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# Bringing Trauma-Informed Practice to Domestic Violence Programs: A Qualitative Analysis of Current Approaches

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Three out of 10 women and 1 out of 10 men in the United States experience violence at the hands of an intimate partner—often with devastating costs. In response, hundreds of residential and community-based organizations have sprung up to support survivors. Over the last decade, many of these organizations have joined other human service systems in adopting trauma-informed care (TIC), an approach to working with survivors that responds directly to the effects of trauma. Although there have been various efforts to describe TIC in domestic violence (DV) programs, there is a need to further synthesize this discourse on trauma-informed approaches to better understand specific applications and practices for DV programs. This study aimed to address this gap. The authors of this study systematically identified key documents that describe trauma-informed approaches in DV services and then conducted a qualitative content analysis to identify core themes. Results yielded 6 principles (Establishing emotional safety, Restoring choice and control, Facilitating connection, Supporting coping, Responding to identity and context, and Building strengths), each of which comprised a set of concrete practices. Despite the common themes articulated across descriptions of DV-specific trauma-informed practices (TIP), we also found critical differences, with some publications focusing narrowly on individual healing and others emphasizing the broader community and social contexts of violence and oppression. Implications for future research and evaluation are discussed.

Three out of 10 women and one out of 10 men in this country will experience domestic violence (DV)<sup>1</sup> in their lifetimes—often with devastating personal, familial, and social costs (Baker, Billhardt, Warren, Rollins, & Glass, 2010; Childress, 2013). In response, hundreds of residential and community-based organizations have sprung up across the country to provide shelter, advocacy, counseling, and legal and economic support (Davies & Lyon, 2013). Over the last decade, many of these organizations have joined other human service systems in adopting trauma-informed care (TIC), an approach to working with participants that assumes the possibility of a trauma history in anyone who walks through the door (Elliott,

Bjelajac, Fallot, Markoff, & Reed, 2005; Harris & Fallot, 2001a, 2001b).<sup>2</sup> Domestic violence (DV) organizations have produced numerous materials on TIC, providing valuable guidance to organizations attempting to address the trauma-related needs of survivors (e.g., Phillips, Lyon, Warshaw, & Fabri, 2013; Warshaw, Gugenheim, Moroney, & Barnes, 2003). Although the various efforts to describe TIC in DV programs have produced a critical foundation (e.g., Warshaw, 2014), there is a need to further synthesize this discourse on trauma-informed approaches to better understand specific applications and practices for DV programs.

<sup>1</sup>We use the term *domestic violence* (DV) here to refer to violence committed by an intimate partner. Although the phrase *intimate partner violence* has become the preferred way to refer to this kind of abuse, we use the term DV to be consistent with the way that programs describe themselves (e.g., “DV programs”).

<sup>2</sup>Some organizations are increasingly adopting the term *trauma-informed approach* rather than *care*, to reflect the fact that being trauma-informed requires attention to organizational and administrative practices and culture in addition to direct service provision, and because the term *care* denotes a power hierarchy that is contrary to the trauma-informed emphasis on shared power (C. Warshaw, personal communication, January 1, 2015). However, because of the history of the term *trauma-informed care* and its widespread usage in the documents reviewed in this study, we chose to use *care* throughout the article.

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This study aimed to address this gap. We conducted a qualitative content analysis of publications and manuals that describe DV-relevant trauma-informed practices to identify key themes. This article begins with a brief history of TIC across human service systems, and within the DV context. Next, we present the study's methodology and a summary of the principles and practices that comprise its results. Finally, we discuss the significance of the findings in the DV context, and describe the tension that emerged across publications between a narrow focus on individual healing and a broader focus on addressing the social contexts of violence and oppression.

### The Evolution of Trauma-Informed Care

The last decade has seen a powerful shift in our collective attention to trauma, with a convergence of voices from research, practice, and policy highlighting its prevalence and devastating consequences (for a review, see National Association of State Mental Health Program Directors [NASMHPD], 2012; SAMHSA, 2014a). As part of this shift, TIC has emerged as a broad approach to human services systems in which all aspects of program culture and service delivery are designed to be responsive to the effects of trauma. First articulated by Harris and Fallot (2001a, 2001b), the early model of TIC focused on instituting universal trauma screening and assessment, minimizing retraumatization in the service environment, and educating providers on the nature and biopsychosocial effects of trauma (Harris & Fallot, 2001a, 2001b). Importantly, Harris and Fallot (2001a) stated that “trauma-informed services are not designed to treat symptoms or syndromes related to sexual or physical abuse;” instead, they are intended to “provide services in a manner that is welcoming and appropriate to the special needs of trauma survivors” (p. 5). Indeed, these authors contrasted trauma-informed care, which focus on everyday interactions, with *trauma-specific treatments*, which are particular models of treatment designed to address symptoms of trauma (e.g., The Trauma Recovery & Empowerment Model; Harris, 1998). The next major step in the evolution was to explore whether TIC in fact makes a unique contribution to survivor outcomes.

In the early 2000s, the Substance Abuse and Mental Health Administration (SAMHSA) led the first large-scale effort to design, implement, and evaluate a comprehensive trauma-informed approach to mental health and substance abuse services through the Women, Co-Occurring Disorders, and Violence Study (WCDVS). As the first longitudinal study of trauma-informed care, the WCDVS indicated that women who received trauma-informed services showed small but significant improvements on mental health outcomes and trauma symptoms relative to treatment as usual, but no effect for substance abuse (e.g., Morrissey et al., 2005). Although the evidence base for trauma-informed care is for the most part limited to the modest findings of the WCDVS, the movement has continued to expand since the completion of this study. The model of TIC that was evaluated in the WCDVS, developed through a collaboration of researchers, practitioners, and trauma survivors from across the country over several years, formed the next major iteration of TIC principles (Elliott et al., 2005). This conceptualization of TIC repeated the original contributions of Harris and Fallot (2001a), and added the provision of one of four trauma-specific treatments (e.g., TREM, for a full list, see Huntington, Moses, & Veysey, 2005), in addition to an increased empha-

sis on an empowering and collaborative approach as a core dimension of working with trauma survivors (Elliott et al., 2005).

In 2005, SAMHSA formed the National Center for Trauma-Informed Care (NCTIC; NASMHPD, 2012), which called TIC a critical “culture change” in our approach to healing and justice. NCTIC and many other organizations continue to provide consultation and training for agencies seeking to adopt TIC within and beyond the behavioral health field. Some national accreditation agencies have even embedded TIC into their requirements (e.g., The Joint Commission, 2014). Indeed, SAMHSA has prioritized developing a “comprehensive public health approach to trauma” by identifying trauma-informed care as the necessary shift that all mental health service systems must undergo to adhere to federal standards of best practices (SAMHSA, 2011, p. 8).

