

Considerations when Implementing Trauma-informed Care into Male Domestic Violence

Offenders' Intervention Programs

by

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Abstract

This project addresses significant factors to consider when implementing trauma-informed care in Batterer' Intervention Programs. Literature addressing trauma informed care and domestic violence interventions is discussed to demonstrate how trauma-informed care might be used with male perpetrators of domestic violence. There is a gap in the literature describing how trauma-informed care is integrated with domestic violence perpetrators, and this gap is surprising due to extensive literature supporting a clear link between trauma history and violent criminality. A checklist was created using the best practices in trauma-informed approaches and is intended to be used by agencies in a clinical setting, including Batterer' Intervention Programs seeking to integrate trauma-informed approaches when working with male batterers.

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Considerations when Implementing Trauma-informed Care into Male Domestic Violence Offenders' Intervention Programs

This project examines important factors to consider when working to implement trauma-informed care (TIC) into Batterer' Intervention Programs (BIPs) when treating male Domestic Violence (DV) offenders. This project will not attempt to demonstrate if TIC will increase retention or success rates of BIPs, but instead, will explore literature regarding Trauma, DV, BIPs and TIC. This project seeks to answer the following research question, "What are significant factors that should be considered when working to implement trauma-informed care into Batterer' Intervention Programs?"

Once these concepts have been reviewed, an application piece in the form of an agency checklist is presented. The checklist is to be used as an instrument to inform as well as guide agencies looking for literature supported TIC strategies that can be incorporated into a clinical setting.

Theoretical Framework

Bronfenbrenner's ecological systems model is ideal for contextualizing the widespread effects of trauma and violence in an individual's life (Boon et al., 2012; Bowman & Roysicar, 2011; Hoffman & Kruczek, 2011; Jun Sung et al., 2010). When examining the role of the ecological systems model and violence, Jun Sung et al. (2010) noted that this "model is ideal for integrating segmented parts into understandable pieces and allows for a more complete analysis of social environmental factors that impact human behavior" (p. 562).

This model is based on the hypothesis that an individual's schema and wellbeing is created and influenced by the various social interactions within each system (Boon et al., 2012). The social interactions that are formed within the system play a role in determining the impact as

well as an individual's response to events (Bowman & Roysicar, 2011). There are five systems which structure an individual's social context, (1) microsystem, (2) mesosystem, (3) exosystem, (4) macrosystem and (5) chronosystem (Bronfenbrenner, 1977). The microsystem encompasses relations between an individual and their immediate environment, including home, work or school (Boon et al., 2012; Bronfenbrenner, 1977). The mesosystem includes interactions between individuals from separate microsystems (Boon et al., 2012); a mesosystem is a system of microsystems, such as the relation between home and school (Bronfenbrenner, 1977; Bronfenbrenner, 1994). The exosystem is comprised of the organizations that an individual is exposed to, intentionally or unintentionally, for example, a parent's workplace and its effects on a child's life (Bronfenbrenner, 1977; Bronfenbrenner, 1994). If an individual does not have direct contact with an organization, it may still have an influence on the individual's behavior (Banyard, 2011). The macrosystem is made up of institutional patterns (Bronfenbrenner, 1977), social norms (Bowman & Roysicar, 2011), sociopolitical factors, governmental systems and economic factors (Hoffman & Kruczek, 2011). Finally, the chronosystem represents time in relation to the individual's environment (Boon et al, 2012; Bowman & Roysicar, 2011).

Understanding trauma through the lens of the ecological model requires a focus beginning on the microsystem and examining how the effects of trauma spread to other systems. An individual's microsystem experience combines with other microsystems to create a larger, shared experience (Bowman & Roysicar, 2011). Understanding the pervasive effect of violence and trauma across systems requires a focus on the individual's life from a micro to macro level, and suggests a helping professional ask what happened to the individual, rather than asking what is wrong with the individual.

Literature Review

Domestic Violence

Domestic violence is categorized as an individual attempting to gain control or power over a current or former intimate partner through physical abuse, intimidation, battery, sexual assault or psychological abuse (National Coalition Against Domestic Violence, 2015; United States Department of Justice, 2016; University of Alaska Anchorage Justice Center for the Council on Domestic Violence and Sexual Assault, 2015). An intimate relationship is categorized as current or former marriage, cohabitation, romantic or sexual interaction (Drijber, Reijnders, & Ceelen, 2013; University of Alaska Anchorage Justice Center for the Council on Domestic Violence and Sexual Assault, 2015).

Rates of domestic violence across the world are high. In 2013, García-Moreno in conjunction with the World Health Organization (WHO) published a groundbreaking report that deemed violence against women a global epidemic and cited that more than one in three women worldwide are affected by intimate partner violence. García-Moreno (2013) found that the regions with the highest rates of DV against women are South-East Asia with 37.7%, the Eastern Mediterranean with 37% and Africa with 36.6%. The report noted these statistics could be relatively low due to the stigma of reporting DV, as well as inefficient reporting and poor data collection methods in remote areas. Matching the trend worldwide, the United States also reports high rates of DV. Black and colleagues (2011) with the Centers for Disease Control and Prevention jointly published a study that estimated nearly one in three women in the United States had experienced or would experience severe physical abuse by an intimate partner in their lifetime.

In the State of Alaska, nearly 50 out of every 100 adult female residents has experienced intimate partner violence or sexual violence (University of Alaska Anchorage Justice Center for

the Council on Domestic Violence and Sexual Assault, 2015). More specifically, 44 out of 100 female residents in the Fairbanks North Star Borough have experienced intimate partner violence or sexual violence (University of Alaska Anchorage Justice Center for the Council on Domestic Violence and Sexual Assault, 2015).

Males on average have a higher likelihood of perpetrating DV towards women (Black et al., 2011; Devaney, 2014; Johnson, 2011). Furthermore, when looking at various treatments for DV perpetrators, much of the literature focuses on males (Alexander, 2007; Babcock, Green & Robie, 2004; Cluss & Bodea, 2011; Corvo et al., 2009; George, 2012; Gondolf, 2012; Hamel et al., 2015; Lehman & Simmons, 2009; Mankowski, Haaken & Silvergleid, 2002; Miller, Drake & Nafziger, 2013; National Institute of Justice & US Department of Justice, 2003; Rizza 2009; Roberts, 2000; Weldon & Gilchrist, 2012). Due to the high rates of female DV victimization and extensive focus in the literature on males as DV perpetrators, this project will focus on males who perpetrate DV against women in intimate relationships

Effects of Domestic Violence. DV has a lasting impact on its victims, which underscores the importance of addressing this global epidemic. Starting in the 1970's individuals who worked with DV victims realized that simply sending the victim back home was not going to change the situation and, consequently, sanctions such as group interventions and compulsory arrest laws for men who commit DV were instated (Babcock & Steiner, 1999).

Women who are victims of DV may experience physical and mental health difficulties that endure long after the abuse has ended (Breiding et al., 2015; Campbell, 2002; Dillon et al., 2013). The effects of DV on women include physical ailments such as irritable bowel syndrome (Campbell, 2002), chronic pain, gynecological difficulties, asthma and headaches (Ferencik & Ramirez-Hammond, 2011). Additionally, there are mental and emotional effects including

lowered self-esteem, anxiety, phobias, depression, Posttraumatic Stress Disorder (PTSD), self-harm and dissociative disorders (Buchanan, Power, & Verity, 2014). Although long-term effects from DV are common, there are protective factors that encourage resilience in abused women. Social support and healthy relationships can work to offset the possible detrimental effects of being a victim of DV (Carlson, 2005).

Children are also susceptible to harmful effects when exposed to DV. Extensive research has found that exposure to DV negatively impacts the social, emotional, cognitive and behavioral development of babies and children (Buchanan, Power, & Verity, 2014; Campbell & Lewandowski, 1997; Huth-Bocks, Levendosky, Theran & Bogat 2004). In addition to the harmful effects on a child's development, their attachment style is negatively affected as well (Huth-Bocks et al., 2004; Sousa et al., 2011). An insecure attachment in childhood due to being a victim of abuse or witnessing DV can lead to anti-social behavior, aggression, poor parenting skills and negative representations of self (Finzi-Dottan & Harel, 2014; Petersen, Joseph & Feit, 2014; Sousa et al., 2011).

