconcile situations in which children are not consenting to participate in activities that their parents have consented to and want them to participate in?

- Do children have the same entitlement to confidentiality with respect to conversations they have with program staff? How should staff address issues that arise when a parent wants to know what a child discussed with program staff, without putting the child in a difficult position?

## 5. Court-Ordered Visitation

### (a) Overview

Visitation-related challenges are likely to be an additional source of stress or re-traumatization for many families in OVW TH programs. Courts determine whether visitation by non-custodial parents needs to be supervised or not, and stipulates the conditions for supervised visits and the role of the supervisor. Common guidelines for visitation include the following: (1) contact is structured to limit parental conflict; (2) transition between parents should be infrequent to avoid conflict and ensure safety; and (3) time with both parents together is limited (Johnson, 1992). Many states place domestic/family violence-related conditions on awards of visitation. The National Council of Juvenile and Family Court Judges' [Model Code on Domestic and Family Violence](#) includes a section (Section 405) on "conditions on visitation in cases involving domestic and family violence." For comparison, the Resource Center on Domestic Violence: Child Protection and Custody (RCDV:CPC), a part of the National Council of Juvenile and Family Court Judges, maintains charts (updated through December 2014) describing the *current state-specific conditions on visitation* ([RCDV, 2014](#)) and *current state-specific conditions on custody* ([RCDV, 2014a](#)). [Saunders and Oehme \(2007\)](#) provides helpful context on judicial thinking about custody and visitation. The [RCDV:CPC website](#) also maintains links to other potentially helpful resources pertaining to domestic violence and child custody, child visitation, child support, and other related matters.

Visitation centers have been established across the country to provide safe places for supervised visitation. *OVW's Safe Havens: Supervised Visitation and Safe Exchange Grant Program* (Supervised Visitation Program)<sup>56</sup> provides opportunities for communities to support supervised visitation. [Guiding Principles: Safe Havens: Supervised Visitation and Safe Exchange Grant Program](#), a 2007 OVW-funded publication, describes six guiding principles for safe implementation of visitation:

- (i) Equal regard for safety for children and adult victims.
- (ii) Value the multiculturalism and diversity of the community and families served.
- (iii) Incorporating an understanding of domestic violence, including the nature, dynamics and impact of domestic violence. In the artificial environment created by a safe haven visitation center, batterers, victims, and their children may behave in ways that may contradict the expectations of staff, and it is important for program staff not to draw conclusions about the underlying family dynamics.
- (iv) Respect and fairness for all persons using services;
- (v) Community collaboration to address families' needs, prevent continued abuse, and eliminate the social conditions that contribute to intimate partner violence; and
- (vi) Advocacy to ensure children and adult victims have meaningful access to services and supports.

Visitation can be a stressful experience for families, even if the child's experience is generally positive. (In fact, a child's positive experience visiting the abusive parent may be an additional source of stress for the abused parent, who may well be concerned about the abusive parent's negative influence on the child.) Supervised

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<sup>56</sup> See the [Safe Haven grant program website](#) for more information. The [Safe Haven technical assistance webpage](#) of the program website lists technical assistance providers who can provide program-level support.

visitation programs are designed to help families safely navigate these experiences, but additional services may be needed to manage all of the complex aspects of parenting in the face of violence. As with other situations faced by families that have experienced DV, providers should be aware of the potential trauma-related responses that visitation may be triggered for children and their parents. Providing support for families around visitation, may include encouraging open dialogue to anticipate potential stressors related to visitation, checking in before and after visits, and helping connect parents and children to services, as needed.

### **(b) Provider Comments**

**Brief Summary:** In interviews, OVW TH providers described varied levels of involvement with visitation. Some providers do not get involved in visitation, except to report potential abuse if a child or parent discloses it to a program counselor. Other providers offer peripheral support around visitation such as safety planning, offering a child advocate as a neutral person a child can talk to if needed, and child groups or counseling if a child is having difficulties around visitation. A few providers are more actively involved in conducting supervised visits or connecting families to others who oversee visitations.