Trauma-informed approaches continue to evolve and expand with new research and clinical practice and, over the last 14 years, have spread to human service systems ranging from child welfare agencies and schools (Ko et al., 2008) to homeless shelters (Hopper, Bassuk, & Olivet, 2010), each with its own set of trauma-informed practices (TIP).<sup>3</sup> The most recent set of TIC guidelines developed by SAMHSA encompass Harris & Fallot's (2001a, 2001b) foundational principles and the later contributions of the WCDVS (Elliott et al., 2005) as well as new additions that attend to social oppression and identity. These guidelines include: establishing a safe environment; developing trustworthiness and transparency; offering systems of peer support; promoting collaboration and mutuality between staff and participants; supporting the empowerment, voice, and choice of survivors; and attending to cultural, gender, and historical issues (SAMHSA, 2014b).

Throughout its evolutions, some have described the trauma-informed approach simply as a rearticulation of ethical best practices (Elliott et al., 2005). However, it goes well beyond that both by introducing new practices and by bringing new meaning to general practices. Regarding the former, TIC evolved alongside a number of reform movements in the medical and mental health fields such as person-centered care (e.g., Institute of Medicine, 2001) and recovery-oriented care (e.g., Anthony, 1993), all of which aimed to move away from a more traditional top-down, medical approach that was seen as disempowering and ineffective for many. Thus, many of the characteristics of TIC, such as a respectful, holistic, and strengths-based approach, overlap with what have become general expectations for competent clinical practice. However, since its inception, TIC has also identified and developed specific practices—for example, universal screening for trauma history, prioritization of physical and emotional safety throughout the program, and the training of all staff in the nature and effects of current and lifetime trauma—that were not identified by these other related movements (Harris & Fallot, 2001a).

Even where TIC does seem to overlap with general best practices, proponents of TIC have argued that these practices take on new meaning and import when they are grounded in a deep understanding of trauma (Elliott et al., 2005). For example, when discussing the notion that a trauma-informed approach involves

<sup>3</sup>Given that the term *trauma-informed care* (TIC) includes organizational and administrative changes, we use the term *trauma-informed practice* (TIP) to denote specific practical applications of TIC that involve direct interactions with program participants.

“open and genuine collaboration between provider and consumer at all phases of the service delivery,” Harris and Fallot (2001a, p. 19) point out that TIC requires special effort, knowledge, and skill in this regard because “the traditional service relationship replicates some of the most damaging dynamics of childhood trauma,” in that survivors must often “accept an unequal relationship in order to avoid worse treatment” (p. 19). Trauma-informed understandings and related practices such as this form the core of the “trauma philosophy” that is central to TIC (Harris & Fallot, 2001a, p. 14). Thus, TIC identifies an important set of new practices and imparts a framework that imbues existing approaches with new depth and meaning.

### Trauma-Informed Care in the Domestic Violence Context

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

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

In response to these critiques, a growing number of DV scholars, policymakers, and practitioners have called for a renewed focus on developing services that support survivors’ needs and goals, that avoid replicating dynamics of coercion, that value the importance of a survivor-centered relationship, and that attend to survivors’ mental health (Goodman & Epstein, 2008; Kulkarni et al., 2012; Serrata, 2012; Warshaw et al., 2003). It is no surprise that DV services have embraced TIC in light of these needs. Adopting TIC in the DV context has involved reframing the

importance of many essential DV practices (e.g., empowerment, peer support) within a trauma framework. At the same time, TIC has integrated new concepts (e.g., historical trauma) and approaches (e.g., psychoeducation) that are meant to support the trauma-related mental health needs of survivors.

Over the past decade, federal and state agencies, community organizations, and researchers have begun to articulate how TIC principles can be translated to the DV context. For example, the National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH) has published numerous tip sheets, webinars, and reports for working with survivors. These resources emphasize that trauma-informed work is social justice driven and closely linked to advocacy work in that it is about “understanding the effects of trauma and what can be done to help mitigate those effects, while at the same time working to transform the conditions that allow for violence in our world” (Warshaw, 2014, p. 15). That is, a social justice-oriented approach to trauma-informed care prioritizes reducing and ultimately eliminating violence by advocating for survivors and working toward social change. These efforts have resulted in a framework of principles and practices that expands on more general conceptualizations, and includes, for example, reducing further harm; establishing empowering, transparent, caring, and respectful relationships; and being responsive to individual and collective needs (Warshaw, 2014). In addition, a growing number of federal, state, and local programs are integrating research and clinical insight to bring TIC to the DV context (e.g., Ferencik & Ramirez-Hammond, 2013). Similarly, culturally specific DV organizations have developed rich articulations of TIC, with particular attention to culture, context, and community (e.g., Kim, 2010; Serrata, 2012). Together, these organizations have published an enormous body of work that describes DV-specific TIC at multiple levels of abstraction. Our goal in this study was to provide a comprehensive description of the current landscape of DV-specific TIP. A comprehensive identification and synthesis of principles and practices across publications would help to consolidate the field’s emerging conceptualization of TIC, identify key discrepancies, and promote its implementation in DV programs.

### Method

To describe the current landscape of conceptualizations of TIP in the DV context, we conducted a qualitative content analysis of publications that describe DV-specific TIP that was informed by expert interviews.

### Selection of Publications

The sample for this study consisted of publications that describe TIP within the DV context. We included any publication by a national, state, or local organization or government agency involved in DV policy, research, or practice that described TIP in the context of DV services for adult survivors. This included publications on sexual assault that had a significant emphasis or subsection on DV as well as publications that focused on a particular population of DV survivors (e.g., survivors with a criminal background). We excluded publications that described services for children who witnessed DV as well as publications that were about

TIP without an explicit focus on DV. Importantly, we chose to focus specifically on staff practices that involve survivors directly rather than on the longer term infrastructure and organizational paradigm shifts required to do this work.

To identify publications, we conducted a Google search using the following search terms in all possible combinations: trauma informed care (or practice or approach); trauma; domestic violence; and, intimate partner violence. We examined the first five pages of search results for each search term, at which point subsequent results did not yield new publications. When possible, we used links and references within publications to snowball additional publications that met our inclusion criteria. The first two authors searched independently and subsequently cross-examined the other's reference list to ensure that no documents were missed. Fifteen expert scholars and practitioners (including mainstream and culturally specific groups) in the field of TIC and DV reviewed this list and added several additional publications. The process yielded a total of 28 documents, 15 of which met inclusion criteria for analysis.

## Qualitative Content Analysis

Qualitative content analysis is a useful method for developing a comprehensive understanding of discourse around a phenomenon or to develop and extend theory regarding that phenomenon (Hsieh & Shannon, 2005). Our goal was to describe comprehensively the practices detailed in each of the selected publications and then integrate them into a set of principles that extend existing theory on general TIC to DV practices.