One of the best predictors of a male becoming a DV offender is witnessing his mother being assaulted, causing further alarm regarding children witnessing DV between caregivers or experiencing their own abuse (Indermaur, D, 2001; Kyu & Kanai, 2005; Unicef, 2006). Multiple authors propose that social learning theory and attachment theory explain the heightened risks of intergenerational transmission of violence due to the substantial impact of early social experiences on adult interpersonal relationships (Banyard et al., 2003; Milner et al., 2010; Unger & Luca, 2014; Weldon & Gilchrist, 2012). In regards to social learning theory, Hamel et al. (2015) posited that childhood exposure to violence creates norms about the use of violence within families.

Bronfenbrenner's ecological systems model postulates that life is dictated by various social interactions within the five connected systems, therefore victims of DV face challenges in each system. Using the information and statistics evidenced above regarding the widespread effects of DV, it is clear that the consequences do not stop in the victim's microsystem, but extend across all of the ecological systems. Furthermore, when an individual commits DV, the ecological system is affected as well. Court ordered interventions for DV perpetrators happen in the exosystem, but the beliefs and experiences that inform the roots of violence start in the microsystem.

Batterer Intervention Programs

After an individual is adjudicated of committing DV, most states in the United States have legislation that requires the perpetrator to attend a court-mandated intervention. Due to the policies created by states' legislatures, court mandated interventions such as BIPs are the most common response to DV charges (Barner & Carney, 2011; Boal & Mankowski, 2014; Desmarais et al., 2012). Boal and Mankowski (2014) estimated that approximately half a million men a year are enrolled in 2,500 BIPs across the United States. Additionally, in a survey of over 2,000 BIPs, Price and Rosenbaum (2009) confirmed that the percentage of men attending BIPs due to a court order was 96%. Ordering DV offenders to attend BIPs is used as a common court-ordered probation intervention (Price & Rosenbaum, 2009) as jail time has been evidenced to be detrimental for the victim and fails to deter recidivism in offenders (George, 2012; Klein et al., 2014; Sloan et al., 2013).

For victims of DV who choose to remain with their offender, incarceration or arrest can have a negative impact (Carey & Solomon, 2014; Davis & Taylor, 1999). While the majority of women who choose to stay want safety, they also do not want to jeopardize their family's

income, financial security or experience negative social stigma by having their partner incarcerated (Barner & Carney, 2011; Carey & Solomon, 2014; Davis & Taylor, 1999).

Furthermore, women who do not report DV do so because of multiple reasons, including fear of experiencing reprisal, family separation, the complicated legal system, and the desire to retain privacy (Barner & Carney, 2011; Felson et al., 2002; Lutgendord et al., 2012).

Jail time can also create a negative outcome for the offender. In a study of 70,000 DV offenders in Washington State, George (2012) in conjunction with the State of Washington found that incarceration because of a misdemeanor DV offense was associated with an increased risk of domestic violence recidivism. Additionally, in a study of differential sentencing for DV offenders in Rhode Island, Klein et al. (2014) found that offenders who are given lighter jail sentences (such as misdemeanors) have a higher rate of recidivism than those who receive sentences that are more punitive. Finally, in an empirical analysis study in North Carolina, Sloan et al. (2013) found that sanctions such as fines or misdemeanor jail time do not deter rates of DV recidivism.

Although short-term incarceration is potentially ineffective in deterring recidivism, letting an individual go freely after committing a domestic violence assault also increases the chances of recidivism. Therefore, rather than incarceration or dropping the charges, probation has been evidenced as a proper intervention in reducing DV assault recidivism (Beldin et al., 2015; Davis & Taylor, 1999; Klein et al., 2014)

Effectiveness of Batterer' Intervention Programs

The large number of DV offenders attending BIPs each year necessitates understanding how these programs work, as well as their effectiveness as a DV intervention. The effectiveness of BIPs as a treatment modality for male DV perpetrators is widely debated in the literature

(Babcock, Green & Robie, 2004; Cluss & Bodea; 2011; George, 2012; Gondolf, 2004; National Institute of Justice & US Department of Justice, 2003). In a report presented to the U.S. Department of Justice, Davis, Taylor and Maxwell (2000) found that the majority of BIP studies conducted have low rates of validity and therefore the accuracy of the reports are questionable. Additionally, Davis and colleagues (2000) theorize the lack of accuracy in the literature regarding the efficacy of BIPs is due to "methodological shortcomings" (p. 8). In a meta-analysis, Gondolf (2007) remarked that many of the batterer program studies are compromised by selection bias, low responses rates and short follow-up periods. Many researchers question the effectiveness of BIPs. Multiple researchers have postured that the Duluth model and CBT are less effective than no intervention whatsoever (Alexander, 2007; Davis, Taylor & Maxwell, 2000; Dunford, 2000). In a thorough meta-analysis, Arias, Acre and Vilarino (2013) examined 49 published BIP efficacy studies between 1975 and 2013 and concluded that the treatment of batterers had no statistically significant effect, regardless of the intervention.

However, there are studies that have produced results that support BIPs as a positive and somewhat effective treatment (Arias, Arce, & Vilariño, 2013; Babcock, Green & Robie, 2004, Davis & Taylor, 1999; Green, 2016). In a meta-analysis of five randomized trials and 17 quasi-experimental studies, Babcock et al. (2004) concluded recidivism for men who are court ordered to attend BIPs is reduced, although the effect size is small. This effect size approximates to 5%, and although this would seem inconsequential, Babcock and colleagues (2004) noted that it means there are nearly 42,000 women a year who are no longer being battered because of BIP interventions. Green (2016) conducted a study regarding rates of recidivism for a specific BIP site. The study evidenced lowered rates of recidivism for individuals who completed the batterer' intervention, compared to those who drop out. The sample was comprised of 101

randomly selected male participants who attended a specific BIP site between 2007 and 2015. The study's results found only 20% of the individuals who completed the program were later arrested for a violent crime, while 41% of the individuals who dropped out of the program re-offended (Green, 2016).

Even with conflicting evidence regarding the effectiveness of BIPs, it is the most common treatment for male DV offenders. In fact, most states have legislation that requires offenders to attend BIPs (Carter, 2010; Pepin, Hoss & Penn, 2015; Price & Rosenbaum, 2009). Although there is still research being conducted regarding the unique practices of each BIP operating in the field (Carter, 2010; Eckhardt et al., 2013; Hamilton, Koehler & Lösel, 2013; Price & Rosenbaum, 2009), most states mandate a standard treatment approach with male DV offenders; additionally the standards prohibit certain harmful modalities, such as couples therapy or anger management (Boal & Mankowski, 2014). As of 2013, there are 45 states in the U.S. that have set standards and requirements for BIPs (Batterer Intervention Services Coalition of Michigan, n.d.).

When turning to the literature for BIP standards, the Duluth model and Cognitive-Behavioral Therapy (CBT) are two prominent approaches that are consistently studied (Babcock et al., 2004; Barner & Carney, 2011; Corvo, Dutton & Chen, 2009; Feder & Wilson, 2005; Gondolf, 2004; Lehman & Simmons, 2009). Although there is some overlap in the techniques used the two models, there are differences in philosophy, approach, as well as the interaction between facilitator and offender.

The Duluth Model. Created in 1981 in Duluth, Minnesota, the Duluth Abuse Intervention Program (commonly referred to as the Duluth model) was the first approach to be used as a form of batterer intervention (Barner & Carney, 2011; Hamel, Ferreira & Buttell, 2015;

Lehman & Simmons, 2009). This feminist psychoeducational approach focuses on the socialization of males and societal inequality in regards to gender roles (Arias, Arce, & Vilariño, 2013; Babcock et al., 2004; Barner & Carney, 2011). It seeks to raise awareness amongst male offenders regarding the ongoing conditioning of males to suppress emotions and behaviors (Lehman & Simmons, 2009; Roberts, 2000; Weldon & Gilchrist, 2012). Furthermore, this approach is used especially when addressing an unequal relationship between two individuals and confronts the belief that men are allowed to use power and control in relationships with women (Arias, Arce, & Vilariño, 2013; Lehman & Simmons, 2009; Roberts, 2000).