***Inclusion of a comment does not imply endorsement by the authors or OVW of a provider's approach.***

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(#01) We're not involved in visitation by non-custodial parents; that's between the parents and the courts. If the child or survivor discloses something to a counselor that might constitute abuse, we're obligated to report it, and we help them contact Child Protective Services (CPS).

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(#02) The needs of the child come before the needs of the visiting parent. Sometimes we do supervised visits here at the office. If the child doesn't want to see the visitor, we respect that. I will stop a conversation if it becomes too critical of the other parent or if they start digging for information about that parent, what they've done, where they've been.

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(#03) If one of the children in our program participates in a court-sanctioned visitation program with a non-custodial parent, we do a safety plan with the child and with our client – the parent – on how to make exchanges safely. If the child is having issues with that process, we recommend that they participate in a children's group or counseling.

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(#04) We don't get involved in child visitation. We leave that to the court.

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(#05) Visitation is always kind of tricky, because they meet at another location, and we usually have a hands-off approach to the other location. But it's important if it's court-ordered that the child sees the other parent, and we encourage that. But we believe that it's important for a child to have an advocate – a neutral person -- with whom they can talk about things that they might not feel comfortable talking about with their mom. If issues come up or if they feel threatened, the child advocate always brings it back to mom. And we'll explore what we can do to change the visitation if necessary -- or establish visitation, because the child needs to see that other parent for whatever reason, needs that support -- so it goes both ways. But at least the child has someone neutral – our child advocate -- they can talk to.

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(#06) We have a couple of programs related to visitation. We're an onsite partner for a non-profit that oversees visitations. So we connect clients who need help with supervised visitation to our partner agency. When we enroll a participant with children, we talk about how the visitation process will work, because we

want to make sure that the mom is safe, as well as the other clients in our residential programs. For example, one client made an arrangement for the non-custodial parent to pick up the child in an offsite location.

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(#07) We do what we can to make sure the non-offending parent can comply with whatever the court order is. If our client has shared custody with an abusive partner or parent, we do safety planning. We have a safe drop-off program, so we might be able to work it that way. We've also safety planned with clients about doing drop-offs at police stations or whatever they felt comfortable with. We've also had parents who didn't want to comply with the court and we've safety planned around that as well, and what the consequences might be.

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(#08) Another program we have that's pretty important is our family safety center or visitation center, where we provide supervised parenting time and supervised exchange services as well as supervised phone calls and Skype visits. It's an accessible resource for transitional clients, shelter clients, or any of our agency clients who wants to utilize a safe, monitored space for the court-mandated exchange of her children with the non-custodial parent. We provide that service seven days a week, and can help participants with any fees.

#### **Questions to Consider**

1. How does the program prepare participants (and their children) for the visitation process, and for the issues that might arise (e.g., tactics used by the abusive (ex-)partner to perpetrate psychological or other forms of abuse, trauma-related triggers for parents and children during encounters with the abusive (ex-)partner, efforts by the abusive (ex-)partner to use meetings with the children to gain information about their mother or to relay disturbing messages to her, etc.)?
  - How does the program help participants and their children process difficult experiences and feelings after visitation/exchange?
2. How can the program offer support and assistance to survivors who have concerns about their own or their children's safety surrounding visitation and custody?

## **6. Appendix A: Project Description and Methodology**

### **(a) Project Description: Summary**

**Transitional Housing for Survivors of Domestic and Sexual Violence: A 2014-15 Snapshot** provides an in-depth look at the challenges and approaches taken by Office on Violence Against Women (OVW)-funded providers to address the needs of survivors who have become homeless as a result of having fled domestic violence, sexual assault, dating violence, and/or stalking.

The information in the twelve chapters of the report and accompanying webinars, broadsides, and podcasts comes from 124 hour-long interviews with providers and an in-depth review of the literature and online resources. Our analysis of provider comments was informed by the insights of a small project advisory committee (Ronit Barkai of Transition House, Dr. Lisa Goodman of Boston College, and Leslie Payne of Care Lodge) and the reviews and comments on the initial drafts of chapters by Dr. Cris Sullivan (Michigan State University) and Anna Melbin (Full Frame Initiative).