Our qualitative content analysis incorporated both deductive and inductive elements, as has been suggested for text documents (Fereday & Muir-Cochrane, 2008). Specifically, we conducted a directed content analysis, a form of qualitative content analysis meant to develop and extend theory using existing theory and research to create initial deductive codes from which inductive coding proceeds (Hsieh & Shannon, 2005). Based on a review of the TIC literature and interviews with our 15 experts, we arrived at a set of initial codes that described trauma-informed practices and principles. These initial codes guided our preliminary reading of selected publications. As we proceeded with the coding, we discussed modifications to the initial codes with our auditors.

As the analysis proceeded, we derived codes from the data and compared them to the initial codes (Hsieh & Shannon, 2005) across three levels of analysis. Level 1 consisted of open coding in which we identified specific practices in each publication, using the publications' own words in chunks that ranged in size from a phrase to three sentences. For Level 2, we organized Level 1 codes into *categories* by grouping together practices and policies that were conceptually similar. Codes at these two levels were constantly compared to existing codes. We created new Level 2 codes when no existing codes applied to particular segments of text (Fereday & Muir-Cochrane, 2008). Level 3 consisted of selective coding, in which we synthesized Level 2 categories into overarching *clusters* or principles. At all three levels of coding, initial codes were applied and revised by continuously referring back to previous steps of the process, consulting with experts, dissolving and regrouping categories, and resolving conflicts via discussion between coders (Fereday & Muir-Cochrane, 2008).

## Results

Our analysis resulted in six clusters reflecting broad TIP principles within the DV context. Each cluster (Level 3) is composed of a set of categories (Level 2), which describe specific ways in which these broad principles can be applied within an organization. Most categories also include a set of subcategories (Level 1) that further describe more concrete examples and practices. We hope that this presentation of concrete practices in the context of higher level principles will be useful to practitioners, program developers, and researchers interested in learning about how the TIC framework is operationalized in the DV context.

It is important to note that we do not include a precise "count" of practices themselves. Instead, consistent with other qualitative descriptions, we report whether "few" (less than 5), "many" (5 to 9), or "most" (more than 9) publications describe each practice. This system is meant to provide a sense of the collective emphasis on certain practices without drawing strong conclusions about their relative importance (Bringer, Johnston, & Brackenridge, 2006).

### Cluster 1: Promoting Emotional Safety

All but one of the publications describe what programs and staff can do to promote emotional safety through the physical environment, staff behaviors, and organizational policies.

**The physical environment of the organization is designed to minimize triggers.** Most publications describe the physical space of the organization as a key arena for eradicating reminders of the unsafe, oppressive environment that often accompanies DV. In aggregate, they suggest three broad ways to design the environment to establish a sense of emotional safety. First, many describe the importance of *creating a welcoming environment* by, for example, adding "'home-like' touches" or having "comfortable sofas and chairs, a selection of magazines, toys or coloring books for children, and coffee, tea, or soft drinks on hand in the waiting area" (Edmund & Bland, 2011, p. 29). Second, most emphasize the need to *demonstrate the safety and security of the space* by, for example, ensuring good security lighting outside of the building (Edmund & Bland, 2011, p. 29), or making sure that staff do not block doors (Ferencik & Ramirez-Hammond, 2013, p. 111). Third, a few highlight the importance of *establishing calm and quiet spaces within the organization*, which "may be nothing more than a corner of a quiet room, set aside for survivors to use to care for their feelings or to help restore a feeling of calmness" (NCDVTMH, 2011c, p. 2).

**Staff adopt a nonjudgmental approach about DV in all interactions with survivors.** Most publications also emphasize the role of staff in reducing interpersonal triggers and creating a sense of emotional safety. Across publications, three general staff-wide methods are suggested. First, many publications recommend that *staff accept survivors' responses without judgment*. Some publications explicitly urge that "reactions from staff do not shame or embarrass clients" (NCDVTMH, 2011b, p. 2). One publication captures the guiding idea by suggesting that, above all, "staff lets clients know she [the survivor] is welcome as she is" (NCDVTMH, 2011b, p. 1).

Second, many publications urge staff to *approach clients with gentle, nonjudgmental questioning*. A few publications specifically focus on the intake process, which is often a women's first point of contact with a DV program. They recommend that the "advocate can alter how he/she asks a question on an intake to be less intrusive or abrupt" (Ferencik & Ramirez-Hammond, 2013, p. 113). One publication suggests that staff should "avoid asking too many questions in a row" and instead recommend that staff ask themselves "Is this information . . . necessary to gather right now? If it can wait, let it wait until she is more comfortable" (Lane, Judy, & Sweet, 2011, p. 39).

Relatedly, many publications emphasize how important it is for *staff to speak with respectful language*, which includes considerations of tone as well as the choice of words. A few publications suggest the use of "people-first" language, recommending, for example, that "the person I work with" might be more appropriate than "my client" (Ferencik & Ramirez-Hammond, 2013, p. 84). Similarly, one publication suggests refraining from using "the term 'survivor' before the person has self-identified this way" (Cave & Pease, 2013, 52:30).

**The program develops and communicates policies clearly and safely.** Most publications discuss several ways in which policies and procedures can be communicated in a manner that counters the manipulation characteristic of DV. First, many publications highlight that *staff describe all policies clearly and explicitly*. One publication articulates the purpose of this practice as "explaining to women why certain things are happening to increase their sense of safety and control" (Kubiak, Sullivan, Fries, Nkiru, & Fedock, 2011, p. 8). In this light, a few publications underscore the need for repetition in communicating policies: "You may have to repeat the rules and other information many, many times. Accept this repetition as a practice to ensure a trauma-informed environment rather than understanding her as non-compliant" (Lane et al., 2011, p. 40).

Many publications expand upon this practice by stating that *staff should be transparent and predictable in their interactions with survivors*. For example, one publication suggests, "She might need to know who is currently working or who is working the next shift. She might become agitated and restless if she does not know who to expect" (Lane et al., 2011, p. 14). One publication suggests that transparency and predictability are critical when explaining procedures that might take place outside of the program (e.g., court), suggesting that staff "consider incorporating a what-to-expect discussion into every survivor's routine preparation for court" (NCDVTMH, 2013, p. 3).

## Cluster 2: Restoring Choice and Control

Across multiple levels of practice, all publications emphasize that it is critical for programs to continually aim to restore choice and control. This can happen in the process of sharing stories, the design of individual services, and in organization-wide programs.