Additionally, the Duluth model concentrates on the deconstruction of male privilege while striving to re-educate participants about pre-conceived beliefs regarding gender hierarchy and the use of power and control (Arias, Arce, & Vilariño, 2013; Corvo, Dutton & Chen, 2009; Jackson et al., 2003). In a recent study of various DV offender interventions, Weldon and Gilchrist (2012) found that current forms of the Duluth model focus on three specific beliefs held by offenders: (a) inflexible beliefs about male and female roles, (b) the need for control and (c) male entitlement. The Duluth model may implement some use of CBT (Hamilton, Koehler & Lösel, 2013) but does not focus group sessions solely upon CBT interventions (Smedslund et al., 2011) and is therefore at times regarded as a “hybrid” of both Duluth and CBT (Lehman & Simmons, 2009; p. 5).

The creators of the Duluth model, Pence and Paymar (1993) designed and developed the curriculum to focus on (a) a women’s reality and victim experiences, (b) explaining how socialization impacts violence, as well as cultural and social diversity, (c) preventing the facilitator from getting stuck on participants’ personal problems, (d) keeping the men focused on their use of violence and not on their partner or relationship, and (e) helping the men discover

and practice ways to change their behavior (Pence & Paymar, 1993). In addition, the curriculum used in the Duluth model includes (a) defining DV, (b) education about historical, cultural and social facets of DV, and (c) examining criminal and legal issues regarding DV (Davis, Taylor & Maxwell, 2000). Through this curriculum, the Duluth model established a protocol that requires a focus on the offender's actions, believing that the offender is the only individual responsible for his behavior (Lehman & Simmons, 2009; Pence & Paymar, 1993) and violence committed by the woman is often an act of self-defense (Dutton & Corvo, 2006; National Coalition Against Domestic Violence, n.d.; Rizza, 2009).

The Duluth model does not view groups as therapeutic (Barner & Carney, 2011), and therefore does not use diagnoses for participants. Furthermore, the Duluth model mandates that facilitators treat voluntary participants the same as individuals who are court ordered. This means holding them to the same standard of open disclosures regarding irrational beliefs, use of violence, as well as homework participation (Lehman & Simmons, 2009). Homework is in the form of a control log, which is intended to force the offender to focus on six key elements of their abusive behavior and explore non-abusive actions (Hamel, Ferreira & Buttell, 2015; Lehman & Simmons, 2009). The control log is often used to facilitate a group confrontation of an individual's abusive actions (Pence & Paymar, 1993).

A cornerstone of the Duluth model is the coordination and collaboration of community agencies such as law enforcement, women's shelters, probation/parole officers, the court system, and child protective services (Barner & Carney, 2011; Duluth Abuse Intervention Program, n.d.; Edleson, 2012; Price & Rosenbaum, 2009). This community response was created in order to take the blame off of the victim, and place the "onus" back on community agencies that are responsible for the protection of the victim and prosecution of the offender (Shepard & Pence,

1999, p. 17). This means that a BIP is only a small piece of a system that is in charge of keeping offenders accountable for their actions. As of 1999, 92% of state standards required community collaboration as an essential aspect in BIPs (Austin & Dankwort, 1999).

The Duluth model is the most common court mandated BIP intervention for men in the U.S. and Canada (Babcock et al., 2004; Corvo et al., 2009). In fact, many states, such as Washington State, forbid BIPs to use treatment modalities other than the Duluth model (Miller, Drake & Nafziger, 2013). Even with its overwhelming popularity, the Duluth model is not as supported by evidence as might be expected. As stated previously, some researchers have found the Duluth model to be an ineffective intervention for male DV perpetrators (Alexander, 2007; Babcock et al., 2004; Corvo et al., 2009; Hamel et al., 2015; Mankowski, Haaken & Silvergleid, 2002; Miller, Drake & Nafziger, 2013; Rizza 2009). The Duluth model has received heavy criticism for its use of aggressive, confrontational tactics and supporting the belief that discussing a perpetrator's previous experience of victimization is colluding and can be dangerous to the victim (Mankowski, Haaken & Silvergleid, 2002; Rizza 2009).

Alexander (2007) cautions against the confrontational approach with a batterer due to the negative outcome it has with populations who are resistant. Furthermore, Corvo and Dutton (2006) proposed that judgment and humiliation are at the center of Duluth intervention groups and this results in clients who are resistant to treatment in addition to dropping out of treatment at high rates. Rizza (2009) found that the Duluth model fails to address substance abuse, psychological problems or trauma as the cause of the abusive behavior and instead focuses solely on the need for power and control as the reason for abuse. Additionally, common risk factors for violence like impulse control problems, previous trauma, stress, anger problems, lack of skills or negative interactions are deemed as excuses made to justify DV (Rizza, 2009). Further, Corvo et

al. (2009) proposed that the Duluth model has factors which prevent it from being an effective intervention, such as (a) lack of research supporting the model as an evidence-based practice (EBP), (b) connection of assessments with treatments, and (c) failure to provide treatment that is specific to client needs.

It is clear there is a paradox regarding the use of the Duluth model in court systems; it is not an evidenced based program and can be potentially harmful to offenders; yet, it is the most common court ordered treatment. A study completed by Buttell and Carney (2000) showed that approximately 40 to 60% of men attending BIPs that implement the Duluth model failed to complete the program, even though it was a condition of probation. Finally, the literature contains criticism of the Duluth model due to its basis in ideological ideas rather than evidence-based concepts (Cluss & Bodea, 2011; Corvo & Dutton, 2006; Rizza, 2009).

Cognitive-Behavioral Therapy. CBT interventions for BIPs are based on the idea that violence is a learned behavior that is functional for the perpetrator and its use allows control over situations and relationships (Adams, 1988; Alexander, 2007). Therefore, new and nonviolent skills can be taught to the perpetrator (Babcock et al., 2004; Eckhardt et al., 2006). When implementing CBT techniques with male DV offenders, the facilitator frames violent behavior and DV as not just a random act of violence but a predictable behavior that can be recognized by the offender and therefore can be relearned (Feder & Wilson, 2005). In addition to reforming beliefs about violence, offenders are taught skills such as relaxation techniques, positive self-talk, communication, thought restructuring and conflict resolution skills (Alexander, 2007; Smedslund et al., 2011). The purpose of using CBT as a BIP intervention is to identify thoughts and beliefs regarding violent behavior and then challenge their use in the client's life. Changing

thoughts and behaviors regarding violence attempts to “interrupt the chain of events that lead to physical abuse” (Smedslund et al., 2011, p. 3).

Using a CBT approach when working with male DV offenders has garnered positive support. Gondolf (2004) concluded that gender-based CBT programs could be appropriate interventions for men who batter because of antisocial tendencies that accompany the personalities of some men who commit DV. In BIPs site evaluations, Gondolf (2007) found that majority of men who attend CBT batterer interventions appear to stop their assaultive behavior and reduce DV behavior. Dutton and Corvo (2006) concluded that CBT groups had more success than BIPs that focus solely upon Duluth model techniques. BIPs who employ CBT intervention such as skills training, motivational interviewing as well as thought stopping and reframing must have offenders who are willing participants to be effective (Alexander, 2007). Additionally, Gondolf (2004) found that CBT is efficient and less costly to implement.

A recent study conducted in Norway by Palmstierna et al. (2012) explored the effectiveness of a CBT group for batterers attending as volunteers. After 15 weeks of CBT groups, the sample size of 26 men evidenced a significant reduction in self-reported violence. Although, limitations include a small sample size, and volunteer status of the batterers, Palmstierna and colleagues (2012) indicated that the results were promising and suggested future duplication in a large sample size with a longer follow-up period. In another study of five U.S. active duty and veteran military members participating in a 12 week, CBT group for batterers, Taft et al. (2007) found the intervention reduced DV in general as well as the participant’s patterns of coercive and controlling behavior.

However, there is criticism in regards to the efficacy of CBT when using it as an intervention with male DV offenders. Cluss and Bodea (2011) found there is little empirical

evidence that supports the efficacy of CBT. In a meta-analysis that compared the efficacy of the Duluth model and CBT interventions, Babcock and colleagues (2004) concluded that CBT had minimal impact on reducing DV and recidivism. Additionally, Andruczyk (2015) raised concern over the teachings of anger management in CBT interventions due to studies that have deemed anger management ineffective for this population. Furthermore, the “here and now” focus of CBT may shift attention away from offenders exploring the root cause of their actions, which may reduce the possibility of change in behavior (Butler et al., 2006). In 2011, Smedslund et al. conducted a meta-analysis of six studies completed in the United States with a total of 2,343 male participants. Through the meta-analysis, Smedslund et al. (2011) sought to answer if CBT interventions in BIPs were better than no treatment at all. Results from the meta-analysis did not provide evidence that CBT was more effective than no treatment whatsoever.

