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

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

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#### **Submitted to:**

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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."*

## 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**.

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