**Staff foreground survivors' way of telling their story.** Many publications recommend that staff make room for survivors to tell their stories in their own ways. First, this means that *staff offer survivors space and time to tell their stories*. Distinct from "nonjudgmental" listening, this category is meant to

highlight survivor agency in sharing information. One publication captures the essence of this idea in stating how critical it is that "clients feel like it is their choice whether or not they share their story [and] telling their story is a choice, not a problem" (Blanch, Filson, Darby, & Cave, 2012, p. 75). Another underscores the importance of ensuring that the process feels manageable for survivors, recommending that staff "offer frequent breaks or break up the 'hard stuff' into smaller sessions with non-threatening activities such as offering time for something creative to happen, a coffee break, or a snack break" (Lane et al., 2011, p. 39). Furthermore, a few publications also stress *offering survivors multiple outlets to share their stories*, including "art, and music, and writing, and movement" (Cave, 2013, 1:11:20).

**Staff provide opportunities for survivors to shape the focus of their work.** Given that the core of DV is the removal of choice and control, most publications highlight that survivors should have choice and control in shaping the focus of their work. First, many publications urge staff to *emphasize shared power in interactions with survivors*. One publication encourages staff to "be willing to learn from survivors" and further, to "respect . . . that survivors are the experts in their lives" (Ferencik & Ramirez-Hammond, 2013, p. 56). Another publication suggests, "Ask before providing any information or options. Listen to what each woman you meet asks for, and collaboratively make a plan of support based on the needs she identifies" (Payne & Clifford, 2011, p. 110).

Additionally, many publications recommend that *staff offer multiple choices regarding their experiences within the program* so that "survivors know that they can ask for what they need and express their opinions and wishes, even if they are different than what the program is offering or what other survivors are doing" (NCDVTMH, 2011c, p. 3). Recognizing that the possibility of choice can be overwhelming to survivors who have often been denied choice, one manual recommends "starting with small choices, if necessary, in order to build trust with women as well as to build her sense of competence" (Kubiak et al., 2011, p. 8).

**Survivors have opportunities to influence program services.** Finally, many publications recommend that *staff actively solicit survivors' perspectives on programming* as another way to restore choice and control. This is sometimes described as informally checking in with survivors (Cave & Pease, 2013); however, some programs have adopted more formal practices such as organized "listening sessions" to obtain input from survivors (Serrata, 2012, 55:48). As an overall goal, one publication explains that "clients feel like their voices and choices matter" (Blanch et al., 2012).

## Cluster 3: Facilitating Connection

Most publications emphasize the importance of helping survivors develop healthy connections. They suggest that programs and staff support survivors in developing meaningful relationships with staff, other survivors, and their own families and communities.

**Staff invest in relationships with survivors.** Most of the publications stress that staff should regard their relationships

with survivors as central to trauma-informed work. One publication reflects on the importance of this relationship as an overall approach:

Often people think that using a trauma-informed approach to providing services involves certain activities and interventions. But it is critical to emphasize that the work that we do with survivors needs to be done with careful attention to *how we* are relating to survivors. (Ferencik, & Ramirez-Hammond, 2013, p. 54)

Accordingly, publications make several recommendations for how staff can invest in meaningful relationships with survivors. Many publications stress that *staff prioritize being present when working with survivors*. “Being present” includes practices such as remaining with survivors, particularly when they are experiencing fear, and being attuned to their needs, especially during stressful situations. For example, one manual encourages “accompanying” women to obtain outside services (Moses, Reed, Mazelis, & D’Ambrosio, 2003, p. 24). Another embraces a more “family” model of relationships that imply “a greater level of intimacy and care in their interactions with survivors” (Kim, 2010, p. 4). Additionally, a few publications emphasize the importance of *staff listening carefully to survivors*. Using language that is distinct from the discourse on “non-judgmental” acceptance and survivor agency, these suggestions describe an active, empathic engagement. Some publications give specific strategies for how to listen attentively: “Reflect and clarify what she has communicated. ‘Did I understand this correctly when you said \_\_\_\_\_?’” (Lane et al., 2011, p. 40).

**Staff create opportunities for survivors to connect with each other.** Many publications highlight the need for programs to facilitate relationship building among survivors, focusing on two major forms of connection. First, many publications recommend that *staff create opportunities for survivors to support their peers* in the healing process and in the development of new strengths and skills. One publication recommends: “Hire/recruit volunteers who have been program participants. They offer valuable insight ‘having been there’” (Lane et al., 2011, p. 38). Additionally, a few suggest that *programs create opportunities for social connection between survivors* within and beyond the organization (Kim, 2010). Although most of these practices are quite general (e.g., encourage friendships), they are put forth with the recognition that many survivors have been socially isolated in their experience with DV.

#### **Staff support survivors’ parenting relationships.**

A few publications devote attention to survivors’ relationships with their children by recommending that *staff support parents in understanding their children’s responses to trauma*. For example, one publication recommends having age appropriate information available on sleep, school, and emotions to help “parents to help their children cope more adaptively with trauma-related responses” (NCDVTMH, 2011d, p. 1). Another publication emphasizes the importance of *creating opportunities for positive parent-child interactions*, suggesting broadly that there be opportunities for “healing types of play and interaction” within the organization (Ferencik, & Ramirez-Hammond, 2013, p. 138).

**Staff support relationships between survivors and their community.** A few publications discuss connecting survivors to supports and resources within their community as a way to expand networks of support and keep survivors connected

to their lives. Particularly when certain resources are not offered within an organization, one publication encourages programs to “find folks in the community” and “reach out to other programs in ways that help to build real networks of training and collaboration” (Cave & Pease, 2013, 51:40). In addition, these publications speak about an underlying philosophy of “connecting to . . . the natural resources and supports that people have” (Cave & Pease, 2013, 1:15:05).

## **Cluster 4: Supporting Coping**

Most publications emphasize the importance of supporting survivors in coping with trauma and stress, which can be facilitated when staff address the nature and effects of DV, validate and strengthen survivors’ coping strategies, and establish a holistic approach to health and recovery.

### **Staff promote an approach to coping that explicitly addresses the effects of domestic violence.**

Many publications specifically emphasize that *staff should promote an understanding of the nature and effects of DV* as part of their work with survivors. This includes providing frequent and accessible psychoeducation (e.g., classes, videos) and written materials about the experience of DV (e.g., coercive control, isolation) as a way to educate and empower survivors. One publication labels this dimension of TIP as being “domestic violence informed” or, in other words, founded in the knowledge of how DV might affect survivors across diverse identities and contexts (Accessing Safety and Recovery Initiative [ASRI] & NCDVTMH, 2012, p. 13).