Although the components of a transitional housing (TH) program -- a place to live and staff support for healing, decision making, and taking next steps -- are simple, the complexities attendant to providing effective survivor-centered assistance are many, as illustrated by the following enumeration of topics covered in the report (which, in many cases, only scratches the surface):

- [Chapter #01](#) - **Definition of Success & Performance Measurement** - Explores how funders and providers define and measure success and program performance; how participant-defined goals are tracked; how participant feedback is collected; and how the definition and measurement of success affects program decisions. Highlights innovative performance and participant outcome metrics. Discusses approaches to collecting, storing, releasing, and destroying data, and the software used to collect, analyze, and report on program data.
- [Chapter #02](#) - **Survivor Access and Participant Selection** - Explores the distinct and overlapping roles of domestic violence (DV) shelters and transitional housing; the pathways that survivors take to get to transitional housing, and how providers select participants from among "competing" applicants for assistance; why providers might decline to serve certain candidates; who is and isn't served; and the regulatory and legal framework within which those processes occur.
- [Chapter #03](#) - **Program Housing Models** - Explores the strengths and challenges of alternate approaches to housing survivors in transitional housing and transition-in-place programs. Examines the pros and cons of time-limited housing vs. transition-in-place housing, congregate vs. clustered vs. scattered site housing, and provider-owned vs. provider-leased vs. participant-leased housing. Discusses how the type of housing can affect participant selection and the services offered.
- [Chapter #04](#) - **Taking a Survivor-Centered/Empowerment Approach: Rules Reduction, Voluntary Services, and Participant Engagement** - Examines the challenges, strategies, and implications of taking a survivor-centered/voluntary services approach, and how such an approach is integral to operating a trauma-informed program. Explores the potential impacts of funder expectations, choice of housing model, staffing patterns, and diverse participant needs and circumstances. Presents comments illustrating the range of providers' interpretations of and responses to the voluntary services requirement, including their approaches to supporting participant engagement and to addressing apparent lack of engagement. Discusses the concept of empowerment, presents comments illustrating the diverse ways that providers see and support survivor empowerment, and cites an innovative approach to measuring safety-related empowerment.
- [Chapter #05](#) - **Program Staffing** - Explores program staffing levels and the kinds of positions providers maintain; the attributes and qualifications that providers look for in the hiring process; and how they assess the value of having a clinician on staff, having child-focused staff, and having survivors on staff. Examines how programs support and supervise staff, and their approaches to staff training. Presents comments illustrating providers' diverse perspectives about utilizing volunteers, and describing how programs that do use volunteers screen, train, and support them.
- [Chapter #06](#) - **Length of Stay** - Explores funders' and providers' approaches to limiting or extending the duration of housing assistance and services, and the implication of those approaches.
- [Chapter #07](#) - **Subpopulations and Cultural/Linguistic Competence** – Discusses cultural and linguistic competence and how providers understand and work to achieve it in their programs. Presents diverse perspectives from the literature and online resources and from provider interviews about the challenges and approaches in serving specific subpopulations, including African American, Latina, Asian American, Native American/Alaska Native, Immigrant, LGBTQ, older adult, deaf, disabled, and ex-offender survivors. Includes an extensive review of the challenges, approaches, and legal framework (e.g., non-discrimination, reasonable accommodation, fair housing) in serving survivors with disabling conditions that affect their mental health, cognition, and/or behavior, including trauma/PTSD, substance dependence, traumatic brain injury, and/or mental illness. Highlights OVW-funded collaborations to enhance the capacity of victim services providers to serve survivors with disabilities and of disability-focused agencies to serve consumers who are also survivors.