Common Practices. As the Duluth model and CBT method for male DV offenders continues to develop, many researchers have noted a difficulty in distinguishing between CBT and Duluth interventions (Babcock et al., 2004; Feder & Wilson, 2005). In a meta-analysis of effective practices in DV offender interventions, Babcock et al. (2004) found that both models have many commonalities, including focusing on thoughts and how they impact behavior;

The extent that CBT groups address patriarchal attitudes and Duluth group models address the learned and reinforced aspects of violence, any distinction between CBT and Duluth model groups becomes increasingly unclear. (p. 1026)

The difficulties in distinguishing between CBT and the Duluth model creates difficulty for researchers to clarify which intervention is more effective, which may explain poor efficacy outcomes in studies conducted. Dunford (2000) noted that the dichotomy in the intervention names are misleading, as current CBT groups are not strictly cognitive or behavioral but in fact

often focus on emotional aspects of DV. To date there has not been a complete comparison between the Duluth model and CBT; Babcock et al. (2004) surmised that this might be due to great difficulty in discerning treatment techniques that are singularly inherent to one model.

Equipped with the knowledge about how little is known about BIPs currently operating (Price & Rosenbaum, 2009), as well as the lack of efficacy of the models used (Cluss & Bodea, 2011; George, 2012; National Institute of Justice & US Department of Justice, 2003), it is difficult to surmise what 100% effective practices look like (Babcock et al., 2004). Deducing which methods that have been evidenced to work with BIPs is difficult due to a lack of definitive, clearly supported literature; therefore there is difficulty in exploring how TIC can be incorporated into BIP methods that have not been shown to be completely effective. In order to properly identify significant factors when applying TIC to BIPs, an examination of commonalities between BIPs is needed. Regardless of the intervention that is used (Duluth model or CBT), BIPs do have components in common.

Price and Rosenbaum (2009) conducted the largest known survey of current BIPs practices. The survey was sent to over 2,500 BIPs in 45 states via an anonymous web survey. Two hundred and seventy-six programs responded with a plethora of information, which, once compiled, provided detailed and in-depth information about program operations that were previously unpublished (Price & Rosenbaum, 2009). The survey was comprised of 57 questions that inquired about various program operations including (a) funding, (b) credentials of group leaders, (c) program philosophies and curriculum, (d) confidentiality, (e) participant characteristics, (f) program evaluations, and (g) the level of coordinated community response. The information that was collected through this survey highlights areas of commonalities in

various BIPs practices. Furthermore, additional literature supports the statistics gathered through this survey (Black et al., 2015; Edleson, 2012; Mills, Barocas & Ariel, 2013).

Eighty-two percent of respondents stated that 95% of the clients served are treated in a group format that is open, meaning individuals join, finish, or terminate at any time (Price & Rosenbaum, 2009). Newer literature cited approximately 95% of BIPs in the United States use group therapy as the main treatment modality (Black et al., 2015; Edleson, 2012; Mills, Barocas & Ariel, 2013). Reasons for use of group therapy for BIPs include: (a) decreased isolation, (b) increased connection, (c) promotion of social accountability, (d) the opportunity to learn from peers, (e) the ability to receive feedback from other group members and the facilitator, and (f) the ability to counter the belief that DV is a private matter between the victim and the abuser (Adams, n.d.; Black et al., 2015). One-third of the programs indicated that groups are co-led by a female and male facilitator (Price & Rosenbaum, 2009). Twenty percent of programs reported being led by a single male, while 15% reported facilitation conducted by a single female and finally, two females or two males led 8% of groups (Price & Rosenbaum, 2009). Many states standards require a male and female co-facilitation if available. Adams (2012) and Boston (2010) noted that there are beneficial aspects to having a male and female facilitator, such as providing the facilitator's opportunity to role model respect in an egalitarian relationship, as well as providing support when interacting with hostile or difficult clients.

Price and Rosenbaum (2009) acknowledged that program descriptors in the literature are not mutually exclusive and therefore asked respondents to select multiple descriptors that described their programs. Descriptors such as psychoeducational, pro-feminist and cognitive-behavioral, were selected, with 59% of respondents choosing psychoeducational. When selecting any of the program models that described their BIP, 53% of programs endorsed using

the Duluth model, while 49% described their program as CBT (Price & Rosenbaum, 2009). Previous research cited postured that many programs use blended models of both Duluth and CBT (Babcock et al., 2004; Feder & Wilson, 2005), which is supported by the survey finding that the most common program descriptor combinations chosen were the Duluth model, CBT and psychoeducational models (Price & Rosenbaum, 2009).

Program length is generally determined by state standards and varies greatly among states, with little research supporting the efficacy of program lengths (Healy et al., 1998; Price & Rosenbaum, 2009). In fact, BIPs can take anywhere from 8 to 52 weeks to complete, depending on program structure and state legislation (Babcock, Green & Robie, 2004; Eckhardt et al., 2013). Respondents indicated the median number of weeks a program required was 31, with an average time of 96 minutes for each session length (Price & Rosenbaum, 2009).

When programs were asked to describe their curricular approach, various methods were selected. Even with the knowledge that DV offenders are heterogeneous, and there are immense differences in men who offend (Lehman & Simmons, 2009), 90% of programs indicated that they use a “one size fits all” approach (Price & Rosenbaum, 2009). A general approach to DV interventions that do not utilize offender typology could be due to a myriad of reasons, including the inability to keep up with a large number of men who are adjudicated to BIPs each year (Lehman & Simmons, 2009). Seventy-six percent of responding programs reported including an anger management component into their curriculum. In their handbook of how to conduct a Duluth program, Pence and Paymar (1993), stated that anger management is a scapegoat for the abuser to blame his actions on anger and therefore does not produce change. Additionally, CBT for male offenders argued that abuse is about power and control, not anger (Adams, 1988, Alexander, 2007). In a report for the National Institute of Justice, Klein (2009) noted that

although anger management is incorporated into BIP curriculum, most states mandated that anger management must not be used as the singular course of treatment.

Studies have suggested a link between individuals who commit domestic violence and a lower socioeconomic status (SES) (Capaldi, 2012; Renzetti, 2009; WHO, n.d.). SES is measured by education level, occupation and income. In their worldwide report on DV, WHO (n.d.), noted that low income, low academic achievement, economic stress and poverty are all risk factors for males who perpetrate DV. The assumption can be made that many individuals who commit DV (and attend BIPs) may have a lowered SES than those who do not. In their survey, Price and Rosenbaum (2009) discovered that half of all programs surveyed were funded solely by BIP clients, 87% of programs were partially supported by client payment and received other funds elsewhere. Government funds and grants are often difficult for BIPs to obtain because monetary help is usually earmarked for the victims, not the offenders (Price & Rosenbaum, 2009).

Although there is deep controversy within the literature regarding the efficacy of BIPs, the effectiveness of interventions as well as the ethical implications of using the Duluth model, this project does not seek to fix these qualms. The extensive literature review of various aspects of BIPs has evidenced that there is room for improvement in the format and application that BIPs implement. A proposed area of improvement is the integration of TIC, as this may be an appropriate intervention for this population due to large amounts of literature published that indicates a link between an individual's history of trauma and committing violent criminal acts (Andruczyk, 2015; Ardino, 2012; Craparo, Schimmenti & Caretti, 2013; Dutton & Corvo, 2006; Dutton & Starzomski, 1993; Smith, Ireland & Thornberry, 2005). Therefore, including an approach that recognizes the widespread effects of trauma, such as TIC may be a significant factor when working with male perpetrators of DV.

Trauma-informed Care

Trauma happens when an individual is exposed to a situation that overwhelms his or her ability to cope and therefore they experience feelings such as fear, helplessness, or horror (Hopper, Bassuk & Olivet, 2009). When an individual is exposed to an event that inhibits his or her ability to process and cope, the individual has been through a traumatic experience (Lee & Young, 2001). Not everyone who experiences a situation that is abnormal is affected, but for those who are affected by the traumatic experience, consequences may be long lasting and have varying rates of debilitation (Hopper, et al., 2009; National Center for PTSD, 2016; Xue et al., 2015). When providing services to clients who have experienced traumatic events, it is important that agencies recognize the signs, symptoms and effects and implement a trauma-informed environment and treatment approach.