Additionally, many publications highlight that *staff should validate survivors’ traumatic responses to domestic violence* so that “survivors recognize these symptoms as adaptive responses, not signs that they are ‘going crazy’ (Ferencik, & Ramirez-Hammond, 2013, p. 34). One document, which focuses on working with survivors in court, suggests: “If you have taken a break because the survivor became upset or agitated, validate their feelings. Acknowledge that what’s happening is very upsetting and that they are doing a great job” (NCDVTMH, 2013, p. 4). Finally, most publications highlight the importance of reframing stigmatizing beliefs and language about coping and trauma so that “clients develop an understanding of ‘symptoms’ as ‘adaptations’ to trauma” (NCDVTMH, 2011b, p. 2).

### **Staff support survivors in strengthening and developing strategies for coping.**

Many publications indicate that supporting survivors involves helping them to *strengthen and develop a number of coping skills and strategies*. One suggestion is to help survivors recognize their own triggers related to trauma by, for example, creating “a user-sensitive checklist to help a survivor begin to identify the triggers that affect her” (Ferencik & Ramirez-Hammond, 2013, p. 132). Many publications also stress that staff assist survivors in developing coping strategies in response to a wide range of difficulties. The coping strategies range from more clinically worded strategies such as “containment skills . . . to deal with flashbacks and dissociation” (Payne & Clifford, 2011, p. 119) to more community-oriented approaches such as the broad suggestion to “support and encourage efforts to reach out for help from friends and family” (Ferencik & Ramirez-Hammond, 2013, p. 71).

**Staff support a holistic culture of healing.** Many publications also emphasize a holistic culture of healing, or one that adopts a multidimensional approach to survivor well-being. This approach is articulated in four general ways. First, a few publications explicitly ask staff to *convey a hopeful message around healing* by, for example, conveying “the message that ‘healing is possible’” (Blanch et al., 2012, p. 5). Second, a few publications encourage staff to *create opportunities for integrating spirituality into healing*, offering examples such as: “providing free time for attendance at church services” (Edmund & Bland, 2011, p. 46) and sharing “inspirational poems and quotes” (Ferencik & Ramirez-Hammond, 2013, p. 46). A few publications also recommend that *staff address the role of physical health in healing*. For example, one publication describes that survivors may have “disrupted typical eating rituals during abuse” and that staff should assist in reestablishing healthy eating patterns (Ferencik & Ramirez-Hammond, 2013, p. 68). More generally, a few publications stress the importance of physical activity such as “daily walks” to “ameliorate stress hormone activation” (Ferencik & Ramirez-Hammond, 2013, p. 68). Finally, a few publications recommend that *staff address the intersection of substance abuse, DV, and coping*. Generally, publications advise staff to “assume an overlap of issues” given that “there is often an underlying trauma issue for both substance abuse and mental illness” (Payne & Clifford, 2011, p. 115).

### Cluster 5: Responding to Identity and Context

Most publications describe DV-specific TIP as being responsive to multiple dimensions of a survivor’s identity, including gender, race, sexual orientation, ability, culture, immigration status, and language, as well as their social and historical contexts. Specifically, they describe ways to engage with a diverse range of survivors through the physical environment, the attitudes and behavior of staff, and the structure of the organization.

**The physical space is inclusive and welcoming to people of all backgrounds.** A few publications contain a variety of suggestions for being inclusive and welcoming to diverse groups of people. For example, a few publications recommend that written materials reflect multiple backgrounds. One publication recommends that all “flyers, brochures, and pictures around the organization represent various cultural groups,” (Missouri Coalition Against Domestic & Sexual Violence [MCADSV], 2011, p. 9) while another specifies that “décor, reading material, and other physical aspects of the environment reflect the diversity of the people being served” (ASRI & NCDVTMH, 2012, p. 5).

**Staff are affirming of and responsive to multiple identities.** Most publications make a number of suggestions for how staff can become knowledgeable and affirming of participants’ diverse identities. The first step, according to a few publications, is that *staff explore their own biases and beliefs*. One publication urges all staff to become aware of their “own beliefs, thoughts, feelings and fears about these issues” (Payne & Clifford, 2011, p. 115), with another reminding staff to “be attuned to cultural differences that might look like ‘bad’ choices or practices to you” (Lane et al., 2011, p. 41). Building from self-awareness, a few publications ask that *staff take time to acquire knowledge about the communities in which they work*, for example, asking staff to “balance . . . what do I need to talk with survivors about

directly and what do I need to learn for myself [sic]” (Cave & Pease, 2013, 59:40). Some publications encourage an active approach suggesting that staff “get to know the [cultural] groups in your community” (Edmund & Bland, 2011, p. 42); however, at the same time, some publications stress the importance of “understanding the differences within one community” (Serrata, 2012, 1:19:25).

Relatedly, many publications highlight the need to *avoid making assumptions about survivors based on their perceived identity*. For example, one publication advises organizations to ensure that “people receiving services are not automatically assigned to staff members from their own cultural, ethnic, racial, or language group” (ASRI & NCDVTMH, 2012, p. 8). Another publication suggests that staff take care “not to pathologize cultural differences or other kinds of diversity. And never imply that violence or abuse is the result of a particular culture’s norms or customs” (Edmund & Bland, 2011, p. 42). Importantly, one publication reminds staff not to assume that domestic violence is the “focus of the work,” acknowledging the complexity of needs and goals that survivors bring to DV programs (Cave & Pease, 2013, 53:14).

This sort of exploration paves the way for a number of practices that acknowledge and affirm survivors’ intersecting identities. First, a few publications urge staff to *incorporate consideration of culture and identity in working with clients*. In some publications, this means thinking critically about help-seeking behaviors and access to resources: “Be aware of additional issues that may make it harder to report abuse or reach outside the family or community for help, such as cultural issues or disability needs” (Edmund & Bland, 2011, p. 42). Other publications simply acknowledge that considerations of culture should be part of conversations with survivors, suggesting that “advocates explore and discuss the meaning of violence within the survivor’s family and culture” (Moses et al., 2003, p. 21).

Second, many publications stress that *staff make it possible for survivors to engage in culturally specific practices*. For example, one publication advises staff to “ensure an understanding of specific cultural dietary restrictions and religious practices and ensure that time and space is available to accommodate these needs” (MCADSV, 2011, p. 9), while others encourage programs to have “information about culturally relevant services or supports available in the community” (Blanch et al., 2012, p. 28). Some publications describe a more community-oriented approach to offering culturally specific services, suggesting that staff “regularly engage community individuals, leaders, organizations and media” (Kim, 2010, p. 23).