- [Chapter #08](#) - ***OVW Constituencies*** - Focuses on the needs and approaches to meeting the needs of survivors of sexual violence -- including survivors of rape and sexual assault, homeless victims of sexual violence, survivors of Military Sexual Trauma, and survivors of human sexual trafficking. Explores possible reasons why survivors of sexual assault constitute only a small percentage of the participants in OVW TH grant-funded programs, even though provider comments generally indicate an openness to serving such survivors. Includes a conversation with senior staff from the Victim Rights Law Center discussing possible options for expanding system capacity to serve sexual assault survivors.
- [Chapter #09](#) - ***Approach to Services: Providing Basic Support and Assistance*** - Explores different frameworks for providing advocacy /case management support (e.g., voluntary services, survivor empowerment, Housing First, Full Frame) and how motivational interviewing techniques could be helpful. Discusses survivor safety and how safety is assessed and addressed (e.g., danger and lethality assessment instruments, addressing batterer- and life-generated risks as part of safety planning, safe use of technology). Looks at strategies and practices for supporting community integration, and providing follow-up support to program alumni.
- [Chapter #10](#) - ***Challenges and Approaches to Obtaining Housing and Financial Sustainability*** - Examines the challenges survivors face in obtaining safe, decent, affordable housing and the approaches providers take to help them, and some useful resources. Explores the added challenges posed by poverty, and approaches and resources leveraged by providers to facilitate access to mainstream benefits, education and training, and decent employment. Other areas of focus include childcare and transportation, resources for persons with criminal records, workplace-related safety planning, and approaches and resources for supporting survivors in enhancing key skills, including financial management.
- [Chapter #11](#) - ***Trauma-Specific and Trauma-Informed Services for Survivors and Their Children*** – Discusses the nature, impacts, and manifestations of trauma; approaches to addressing trauma; what it means to be trauma-informed; and the steps providers take -- and can take -- to become more trauma-informed. Reviews the impact of trauma on children and families, especially the trauma of witnessing abuse of a parent; and discusses the challenges posed and approaches taken in addressing the effects of that trauma. Includes brief sections on custody and visitation.
- [Chapter #12](#) - ***Funding and Collaboration: Opportunities and Challenges*** - Examines sources of funding for TH programs, focusing on OVW and HUD grants -- the regulatory requirements, strengths and constraints of each funding source, and the challenges of operating a program with combined OVW/HUD funding. Explores the potential benefits, challenges, and limitations of partnerships and collaborations with mainstream housing/service providers, including confidentiality issues. Presents provider comments citing the benefits of being part of a statewide coalition; discussing the opportunities and challenges of participating in a Continuum of Care; and illustrating the range of gap-filling service agreements and collaborations with mainstream providers. Highlights published reports describing successful collaborations.

Although the report chapters attempt to divide the component aspects of transitional housing into neat categories, the reality is that many of those aspects are inextricably linked to one another: the definition of success, the housing model, and sources of funding play a key role in how services are provided; the housing model, sources of funding, and length of stay constraints can play a role in influencing participant selection; the subpopulations targeted and served and the program's approach to cultural/linguistic competency, the program's understanding and embrace of voluntary services, survivor-defined advocacy, and what it means to take a trauma-informed approach all inform how the program provides basic support and assistance; etc.

#### **(b) Project Description: Overall Approach**

This project was originally conceived as a resource guide for "promoting best practices in transitional housing (TH) for survivors of domestic and sexual violence." However, over the course of our conversations with

providers, it became clear that while there are certainly commonalities across programs -- for example, the importance of mutual trust and respect between participants and the providers that serve them, and the fundamental principles of survivor-defined advocacy and voluntary services -- there is no one-size-fits-all "best practices" template for providing effective transitional housing for survivors. Instead, there are a multitude of factors which go into determining providers' approaches:

Survivors from different demographics and circumstances may experience domestic and sexual violence differently and may respond differently to different service approaches. Age, class, race, cultural and linguistic background, religious affiliation, gender identity, sexual orientation, military status, disability status, and, of course, life experience all play a role in defining who a survivor is, how they experienced victimization, and what they might need to support healing and recovery. Each survivor's history of violence and trauma and its impact on their physical, physiological, emotional, and psychological wellbeing is different, and their path to recovery may require different types or intensities of support.