TIC involves shifting the focus away from the client's problems and requires the clinician attempt to understand the client as a whole (Harris & Falot, 2001). Additionally, TIC requires an organization to be vigilant in anticipating and avoiding policies and procedures that may re-traumatize individuals with a past history of trauma (Substance Abuse and Mental Health Services Administration [SAMSHA], 2014). Creating a trauma-informed environment for all who visit or receive care from an agency goes beyond clinician and client interaction, creating a TIC environment is a systematic commitment (Lehman & Simmons, 2009; SAMSHA, 2014).

In a literature review of TIC in trauma-focused organizations, Hopper and colleagues (2010) assembled four principles of trauma-informed care that are recognized throughout the literature; (a) trauma awareness, (b) emphasis on safety, (c) opportunities to rebuild control, and (d) a strengths-based approach. Trauma awareness speaks to the agency's onus on providing services that recognize the impact of trauma on an individual's life. This tenet is found as a main

focus of TIC in large amounts of literature and is often regarded as the first step in ensuring that an agency is trauma-informed (Elliott, et al., 2005; Guarino et al., 2009; Harris & Fallot, 2001; SAMSHA; 2014). Emphasizing safety focuses on ensuring that both the client and agency employees feel safe, not only physically but also emotionally. Emotional safety is created through respectful interactions between all clients and staff; furthermore, clear and fair roles and boundaries must be implemented in order to ensure that unethical power dynamics over clients are avoided (Hopper et al., 2010). This is an important aspect in avoiding a climate of traumatization for clients. Opportunities to rebuild control acknowledges that individuals who experience trauma may feel as though they do not have power, therefore allowing clients to have a sense of efficacy and personal control over their treatments through creating predictable environments can be beneficial for those with a trauma history (Elliott, et al., 2005; Muskett, 2014). A strengths-based approach to TIC assists the client in discovering strengths and coping skills that develop resiliency (Hopper et al., 2010). Lehman and Simmons (2009) noted that a strength-based approach must focus on helping an individual achieve optimal health, and does not contain condemnation for past behaviors.

Harris and Fallot (2001) ascertained that an agency must have certain conditions in place in order for TIC to be implemented such as (a) administrative commitment to change, (b) universal screening, (c) training and education, (d) hiring practices, and (e) review of policies and procedures. Administrative commitment to change involves administrators committing to creating an agency that understands the impacts of violence and trauma. This encompasses staff members understanding the effects of trauma, as well as receiving ongoing training regarding how to properly serve clients who have a history of trauma (SAMSHA, 2014). Universal screening involves integrating a trauma screening into agency intakes (Ferencik & Ramirez-

Hammond, 2011; Guarino et al., 2009). Including an awareness of trauma can create a platform for exploration between client and clinician. Furthermore, making trauma screening a part of agency intakes will encourage an agency to be trauma-informed on every level (Harris & Fallot, 2001). Training and education of all staff members on TIC is pertinent, as each interaction can benefit or harm the client, even if it is between receptionist and client. Harris and Fallot (2001) recommended using the RICH acronym as a basic guideline to running a trauma-informed agency. RICH involves four rules that are imperative to interaction with all clients, especially clients who have been exposed to trauma, (a) respect, (b) information, (c) connection, and (d) hope. Hiring practices are important in ensuring an agency adheres to TIC. Hiring an individual who is a “trauma champion” can be especially beneficial, as this individual thinks of a trauma history first and has in-depth experience or extensive knowledge about working with individuals who have been exposed to trauma (Harris & Fallot, 2001; SAMSHA, 2014). Finally, intrusive interactions with clinicians and staff members who are following agency policy can be extremely detrimental for clients with a trauma history due to creating an atmosphere of traumatization (Harris & Fallot, 2001). Therefore, consistent review of agency policies and procedures can ensure that clients of all life experiences can feel safe at the agency (Ferencik & Ramirez-Hammond, 2011; Guarino et al., 2009; Harris & Fallot, 2001; SAMSHA, 2014).

SAMSHA (2014) published a treatment improvement protocol (TIP) that provided evidence-based and best practice information for clinicians and administrators who seek to increase their treatment effectiveness with clients with a past history of trauma. SAMSHA (2014) stated that

TIC is a strengths-based service delivery approach that 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.22)

This TIP provided specific strategies that an agency can implement in order to provide a TIC approach including (a) show organizational and administrative commitment to TIC, (b) use trauma-informed principles in strategic planning, (c) review and update vision, mission, and value statements, (d) assign a key staff member to facilitate change, (e) create a trauma-informed oversight committee, (f) conduct an organizational self-assessment of trauma-informed services, (g) develop an implementation plan, (h) develop policies and procedures to ensure trauma-informed practices and to prevent re-traumatization, (i) develop a disaster plan, (j) incorporate universal routine screenings, (k) apply culturally responsive principles, (l) use science-based knowledge, (m) create a peer-support environment, (n) obtain ongoing feedback and evaluations, (o) change the environment to increase safety and (p) develop trauma-informed collaborations (SAMSHA, 2014).

When exploring TIC implementation, staff training on trauma and understanding the effects on physical and mental health are at the forefront (Ferencik & Ramirez-Hammond, 2011; Guarino et al., 2009; Harris & Falot; 2001; SAMSHA, 2014). In a guide for best practices and protocols when working with victims of DV, Ferencik and Ramirez-Hammond (2011) encouraged agencies to have staff members, regardless of position or educational background educated on trauma to ensure that all interactions with clients are conducted through a trauma-informed lens. In addition to receiving training on trauma, staff members understanding the specific connection between trauma and how it affects physical and mental health is pertinent in providing unbiased services. Guarino and colleagues (2009) noted that labeling survivors of

trauma as "out of control" or with a mental health diagnosis without the full understanding of their history could damage the relationship between client and agency (p. 66). Additionally, some individuals can have long-term or short-term reactions to the traumatic event, including mental health issues and medical problems; therefore, it is important to place emphasis on understanding the client as a whole, rather than just through their behavior. (SAMSHA, 2014)

Clearly, creating a trauma-informed care environment for all who visit or receive care from an agency goes beyond clinician and client interaction, creating a TIC environment is an agency commitment that is fluid, constantly receiving changes and re-evaluations (SAMSHA, 2014). Specific strategies and sources for implementing TIC are outlined and evidenced further in the application section.

Trauma-informed Care and Batterer Intervention Programs

“In a trauma-informed approach, the emphasis is on understanding the whole individual and appreciating the context in which the person is living their life” (Harris & Fallot, 2001, p. 14). Clear support and criticism regarding TIC integration with offenders are difficult to unearth, simply due to the fact that it is a new concept (Miller & Najavits, 2012; Taft et al., 2016). There are small amounts of literature that address the incorporation of TIC when working with sexual offenders (Levenson, 2013), but to date, there are limited studies that have been conducted in regards to DV batterers (Taft et al., 2007; Taft et al., 2016). With multiple sources citing a connection between trauma and violent criminal behavior (Andruczyk, 2015; Ardino, 2012; Craparo, Schimmenti & Caretti, 2013; Dutton & Corvo, 2006; Dutton & Starzomski, 1993; Smith, Ireland & Thornberry, 2005) and additional literature that link heightened rates of violence towards intimate partners following a traumatic experience (Shorey, Febres, Brasfield & Stuart, 2012; Sippel, & Marshall, 2011), it seems as though a TIC counseling approach when

working with male DV offenders who have experienced trauma may be important in providing effective interventions that could possibly reduce recidivism. The culmination of this extensive literature review evidenced that BIPs and TIC can be integrated, but because there is only one published piece of literature (Taft et al., 2016) addressing TIC and BIPs, it is not possible at this time to definitely conclude how it can be done without conducting extensive research.

The purpose of this project was not to conduct original research but to identify a gap in the literature and explore it further. Therefore, this project is to be used as a starting point for individuals or agencies seeking to gain more information about implementing TIC into BIPs.