Finally, many publications highlight the need for staff to *recognize current and past social injustice* as part of the experience of DV, highlighting the need for staff to understand and respond to forms of discrimination that survivors might face. A few publications also devote attention to the role of historical trauma, or the “cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma” (Brave Heart, 2003, as cited in Serrata, 2012). Noting that historical trauma is often absent from definitions of trauma, one publication argues that this concept needs to be part of how we understand, and thus, work with, survivors (Serrata, 2012). One organization captures this overall approach by suggesting that



trauma-informed practice must be developed from “social justice and human rights perspective” (Serrata, 2012, 48:20).

**The organization is designed to represent the diversity of its clients.** On a system-wide level, a few publications advise staff to *ensure that clients can communicate in their language of choice* as part of a culturally competent approach. This could mean avoiding or explaining the common use of jargon or abbreviations when describing resources to clients, (Ferencik & Ramirez-Hammond, 2013, p. 129), or having access to interpreters or language advocates (Serrata, 2012, 1:11:25), and “planning for the extra time needed when interpreters are used” (Cave & Pease, 2013, 1:07:50). A few publications also recommend that program staff *reflect the cultural diversity of program participants*. This often means that organizations need to “hire staff that are representative of diverse racial, cultural, and social backgrounds, and who speak languages other than English” (MCADSV, 2011, p. 9), as well as those who “demonstrate respect for diversity and cultural competency” (ASRI & NCDVTMH, 2012, p. 4).

**Cluster 6: Building Strengths**

Many publications emphasize that a strength-based approach is a critical part of TIC in the DV context. This broader principle includes recommendations that staff actively focus on survivor strengths in their work and help survivors to further develop their leadership skills.

**Staff recognize and value strengths.** Many publications emphasize the importance of naming and valuing survivors’ strengths, especially in relation to the experience of DV. One publication suggests: “Ask her what has helped in the past . . . She has survived and has a host of resources to draw from” (Lane et al.,

2011, p. 40). Two publications capture the core idea by suggesting that the practice of simply asking survivors “how they have made it this far” is essential to a trauma-informed approach (ASRI & NCDVTMH, 2012; Serrata, 2012).

**Staff provide opportunities for survivors to develop leadership skills.** For a few publications, building strengths extends beyond survival and resilience to include practices that encourage leadership. One publication suggests that survivors be involved in selecting topics for group meetings, explaining that this is a reflection of “giving power to their voices” (Ferencik & Ramirez-Hammond, 2013, p. 93). In regards to more specific practices, one publication describes a 6-week curriculum (“Líderes”) that engages survivors in a strengths-based approach to developing leadership within the organization, community, and beyond (Serrata, 2012).

**Discussion**

The goal of this study was to provide a comprehensive description of the current landscape of DV-specific TIP. By connecting broader principles (Level 3) to more specific applications (Level 2) and, where possible, even more concrete practices (Level 1), we endeavored to present a conceptualization that is both theoretically coherent and practically accessible. See Table 1 for a summary of this framework.

It is critical to note that the implementation of a comprehensive trauma-informed approach requires an organizational paradigm shift that entails buy-in from all levels of leadership, extensive training and supervision for staff, and a significant investment of time and resources (Harris & Fallot, 2001a; Huntington et al., 2005). There are publications dedicated entirely to this process; however, given the natural limits of a single study, as well as the

**Table 1. Principles and Practices of DV-Specific TIP**

<i>Promoting emotional safety</i>	<i>Restoring choice and control</i>	<i>Facilitating connection</i>	<i>Supporting coping</i>	<i>Responding to identity and context</i>	<i>Building strengths</i>
The physical environment of the organization is designed to minimize triggers.	Staff foreground survivors’ way of telling their story.	Staff invest in relationships with survivors.	Staff promote an approach to coping that explicitly addresses the effects of domestic violence.	The physical space is inclusive and welcoming to people of all backgrounds.	Staff recognize and value strengths.
Staff adopt a nonjudgmental approach about DV in all interactions with survivors.	Staff provide opportunities for survivors to shape the focus of their work.	Staff create opportunities for survivors to connect with each other.	Staff support survivors in strengthening and developing strategies for coping.	Staff are affirming of and responsive to multiple identities.	Staff provide opportunities for survivors to develop leadership skills.
The program develops and communicates policies clearly and safely.	Survivors have opportunities to influence program services.	Staff support survivors’ parenting relationships.  Staff support relationships between survivors and their community.	Staff support a holistic culture of healing.	The organization is designed to represent the diversity of its clients.	

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current interest in the “what” of TIC for DV survivors, we chose to focus directly on program and staff practices and the principles that inform them. It is also important to note that our intent was to describe and synthesize, rather than evaluate, the field’s current implementation of TIC.

We hope that this analysis can serve as one more step forward in bridging theory and practice for DV organizations and researchers eager to develop and strengthen a trauma-informed approach.

This discussion begins by highlighting the significance of the six core principles and their constituent practices within the DV context. Following this, we outline a tension that emerged within and across clusters regarding the scope of TIC and varying conceptualizations of trauma, cultural competence, and power. Finally, we discuss the study’s limitations and highlight implications for future research and evaluation.

### TIP Principles in the DV Context

The principles that emerged from the analysis are consistent with TIC theory across multiple human service systems (e.g., Elliott et al., 2005; Harris & Falot, 2001b; SAMHSA, 2014b); however, as highlighted through our results, they include practices that are uniquely responsive to the lived experiences of DV and the settings in which DV services are offered. Whereas “universal” TIC is built on the assumption that anyone seeking services might be a survivor of trauma, DV programs assume that all people seeking services have experienced physical, sexual, and/or psychological trauma as well as a host of intersecting challenges (e.g., poverty, lifelong victimization; Melbin, Smyth, & Marcus, 2014; Warshaw et al., 2009; Warshaw, 2014). In this context, DV programs have applied TIC principles to reiterate and revitalize their long-standing commitment to survivor well-being, in addition to adopting new, DV-specific trauma-informed practices.

**Cluster 1: Establishing emotional safety.** The call to establish emotional safety through careful attention to potential triggers emerged resoundingly in this analysis. Three sets of practices followed that speak specifically to the DV context: The idea of creating a safe and welcoming environment aims to counter survivors’ sense that their privacy has been invaded and that their own homes are dangerous (Childress, 2013). An emphasis on nonjudgmental staff aims to minimize the effects of social stigma and internalized blame associated with DV (Barnett, Martinez, & Keyson, 1996). Finally, transparent and predictable communication of policies and procedures addresses survivors’ history of coercive and unpredictable interpersonal interactions (Stark, 2007). This cluster speaks to the developing critique of the over-reliance on rules in some DV organizations (Glenn and Goodman, *in press*) and the importance of minimizing such stringent policies and related triggers to establish a sense of safety, and promote the possibility of healing.