Where a program is located and how it is resourced plays a significant role in shaping a program, the challenges it faces, the opportunities it can take advantage of, the logistics of how housing and services are provided, and the kinds of supplementary resources the program might be able to leverage from other sources. Different parts of the country have different types of housing stock, different housing markets, different levels of supply and demand for affordable housing or housing subsidies, and different standards for securing a tenancy; different regions of the country have different economic climates, different labor markets, and different thresholds for entering the workforce; depending on where they are located, low income survivors could have very different levels of access to emergency financial assistance, health care, mental health care, addiction services, child care, transportation, legal assistance, immigration services, and/or other types of supplemental support.

"Best practices" for a stand-alone TH program in which a part time case manager serves a geographically scattered clientele in a rural, under-resourced region will mean something different than "best practices" for a well-resourced, full-service metropolitan-area provider that affords participants access to different types of transitional housing; that can leverage the support of culturally and linguistically diverse in-house staff and volunteers, that can contribute the services of in-house therapists, child specialists, employment specialists, and other adjunct staff; and that can rely upon nearby providers for additional gap-filling services.

"Best practices" in providing transitional housing for a chronically poor survivor whose education was interrupted, who has never been allowed to work, and who suffers from complex trauma as a result of childhood abuse may well look different from "best practices" in serving a survivor who is better educated, has a credible work history, but who was temporarily impoverished due to her flight from an abusive partner.

"Best practices" in serving a recent immigrant, with limited English proficiency, who lacks legal status, whose only contacts in America are her abusive partner's extended family -- will likely look different from "best practices" in serving a teenage girl who ran away from sexual abuse in her small town home, only to end up pregnant and in an abusive relationship, which she fled when he threatened to hurt her baby -- which, in turn, will look different from "best practices" for serving a middle-aged woman who tolerated her husband's abuse for years, because he supported the family and because she couldn't, and because keeping the family together was what her community and her church expected her to do, and what she would have continued to do until he finally went too far.

While there are commonalities to the approaches taken by the diverse programs awarded OVW TH grant funding, the very nature of the kind of "holistic, victim-centered approach ... that reflect[s] the differences and individual needs of victims and allow victims to choose the course of action that is best for them," called for in the [OVW's annual solicitation for TH grant proposals](#), argues against too many generalizations about one-size-fits-all "best practices."

Recognizing that survivors from a broad spectrum of demographics and circumstances may have different needs and priorities and goals, may have and/or perceive different options for moving forward in their lives,

and likewise, may have different definitions of "success," the OVW refrains from asking its TH grantees to render judgments about the quality of specific program outcomes.

In the absence of a consistent measurement of success and a framework for measuring differences in clientele and program operating environments -- that is, lacking a data-informed basis for assessing whether a particular intervention constitutes a "best" practice -- we chose to take a more descriptive approach for this report. Drawing from providers' own words, the literature, and online resources, we have attempted to frame and provide context for the broad range of challenges and choices that providers face; to describe and offer context for and examples of the approaches they take in furnishing transitional housing for survivors; and to highlight some of the unresolved issues and difficult questions that providers wrestle with.

### **(c) Project Methodology: Collection and Analysis of Data from Provider Interviews**

#### ***(i) Development and Implementation of the Interview Protocol***

Drawing from information gleaned from the literature and online resources, and from some of the project and advisory team members' personal experience in working with transitional housing programs and/or providing services to survivors of domestic violence, we developed a list of topics and potential questions that we hoped to cover in our provider interviews.