Application

As there is very limited literature support for the integration TIC into BIPs (Taft et al., 2016), no previous framework exists to use as a model for a TIC application piece specifically for batterers. Therefore, the application piece that was created through the culmination of this project is a general TIC checklist that can be used in a clinical setting. Using the information gleaned from the literature review regarding the various aspects of BIPs as well as information regarding TIC, the checklist integrates accumulated knowledge about both. This means that the checklist is applicable to TIC in a clinical setting, including BIPs.

There were four specifically chosen sources to be used as literature support in the application piece. The sources cover four distinct areas of TIC including homelessness (Guarino et al., 2009), multi-abuse trauma (Edmund & Bland, 2011), domestic violence survivors (Ferencik & Ramirez-Hammond, 2011) and substance abuse and mental health trauma (SAMSHA, 2014). These sources were selected in an attempt to pull TIC techniques from various areas of trauma that could be applicable in a clinical setting. These sources guided the creation of the checklist statements, as well as follow-up information.

There are four sections in the checklist, each containing four statements which cover various areas of TIC that stood out in the literature: (1) staff training, (2) agency policies, (3) agency environment and (4) clinician and client interaction. Sections 1, 2 and 3 are to be completed by all members of an agency, while clinicians should complete sections 1 through 4. To the left of each statement, individuals are asked to check a box if they believe that their agency already implements the specific TIC statement, if the completer is unsure or the answer is no, the box is to be left blank. After completing the checklist, the individual is prompted to seek more information regarding each statement in the “more information” section. Within this area of the checklist, each statement is supported by specific quotes from two to four of the specifically used resources. Quotes from these handbooks and toolkits were used in order to allow individuals easily accessible information regarding the specific TIC statement. Many of the statements used from the sources provide further information as to the importance of the statement as well as steps that can be taken to implement TIC into the agency.

This application piece differs from other toolkits and handbooks for TIC because it is intended for all members of an agency; additionally, agencies who wish to implement TIC can use this checklist as a quick and easy to understand guide. Reading through the breadth and depth of many TIC toolkits and handbooks can be overwhelming and time-consuming, which may decrease motivation for implementing TIC. Individuals who are completing this checklist are encouraged to do so in a positive, productive and purposeful manner. Furthermore, individuals are encouraged, rather than shamed into creating a TIC environment in their agency through the low to no cost, low time and little clinical experience required to implement any of the statements used in the checklist.

Conclusion

DV is widespread and leaves pervasive, lasting effects on victims and witnesses. Individuals who commit DV are most often ordered to BIPs, where they receive interventions that have yet to be proven effective. Through the exploration of BIPs, a gap in the literature was evidenced; even with high rates of clients with a trauma history, BIPs do not implement TIC. With a clear link supported in the literature between trauma history and aggression, it is alarming that this topic has received almost no literature recognition. Therefore, this project and application piece may be the first of its kind, possibly due to the fact that integrating TIC into BIPs is controversial due to the polarity of ideas. Future studies and research focusing on TIC with BIPs is recommended, as there is a strong lack of information regarding this topic.

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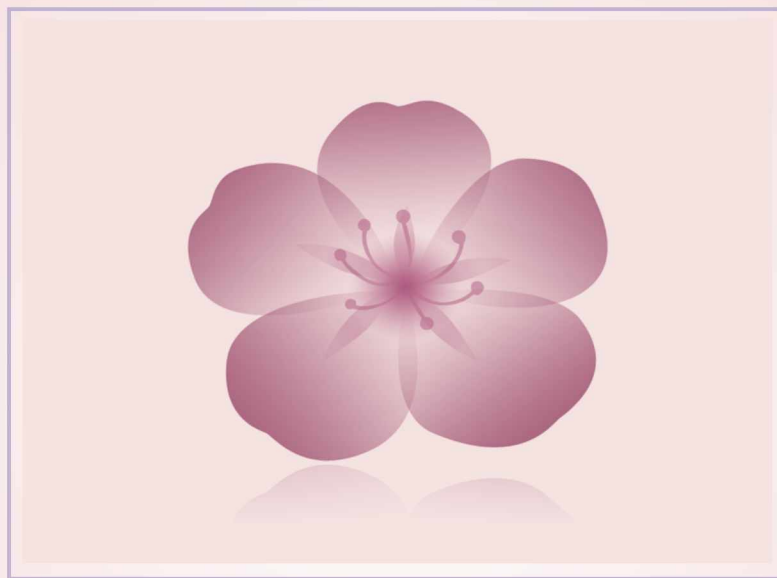
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Trauma-informed Care in a Clinical Setting



A checklist for creating a trauma-informed agency



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Trauma-Informed Care in a Clinical Setting:

Introduction

This checklist is intended as a beginning guide for agencies in a clinical setting that work with clients who may have a past history of trauma. No matter the population that you are working with, everyone deserves to have their trauma recognized and understood.

If your agency does not have Trauma-informed care (TIC) practices in place, do not worry! This checklist is a simple and easy place to begin! The checklist was created with three goals in mind. It is:

Positive

Purposeful

Proactive

No matter your position at your agency, you can make a positive difference in the life of clients!

Taking small steps in your agency to implement TIC *does not* require large amounts of time, money or clinical experience! This checklist contains items that are little to no cost or time to you, or your agency, but will make a world of difference for some of your clients.

Instructions

There are four sections to this 16-statement checklist covering multiple areas of possible TIC in a clinical setting. *All staff members should complete sections 1, 2 and 3. Clinicians working with clients should complete sections 1, 2 3 and 4.*

If your agency already implements the item, check the box! If your agency does not, or if you are unsure, leave the box blank. After you have completed the checklist, refer to the **Resource Guide** for more information and tips on correlating checklist statements.

Checklist: Trauma-Informed Care

* Please check the box if your agency implements the statements below

SECTION 1: STAFF TRAINING

- 1a) Staff members at all levels of client interaction have received training on trauma.
- 1b) All staff members have received training on the relationship between trauma, mental health and physical health.
- 1c) All staff members have received training on HIPAA and client confidentiality.
- 1d) Staff members have received training on how to respect client boundaries.

SECTION 2: AGENCY POLICIES

- 2a) The agency has policies and procedures that recognize trauma-informed care.
- 2b) Agency policies and procedures promote self-care for staff members.
- 2c) Agency policies purposefully avoid re-traumatization of clients.
- 2d) Agency policies and procedures purposefully avoid labeling clients.

SECTION 3: AGENCY ENVIRONMENT

- 3a) The agency environment is predictable.
- 3b) A client's desire for personal space is provided and respected.
- 3c) Agency layout purposefully avoids re-traumatization.
- 3d) The agency is decorated with client's needs in mind.

SECTION 4: CLINICIAN AND CLIENT INTERACTIONS

- 4a) Clients are informed of their right to privacy.
- 4b) Clinicians conduct intakes that are trauma-informed.
- 4c) Trauma history is screened for during client intakes.
- 4d) Client's culture and customs are recognized and respected.

Resource Guide: More information!

This resource guide provides literature support in order to evidence the importance of the statements used in the checklist. There are four specific resources that are used to provide rationale as to why certain TIC practices should be implemented into an agency. Links and more information to the four resources can be found on the references page at the end of this resource guide.

If you checked any of the statements above, do not fear! You now have an *opportunity* to take initiative in making your agency trauma-informed! The steps below are low cost and low time, meaning low stress for you, but a large amount of relief for your clients!

SECTION 1: STAFF TRAINING

1a) Staff members at all levels of client interaction have received training on trauma.

- ❖ *Trauma-Informed Care: Best Practices* (p. 65)
“All staff members of the agency, regardless of their training, education or position should be trained in basic trauma knowledge to insure that advocates perform their interactions in a trauma-informed manner.”
- ❖ *Trauma-Informed Organizational Toolkit* (p. 23)
“Staff training and education is crucial to becoming trauma-informed. Training everyone—administrators, direct care staff, case managers, support staff etc.—about trauma and trauma-related topics ensures that all staff members are working from the same level of understanding and are capable of providing the same types of trauma-sensitive responses.”

1b) All staff members have received training on the relationship between trauma, mental health and physical health.