**Cluster 2: Restoring choice and control.** Restoring choice and control has historically been a guiding philosophy for working with survivors (Goodman et al., 2014); however, the TIC framework lends it greater nuance and context. This cluster reflects an emphasis on survivor empowerment that directly counters the coercion associated with domestic violence (Goodman et al., 2014). The practices promote survivors’ agency from their earliest

experiences of sharing information, through their work with staff, and finally, through the opportunity to offer their perspectives as valuable to the organization. In direct contrast to the one-size-fits-all approach to service delivery, this cluster highlights the importance of survivors’ charting their own course through the program as an integral part of responding to trauma.

**Cluster 3: Facilitating connection.** Reflecting the fact that relational disruption is at the core of DV, the third cluster—facilitating connection—emphasizes the importance of survivors’ relationships with staff, other survivors, their families, and their communities. The broad emphasis for staff is on “how to be with survivors” to form collaborative and mutual relationships (Ferencik & Ramirez-Hammond, 2013). Regarding survivors’ relationships with each other, the publications highlight peer support; indeed, a handful of publications are dedicated entirely to this topic (e.g., Blanch et al., 2012). Some publications (e.g., Cave & Pease, 2013; Serrata, 2012; Kim, 2010) also point out that an individual survivor cannot be understood or assisted outside the context of her or his relationships with family, friends, neighbors, colleagues, and others who will provide support long after contact with a program ends (Goodman & Smyth, 2011). In this light, DV scholars have advocated for a “network-oriented” approach to services that recognizes survivors’ communities as critical to the social change goals of the DV movement (Family Violence Prevention Fund, 2004; Goodman & Smyth, 2011).

**Cluster 4: Supporting coping.** Scholars of TIC generally (e.g., Elliott et al., 2005) as well as DV specifically (e.g., Phillips et al., 2013; Warshaw et al., 2003) have underscored the need to validate and strengthen survivors’ style of coping, as opposed to judging them. As a foundation for supporting and validating survivors’ coping responses, many publications also highlight the importance of staff acquiring deep knowledge of DV, including the diversity of trauma experiences associated with it (Warshaw et al., 2009). This cluster represents a meaningful response to another challenge within the DV movement: that programs have struggled to address survivors’ mental health difficulties without inadvertently blaming them for their involvement in abusive relationships (Walker, 2009). Helping survivors understand their responses to trauma as powerful methods of coping validates their experiences and offers the opportunity to consider new possibilities for supporting survivor mental health.

**Cluster 5: Responding to identity and context.** Reflecting the fact that a lack of culturally inclusive services has contributed to retraumatization within programs and prevented some survivors from feeling safe accessing DV services (e.g., Richie, 2000), many publications underscore the need to respect, understand, and engage with survivors’ intersecting identities. Although seemingly taken for granted as part of the universal trauma-informed approach (SAMHSA, 2014b), the emphasis on responsiveness asks that we extend the classic TIC shift from “What is wrong with you?” to “What happened to you?” to also consider, “Who are you?” Thus, this cluster—responding to identity and context—addresses the ways in which the physical environment, staff practices, and organizational structure can foster an experience that is welcoming to all survivors.

**Cluster 6: Building strengths.** Finally, the building strengths cluster—described as a counterweight to the diminishing of self-worth that accompanies DV (e.g., Barnett et al., 1996)—comprises two sets of practices: recognizing the strengths that survivors bring to programs, and providing opportunities for them to build on their strengths by taking on leadership positions within and outside the organization. Publications describe opportunities that utilize preexisting programs (e.g., survivors facilitate groups) or extend survivor roles (e.g., developing community advocacy skills). Underlying many of these recommendations is the notion that there must be a space for survivors to experience themselves as the opposite of victims—as powerful contributors with the capacity to shape their worlds (Herman, 1997).

### The Scope of Trauma-Informed Practice: Critical Differences and Tensions

Despite the common themes that emerged across descriptions of DV-specific TIP, our analysis also reveals critical differences that echo across DV work more broadly. To a certain extent, these differences within the DV field parallel the evolution of thinking about TIC in the larger human services field (e.g., Harris & Fallot, 2001a, SAMHSA, 2014b). Within the DV context, however, they reflect divergences in how publications describe the scope of trauma-informed work—ranging from a narrow focus on individual healing in the aftermath of DV to a broader focus on addressing social contexts of violence and oppression. In this section, we provide a brief analysis of how these differences manifest in conceptualizations of trauma, cultural competence, and power, as well as the practices that flow from each. We believe that drawing attention to this range of ideas opens up space for continuing dialogue and debate as elements of TIC are applied across diverse contexts.

Specifically, we discerned an implicit tension between an orientation that focuses on improved social service provision to address the aftermath of DV—what we call a “direct service approach”—and one that engages with the larger context of systemic oppression in which DV is embedded—what we call a “social justice approach” (e.g., Warshaw, 2014, SAMHSA, 2014b). In some ways, the reviewed publications can be seen as incorporating elements of each of these orientations, with some placing much more emphasis on one or the other. Yet, this range in approaches means that there are some key differences in the ways in which TIC is imagined in practice.

**Trauma.** When organizations ask the key trauma informed question—“What happened to you?”—the publications reviewed in this study reveal different ideas regarding the nature of survivors’ suffering. These differences span from a narrow lens in which the trauma of interest is primarily DV to a broader lens in which trauma includes various forms of social and community violence. For example, some publications characterize trauma as physical, sexual, or psychological abuse in an intimate relationship. Accordingly, the approach emphasizes improved services that respond to the traumatic consequences of DV, such as avoiding relevant triggers (e.g., feeling trapped) or tailoring psychoeducation to focus on coping with experiences of partner abuse.

However, most DV-specific TIP publications use a broader lens to describe other challenges that survivors face, including

poverty, physical health issues, and discrimination related to immigration, race/ethnicity, homophobia, or disability concerns. Accordingly, in addition to trauma-informed services related to DV, they emphasize multisystem advocacy and culturally responsive services that address some of these systemic challenges. These practices suggest a broadened view of trauma; however, the focus of the work is still individual healing.

Moving even further from this more individual lens, some publications conceptualize the trauma of DV as inextricably connected to other forms of interpersonal, family, social, and political oppression (Sokoloff & Dupont, 2005; Tummala-Narra, 2007; Warshaw, 2014). The trauma-informed practices associated with this expanded lens emphasize not only engagement with the individual as part of her community, but also with community change itself as part of the healing work. Additionally, a few publications underline historical trauma as integral to the work of TIC. Historical trauma—that is, cumulative psychological suffering that spans generations as a result of membership in a group that has previously endured massive trauma (Brave Heart, 2003)—is part of universal formulations of TIC (e.g., SAMHSA, 2014b); however, it is briefly mentioned within DV-specific TIC literature and often without clear links to practical applications. This range seems to reflect the gradual development of TIC toward engaging with collective experiences of suffering and coping (SAMHSA, 2014b).