Because there were so many potential subjects to discuss and only an hour to have those conversations, we divided the topics into separate interview protocols. In addition to basic descriptive information ("universal topics")<sup>57</sup> that would be collected in each interview, we defined four distinct sets of topics<sup>58</sup> that would be sequentially assigned as interviews were scheduled. Over time, we eliminated certain areas of questioning

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<sup>57</sup> **"Universal" Topics:** Program size (number of units, individuals, families); type and configuration of program housing (e.g., temporary vs. transition-in-place; congregate vs. clustered vs. scattered-site; provider-owned vs. provider-leased vs. participant-leased); target constituency (e.g., survivors of domestic violence, sexual assault, etc.); type/number of direct services staff, use of consultants, involvement of other agency staff; other DV- or non-DV-focused programs operated by agency; how survivors access program and participant selection/prioritization; how staff understand the different roles of DV shelter vs. TH; characterization of service area (e.g., metropolitan area, small city, suburban, rural, mixed); program definition of a "successful" outcome and how program promotes success; how program implements voluntary services; maximum, typical, and targeted length of stay; other sources of funding; involvement with local or regional network of DV-focused providers and/or with Continuum of Care; most significant challenges faced by program; perceived differences between TH for other homeless populations and TH for survivors of domestic violence/sexual assault.

<sup>58</sup> **Group 1 Topics:** staffing details (roles, training, support, etc.); use of volunteers (roles, reasons for/against using, training and support); program philosophy and underlying approach (e.g., trauma-informed, empowerment, survivor-centered, etc.); consumer involvement (Board membership, advisory roles, options for current participants).

**Group 2 Topics:** assistance obtaining housing (challenges faced, strategies used, partnerships, etc.); employment assistance (challenges faced, strategies pursued, partnerships, etc.); approach to working with participants with significant barriers (e.g., economic, mental health, substance abuse issues, etc.); child- and family-focused services (what triggers needs assessment, needs assessed, how needs are addressed and by whom, interface with schools); follow-up services (type offered, challenges faced, insights into utilization patterns).

**Group 3 Topics:** challenges, advantages, and reasons for choosing type of program housing and approach to offering financial assistance with housing-related costs; distinctive subpopulations served (population-specific challenges and approach, challenges/approaches pertaining to serving a mixed clientele, etc.); meaning and dimensions of cultural competence; approach to ADA compliance in serving persons with disabilities; collaborations (strategies, challenges).

**Group 4 Topics:** program rules and the consequences of violating them; performance measurement (formal vs. informal approach, specific measures, whether/how participant progress is measured and used to gauge program performance, impact on program design) ; approach to data collection (software used, data collected above and beyond funder requirements, compliance with HUD comparable data base requirement); funding opportunities and constraints (challenges/strategies for government and non-government funding); challenges and benefits of collaboration with local/regional HUD-funded planning entities (Continuum of Care, Consolidated Plan).

from the interview protocol if we were not getting new information, and added topics or questions, as we identified gaps in our information. By the time half the interviews had been completed, the four lists of topics/subtopics had been condensed into three lists/interview protocols.

Pursuant to early discussions with the OVW, we agreed that the initial protocol would be "field-tested" by conducting interviews of staff from nine TH providers that the OVW identified and reached out to on our behalf. We also agreed that our interviews would be conversational and driven by the providers we were interviewing. That is, ***although we had lists of topics and questions that we might want to address, we would follow the lead of the provider to make sure we covered any issues or concerns or approaches that they wanted to highlight. Rather than asking a uniform series of questions, we would use our protocols as guides, rather than as interview scripts.*** To realize this objective, our team worked together to make sure we had the same general understandings of the protocol and the purpose of the interviews. The nine initial interviews were all conducted by pairs of team members, to facilitate full-team participation in our review of those interviews and in any revisions to the protocol based on that review.

Our team followed up the OVW's initial outreach to the nine providers with emails elaborating on the project (and attaching the OVW's initial letter), and providing supplemental information emphasizing the voluntary nature of participation and how ***provider responses would be kept confidential.***

Each interview began with an introduction of the project; an explanation of how we intended to create a resource document that would describe the what, how, and why of providers' efforts ***in their own words***; a request to record the conversation; and an assurance that ***once the project was over, recordings and transcripts would be deleted, so that all that would be left would be anonymous comments.*** We followed this same procedure throughout the project, eventually reaching out to almost 250 providers and securing the participation<sup>59</sup> of over 50%. Early on, we modified the process, per the request of some of the providers, and began sending a tentative list of topic areas along with the email confirming the date and time of each interview. The email emphasized, however, that the provider should feel free to steer the conversation as they saw fit, to make sure we covered any issues, concerns, or approaches that they wanted to highlight.