- ❖ *Trauma-Informed Care: Best Practices* (p. 66)
“Often, advocates will describe the individual/survivor as out of control, manipulative, or she has mental health diagnosis, such as being borderline or bipolar. This can be damaging to survivors and to your relationship with them.”
- ❖ *Trauma-Informed Care in Behavioral Health Services* (p. 7)
“For some people, reactions to a traumatic event are temporary, whereas others have prolonged reactions that move from acute symptoms to more severe, prolonged, or enduring mental health consequences (e.g., posttraumatic stress and other anxiety disorders, substance use and mood disorders) and medical problems (e.g., arthritis, headaches, chronic pain).”

1c) All staff members have received training on HIPAA and client confidentiality.

- ❖ *Trauma-Informed Care in Behavioral Health Services* (p. 184)
“Protecting client confidentiality, particularly in relation to clients’ trauma histories. Organizations should comply with the State and Federal laws that protect the confidentiality of clients being treated for mental and substance use disorders.”
- ❖ *Trauma-Informed Care: Best Practices* (p. 69)
“The agency needs to establish a framework for privacy and confidentiality, considering the power differential between the advocate and the survivor.”

1d) Staff members have received training on how to respect client boundaries.

- ❖ *Trauma-Informed Organizational Toolkit* (p. 34)
“Written policies are in place to outline professional conduct for staff (e.g. boundaries, responses to consumers, etc.).”
- ❖ *Trauma-Informed Care in Behavioral Health Services* (p. 188)
“Establishing and maintaining appropriate guidelines and boundaries for client and counselor behavior in the program setting. Clients with trauma may have particular sensitivity about their bodies, personal space, and boundaries. Intrusive shaming or insensitive behavior demonstrated by another client in the program can threaten a trauma survivor whose boundaries have been disregarded in the past—thus making the experience of treatment feel dangerous rather than safe. Cultural considerations also influence therapeutic boundaries.”
- ❖ *Trauma-Informed Care: Best Practices* (p. 69)
“An advocate should proceed in a trauma-informed manner with issues of privacy and boundaries considering past violations and potential triggers.”

SECTION 2: AGENCY POLICIES

2a) The agency has policies and procedures that recognize Trauma-informed care.

- ❖ *Trauma-Informed Care in Behavioral Health Services* (p. 166)
“Policies and procedures must incorporate trauma-informed practices across all domains and standards, such as admissions, plant/environmental standards, screening and assessment processes, referrals (to other services, including hospitalization, or for further evaluations), treatment planning, confidentiality, discharge, and more.”
- ❖ *Trauma-Informed Organizational Toolkit* (p. 34)
“A trauma-informed program considers trauma and its impact when creating policies to avoid recreating feelings associated with traumatic experiences (e.g., powerlessness, shame, lack of control, etc.). As the needs of consumers evolve and the role of the organization changes, policies that were once effective may no longer be helpful.”

- ❖ *Trauma-Informed Care: Best Practices* (p. 54)
“Intentionally reviewing policies and procedures to determine if practices and interactions are hurtful or even harmful to trauma survivors is an important part of providing trauma-informed services.”

2b) Agency policies and procedures promote self-care for staff members.

- ❖ *Responding to Multi-Abuse Trauma* (p. 135)
“Create policies that encourage self-care. Policies allowing flexible work schedules and mandating that staff use compensatory and annual leave in a timely manner provide opportunities to rest and to process and integrate the efforts of the work. Provide adequate vacation, sick time and personal leave time. Benefits such as paid vacation time and insurance policies covering the cost of counseling are also helpful.”
- ❖ *Trauma-Informed Care: Best Practices* (p. 125)
“One way in which programs can respond to vicarious trauma is by recognizing and acknowledging the challenges of working with trauma and trauma survivors, especially in an environment of limited resources. Agencies can also provide information about vicarious trauma to their staff, and review staff policies and procedures to make sure they support and encourage employee well being. Supervisors and directors should establish a vicarious trauma prevention program that focuses on the wellbeing of front-line advocates and can decrease individual and organizational problems such as low staff morale, staff turnover and burnout.”
- ❖ *Trauma-Informed Organizational Toolkit* (p. 196)
“In agencies and among individual providers, it is key for the culture to promote acceptability, accessibility, and accountability in seeking help, accessing support and supervision, and engaging in self-care behaviors in and outside of the agency or office. Agencies should involve staff members who work with trauma in developing informal and formal agency practices and procedures to prevent or address secondary trauma. Organizations can support counselors’ individual efforts to enhance positive personal coping styles, find meaning in adversity, and reduce stress by providing time for workers during the workday for personal self-care activities, like mindfulness meditation and other stress reduction practices.”
- ❖ *Trauma-Informed Care in Behavioral Health Services* (p. 176)
“Establishing an organizational policy that normalizes secondary trauma as an accepted part of working in behavioral health settings and views the problem as systemic—not the result of individual pathology or a deficit on the part of the counselor.”

2c) Agency policies purposefully avoid re-traumatization of clients.

- ❖ *Responding to Multi-Abuse Trauma* (p. 51 & p. 52)
“People with multiple trauma issues who seek help from social service agencies sometimes end up being re-traumatized by the very system that was supposed to help them. For many survivors of trauma who have psychiatric issues, or who have other

disabilities, systems of care perpetuate traumatic experiences through invasive, coercive or forced treatment that causes or exacerbates feelings of threat, a lack of safety, violation, shame and powerlessness.”

❖ *Trauma-Informed Organizational Toolkit* (p. ii)

“In order to respond empathically to the needs of trauma survivors, ensure their physical and emotional safety, develop realistic treatment goals, and at the very least avoid re-traumatization, all practices and programming must be provided through the lens of trauma.”

❖ *Trauma-Informed Care in Behavioral Health Services* (p. 166)

“In the early stage of evaluating current services and planning for TIC, the committee needs to assess practices, procedures, and policies that may have been or could be re-traumatizing to any individual, at any level of the organization, from consumers to administrators.”

2d) Agency policies and procedures avoid labeling clients.

❖ *Responding to Multi-Abuse Trauma* (p.59)

“As individuals revolve around the system, acquire multiple labels and become defined by those labels rather than viewed as human beings, they find it even more difficult to address their issues. It is important for advocates to refrain from listing a specific referral or making notes in someone’s chart that are labeling, diagnostic or that could be used against the individual.”

❖ *Trauma-Informed Care in Behavioral Health Services* (p. 55)

“Clients in behavioral health treatment who have histories of trauma can respond negatively to or seem disinterested in treatment efforts. They may become uncomfortable in groups that emphasize personal sharing; likewise, an individual who experiences brief bouts of dissociation (a reaction of some trauma survivors) may be misunderstood by others in treatment and seen as uninterested. Providers need to attend to histories, adjust treatment to avoid re-traumatization, and steer clear of labeling clients’ behavior as pathological.”

SECTION 3: AGENCY ENVIRONMENT

3a) The agency environment is predictable.

❖ *Trauma-Informed Organizational Toolkit* (p. 28)

“Maintaining a consistent and predictable environment can help to instill a sense of calm, which in turn allows the consumer to focus on recovery. Consistency at the service level creates trust between the consumer and the provider, serves as a foundation for building healthy relationships. Ways to establish consistency and predictability with consumers include having regular meetings, keeping and being on time for appointments, following

up on consumer requests or concerns, clearly defining roles and boundaries, and maintaining empathic responses to consumers in the face of both successes and setbacks.”

- ❖ *Trauma-Informed Care in Behavioral Health Services* (p. 19)
“Beyond anticipating that various environmental stimuli within a program may generate strong emotions and reactions in a trauma survivor (e.g., triggers such as lighting, access to exits, seating arrangements, emotionality within a group, or visual or auditory stimuli) and implementing strategies to help clients cope with triggers that evoke their experiences with trauma, other key elements in establishing a safe environment include consistency in client interactions and treatment processes, following through with what has been reviewed or agreed upon in sessions or meetings, and dependability.”
- ❖ *Responding to Multi-Abuse Trauma* (p. 30)
“Tell every person who enters your program, if something here makes you feel unsafe or uncomfortable, let me/us know. We will try to make things more comfortable and safer”

3b) A client’s desire for personal space is provided and respected.