**Cultural competence.** The question “What happened to you?” is incomplete without also exploring the question “Who are you?” Cultural competence—an approach implicitly designed to engage with this question—is regarded as a fundamental value of TIC (SAMHSA, 2014b) and is stressed across review publications. However, the publications’ varied descriptions of cultural competence imply different conceptualizations of the cultural identity and contexts of survivors. This range spans from a relatively more narrow “kind of person” approach (e.g., Sue, Zane, Nagayama Hall, & Berger, 2009) in which cultural competence comprises staff awareness, knowledge, and skills staff to a broader approach in which staff engage with a more complex, contextual understanding of survivors’ lives (Crenshaw, 1994; Sokoloff & Dupont, 2005; Sue & Torino, 2005).

Most publications describe cultural competence using the “kind of person” model and thus prioritize competent staff behavior (e.g., examining biases) and an inclusive, welcoming environment (e.g., program materials, décor, and food consistent with survivors’ culture). These practices are primarily concerned with working more effectively with a diverse group of survivors. However, a handful of publications propose a more systemically engaged vision of cultural competence. For example, some reference the importance of addressing issues of structural inequity and oppression when working with survivors. Others stress that staff must seek to understand and draw upon collective sources of strength, resilience, and coping as they have developed in contexts of chronic abuse. Still others make recommendations regarding organizational structure, such as ensuring that those in leadership positions share identities with participants. Taken together, these descriptions reflect an expanded view of culturally competent services that attends not only to individuals, but also to systems of

power, oppression, and collective well-being for DV survivors (Sue & Torino, 2005).

This tension echoes a larger critique within DV literature of the ways in which cultural identities have either been dismissed or used to blame women for their abuse. Accordingly, many scholars argue that we must move beyond a simplistic focus on “culture” and engage in a structural analysis of power that seeks to understand how systems of oppression, such as social inequality or racial discrimination, shape different experiences of violence and coping across contexts (Collins, 1998; Sokoloff & Dupont, 2005). Thus, while the emphasis on cultural competence across publications is pervasive, this range of ideas underscores the challenges associated with ensuring true access and inclusivity for a diverse range of survivors. Importantly, SAMHSA’s (2014b) most recent articulation of TIC emphasizes gender, cultural issues, and historical trauma more than previous models (e.g., Harris & Fallot, 2001a, 2001b), underscoring the need for a more thorough adoption of these ideas within the DV context.

**Power.** Survivor empowerment, voice, and choice comprise fundamental principles of TIC (SAMHSA, 2014b) that are widely represented across reviewed publications. However, there are important differences in how publications conceptualize the ways that power is “shared” with survivors. At one end of the spectrum, publications emphasize collaboration and shared decision making, and programs are encouraged to invite survivors to provide their perspectives on programming. However, in many of these descriptions, survivors remain in the role of recipients of services. Sharing power aims to avoid potentially coercive practices, yet its scope is limited by a service system in which staff maintain authority and expertise.

Some publications offer a broader form of shared power in their emphasis on peer support. Here, “expertise” lies within survivors themselves, seen as the primary sources of knowledge and insight. Survivor-led programming represents an expansion of power that opens up space for survivors to develop facilitation skills, mentorship roles, and a sense of purpose within the organization. Moving still further along the spectrum, some descriptions of DV-specific TIP position survivors with an even greater degree of power, as leaders in their community and critical voices of social change. Indeed, beyond the discourse of TIC, DV organizations differ profoundly in their power dynamics, including those that are rigidly structured as well as radically oriented toward community organizing (Melbin et al., 2014). This range of perspectives represented in this analysis suggests that there is still substantial work required to enact “shared power” in a way that balances the needs of programs and survivors.

Reflecting the broader evolution of TIC, these different descriptions of trauma, cultural competence, and power—and the practices that flow from them—raise important questions about what it means for programs to fully engage with survivors’ experiences of DV and trauma, to understand survivors’ identity, culture, and context, and to collaboratively provide services that will promote individual and collective healing.

### Limitations and Future Research Directions

This study has several limitations. First, because we needed clear inclusion criteria, we captured only those publications that

characterized themselves as addressing TIP in the DV context. This inevitably meant excluding documents that may have contained elements of DV-specific TIP but did not use this terminology (e.g., National Coalition of Anti-Violence Programs, 2013). We hope that the principles and tensions described here serve as a foundation for an expanded discussion of the nature of TIC that broadly encompasses practices that fit within its conceptual umbrella whether or not they are labeled exactly in this way.

Second, we were not able to capture the practices adopted by innovative DV programs around the country that are not yet articulated in published documents. As TIC publications continue to develop, we expect that the snapshot of the field described here will need to be revisited. Indeed, an important next step in the development of a set of inclusive and effective trauma-informed practices will be for researchers to engage in a cyclical process of implementation, evaluation, and revision. Evaluation is a critical part of this process that will enable organizations to grow and strengthen their trauma-informed practices (SAMHSA, 2014b), so we must begin to develop tools to assess them, especially as they are experienced by survivors. Toward this end, a forthcoming article (Goodman et al., in press) will describe the Trauma Informed Practice (TIP) Scales, a measure informed by the same expert consultation that formed the basis of this qualitative analysis and developed with support from the NCDVMH. This measure is intended to enable programs to assess trauma-informed practice from the perspective of survivors.

Finally, this study did not include the voices of survivors themselves. Because TIC is conceptualized as being fundamentally survivor-driven (SAMHSA, 2014b), a full conceptualization of TIC in the DV context must center survivors’ voices. This will be critical as programs and researchers continue to develop and implement TIC.

### Conclusions

In conducting this study, it was our goal to offer a comprehensive description of the current landscape of DV-specific trauma-informed practices. Through this analysis, we identified six core principles, as well as example practices, that offer a meaningful foundation for conceptualizing TIC in the DV context. Taken together, these principles reflect the symbolic shift at the heart of the trauma-informed approach: the movement from “What is wrong with you?” to “What happened to you?” TIC’s emphasis on identity, strengths, and context suggests that we must also ask, “Who are you?” In moving toward a consensus on TIC, it is critical that researchers and programs remain engaged with the wide range of experiences, systems, and histories that shape a survivor’s experience with DV to help ensure that all survivors are included in this discourse and that there can be space for TIC to evolve in response to survivor and program-level contexts. By offering one more step toward an understanding of trauma-informed practice in the DV context, we hope to establish a foundation for continued action, raise critical questions for future research, and move closer to a more inclusive, collaborative, and humane system of support for diverse survivors.

**Keywords:** domestic violence; intimate partner violence; domestic violence services; trauma-informed care; trauma-informed services

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