Starting with the first "field test" interviews in June 2014 and ending in February 2015, the project team completed interviews with 122 TH providers and one legal services provider that partnered with a TH provider (the Victim Rights Law Center, which asked to be specifically identified), and conducted a joint interview with two providers of LGBTQ domestic violence-related services (identified by Project Advisory Team members, in response to our request for help identifying experts who could help fill that information gap). The project director conducted 62% of the interviews and read the transcripts of all the other interviews.

Of the 122 providers, 92% (112 providers) were current recipients of OVW TH grants; another eight providers had recently lost their OVW grants and, at the time of their interview, were either operating a TH program with other funds, or had ceased TH operations. (Some of these providers subsequently received OVW TH grants.) Only two of the 122 TH providers interviewed had never received OVW TH grants (and were HUD- or state-funded). Fifty-one (42%) of the TH providers we interviewed were current recipients of one or more HUD Continuum of Care Transitional Housing (TH) or Rapid Rehousing (RRH) grants and/or a HUD Emergency Solutions Grant (ESG) RRH grant.

### ***(ii) Processing of Interview Data***

All interviews were submitted to a transcription service and the transcript was reviewed for accuracy (and corrected, as needed) by the project director. Transcripts of the interviews were entered into NVivo, a qualitative data analysis software, and then sentences or paragraphs that pertained to each of 27-30 project-

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<sup>59</sup> We actually secured the participation of 130 providers; however, six interviews were not included in the analysis because the interviewee was not adequately familiar with the TH program, or the program was too new to have any experience, or the provider no longer operated the TH program and no longer had staff who could answer our questions.

defined topic areas<sup>60</sup> were coded as being related to that topic area. The project director performed the large majority of coding, and reviewed (and, as needed, modified) all of the coding decisions by the project associate, thereby ensuring coding consistency.

The selected provider comments pertaining to each topic area constituted a voluminous amount of data, and had to be boiled down, so that they could be shared with our Project Advisory Team members, and eventually incorporated into the report. Interview comments were edited for clarity and brevity, with an absolute emphasis on retaining the voice and essential message of provider comments. The interviewer's voice was removed. Names of people, places, and programs were removed and replaced with generic references to ensure confidentiality and anonymity, as had been promised to providers at the outset of each interview, and in our outreach correspondence. The project director did the overwhelming majority of all such editing, and reviewed (and, as needed, modified) all edits proposed by the project associate.

These compilations of provider comments (still averaging 20-30 pages, after editing) were shared with members of our Project Advisory Team and reviewed and discussed in a series of thirteen 90-minute meetings over the course of several months. Insights from those conversations, as well as information and perspectives from the literature and online sources were integrated into narratives that supplement the extensive presentation of provider comments in each of the twelve chapters.

Although this is a qualitative study and not quantitative research, we have included the large majority of the provider comments pertaining to each of the covered topics to provide the reader with not only a ***sense of the range of challenges, approaches, and philosophies***, but also with a ***sense of the frequency with which they were mentioned or reflected in provider comments***. Some of the comments will seem very similar to one another, some will differ by nuance, and some will be dramatically different.

This report does not include the very important perspective of victims/survivors. Collecting the feedback of survivors served by OVW TH grant-funded programs was deemed by the OVW to be outside the scope of the Technical Assistance grant that generously funded this project. Although our "***Snapshot of Transitional Housing for Survivors Of Domestic and Sexual Violence***" is missing that perspective, we hope it is nonetheless useful to the dedicated providers, researchers, and government officials who are committed to supporting and strengthening these and other efforts to address the scourge of domestic and sexual violence.

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<sup>60</sup> Several codes were consolidated as the coding process evolved.

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