- ❖ *Trauma-Informed Care in Behavioral Health Services* (p. 96)
“Cultural and ethnic factors vary greatly regarding the appropriate physical distance to maintain during the interview. You should respect the client’s personal space, sitting neither too far from nor too close to the client; let your observations of the client’s comfort level during the screening and assessment process guide the amount of distance. Clients with trauma may have particular sensitivity about their bodies, personal space, and boundaries.”
- ❖ *Trauma-Informed Organizational Toolkit* (p. 26)
“Specific areas within the building, such as bathrooms and bedrooms can be particularly triggering for those who have abuse histories. Poor lighting or building security, and a lack of control over personal space and belongings can also trigger past feelings of fear and helplessness. Features include providing adequate lighting inside and outside of the program, making sure consumers can lock bathroom doors and have locked spaces for their belongings, and having a program security system.”
- ❖ *Responding to Multi-Abuse Trauma* (p. 191)
“Address safety concerns and provide safe space. Participants in the group need to feel safe in order to tell their story and benefit from being believed. Be sure to listen and validate each person’s experience, strength and hope.”
- ❖ *Trauma-Informed Care: Best Practices* (p.84)
“Perform an environmental scan and be mindful of your space and how it may feel to the individual.”

3c) Agency layout avoids re-traumatization.

- ❖ *Trauma-Informed Care: Best Practices* (p. 86)
“People who are traumatized very seldom sit with their back to the doorway. Always provide a way out by not blocking the door. Be mindful of glass windows, where some survivors may not feel safe either. This is a result of being always prepared to “take action” at a second’s notice to ensure safety.”
- ❖ *Trauma-Informed Care in Behavioral Health Services* (p. 171)
“Practices that generate emotional and physical safety are necessary. Another aspect of creating safety is reevaluating the physical facilities and environment to enhance safety and to circumvent preventable re-traumatization.”

3d) The agency is decorated with client’s needs in mind.

- ❖ *Responding to Multi-Abuse Trauma* (p. 29)
“Details ranging from staff behavior and attitudes to the way physical space is designed can send a subtle message regarding how agencies feel about the people they serve, and can either reduce or add to stress. Add “home-like” touches. Some inexpensive ways to make physical space more inviting include plants, fish tanks, throw pillows on couches and chairs, area rugs, and artwork on the walls”
- ❖ *Trauma-Informed Organizational Toolkit* (p. 27)
“In addition to ensuring physical safety, establishing a supportive environment is an essential aspect of trauma-informed care. How consumers are welcomed and how staff responds to their individual needs sets the stage for future success or difficulty. Establishing a safe and welcoming emotional environment requires programs to create a culture of open communication, tolerance, respect, and community.”
- ❖ *Trauma-Informed Care: Best Practices* (p. 59)
“An individual who has experienced repeated acts of harm and degradation to [their] sense of self and is seeking services will most likely feel nervous, hyper-vigilant and/or concerned for [their] present safety. When a survivor reaches out for help and arrives at the shelter, court or a support group, greet [them] with compassion and kindness. The use of empathy will set an atmosphere of caring and respect, which can enhance an individual’s sense of safety.”

SECTION 4: CLINICIAN AND CLIENT INTERACTIONS

4a) Clients are informed of their right to privacy.

- ❖ *Trauma-Informed Care in Behavioral Health Services* (p. 182)
“Counselors have a responsibility to practice the principles of confidentiality in all interactions with clients and to respect clients’ wishes not to give up their right to privileged communication. Counselors are responsible for educating clients about the limits of confidentiality and what happens to protected health information, along with the client’s privilege, when the client signs a release of information.”

- ❖ *Trauma-Informed Organizational Toolkit* (p. 27)
“Often, trauma survivors have had their privacy violated and their dignity taken away – their bodies may have been invaded by abuse, they may have spent long nights on the streets with no where to sleep and no bathroom facilities, they may have had re-traumatizing experiences with other service systems/providers, with law enforcement, etc. If providers aim to treat consumers with respect and dignity, they must respect their privacy.”
- ❖ *Trauma-Informed Care: Best Practices* (p. 88)
“While explaining that information will be kept confidential, it is important to clarify to survivors what information you can’t keep confidential, due to ethical, professional, or legal obligations. This often includes information about imminent harm to a child or credible threats to hurt another individual or oneself.”
- ❖ *Responding to Multi-Abuse Trauma* (p. 34)
“Conversations must be respectful, private and confidential. Make the individual as comfortable as possible and assure confidentiality of records when applicable. Confidentiality is extremely important. People experiencing domestic violence or suffering from substance abuse issues may have been told they will be harmed if they reveal what is happening.”

4b) Clinicians conduct intakes that are trauma-informed.

- ❖ *Trauma-Informed Care: Best Practices* (p. 86)
“Tell the survivor about the intake process and what types of information you are going to be discussing. Inform the individual they have the right to “put on the brakes” by asking to stop the process. This communicates that they have the power to manage the situation if they becomes triggered, exhausted or needs to take a physical or emotional break.”
- ❖ *Trauma-Informed Organizational Toolkit* (p. 30)
“Conducting the intake assessment in a trauma-informed manner may include conducting the intake in a private space, offering consumers options about where to sit, who is in the room with them, what to expect, asking consumers how they are doing throughout the assessment, offering water and breaks, and being aware of body language that may indicate that a consumer is feeling overwhelmed. Using a strengths-based approach also sets a tone of respect for the consumer and enhances the process of relationship-building between consumer and provider.”
- ❖ *Responding to Multi-Abuse Trauma* (p. 144)
“When concluding the intake process, ask how the individual is feeling. Make sure you are not letting the person leave feeling vulnerable. Questions to check out include: How are they feeling both physically and emotionally? Do they have any questions they wanted to ask?”

4c) Trauma history is screened for during client intakes.

- ❖ *Trauma-Informed Care in Behavioral Health Services* (p. 25)
“Screening universally for client histories, experiences, and symptoms of trauma at intake can benefit clients and providers. Most providers know that clients can be affected by trauma, but 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 across the continuum of care.”
- ❖ *Trauma-Informed Organizational Toolkit* (p. 30)
“Adults and children who have experienced trauma have specific needs that may remain mislabeled or misinterpreted if their experiences of trauma are not addressed as part of the intake process. In a trauma-informed program, the intake assessment process includes gathering information about experiences of emotional, physical and sexual abuse and other types of trauma (e.g., neglect, loss, community violence, and combat). Also included are questions about current level of danger from other people (e.g., restraining orders, history of domestic violence, and threats from others). In light of the fact that many families have experienced”

4d) Client’s culture and customs are recognized and respected during therapeutic interactions.

- ❖ *Trauma-Informed Care in Behavioral Health Services* (p. 53)
“Counselors should strive to appreciate the cultural meaning of a trauma. How do cultural interpretations, cultural support, and cultural responses affect the experience of trauma? It is critical that counselors do not presume to understand the meaning of a traumatic experience without considering the client’s cultural context. Culture strongly influences the perceptions of trauma. For instance, a trauma involving shame can be more profound for a person from an Asian culture than for someone from a European culture. Likewise, an Alaska Native individual or community, depending upon their Tribal ancestry, may believe that the traumatic experience serves as a form of retribution.”
- ❖ *Trauma-Informed Care: Best Practices* (p. 67)
“The manner in which a survivor experiences traumatic reactions will certainly be affected by the culture to which [they] belongs. Both the culture of [their] immediate family and the larger society will give context to [their] original experience of trauma, the resulting symptoms, and the meanings [they] attach to [their] experience.”
- ❖ *Responding to Multi-Abuse Trauma* (p. 22)
“People from marginalized groups often find it harder to access social services – especially if most of the staff represent the dominant culture, or services are based on the values and customs and beliefs of the dominant group. A social service system dominated by Western ways of approaching issues may feel intimidating. There may be language barriers, or customs that feel alien to the individual. Even the food served at a shelter or residential facility may be alien.”

❖ *Trauma-Informed Organizational Toolkit* (p. 27)

“Culture plays a significant role in the types of trauma that may be experienced, the risk for continued trauma, how survivors manage and express their experiences, and which supports and interventions are most effective. Violence and trauma have different meanings across cultures, and healing takes place within one’s own cultural and “meaning-making” system. Providers must be aware of their own cultural attitudes and beliefs, as well as those of the families being served. Cultural awareness may include offering people opportunities to engage in various cultural rituals or religious services, cook specific foods, and speak in their language of origin. A culturally competent approach helps to create a respectful environment in which survivors can begin to rebuild a sense of self and a connection to their communities.”

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