

# INTRODUCTION

Trauma is life altering, and its effects are pervasive. It affects many life domains, and it may hinder the development of treatment relationships and help-seeking behaviors (Fallot & Harris, 2001). For services to be truly trauma informed, all aspects of service delivery must recognize and account for the impacts of trauma and the ways in which trauma may affect behavior change processes (Fallot & Harris, 2001). Our goal for this book is to provide a trauma-informed approach for understanding and intervening with individuals who engage in intimate partner violence (IPV). Although trauma-informed approaches are increasingly common in services for IPV survivors, in the chapters that follow we present evidence indicating that trauma-informed services are also very important in work with individuals who perpetrate IPV and represent an innovation over long-held approaches that tend to disregard or minimize the role of trauma.

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There is seemingly universal acknowledgment that exposure to trauma and abuse contributes to aggression and other problem behaviors in children. Interventions designed to prevent these problem behaviors address the abused child's faulty ways of interpreting the world around them resulting from their experience of abuse (Dodge, Godwin, & The Conduct Problems Prevention Research Group, 2013). Although numerous books have addressed the topic of preventing aggression in trauma-exposed children (Crenshaw & Mordock, 2005; Gil, 2011; Goodyear-Brown, 2009; Levine & Kline, 2006), heretofore no such resource has focused on accounting for trauma in interventions for adults who engage in IPV. There is little reason to think that problem behaviors resulting from childhood trauma simply go away on their own when abused children reach adulthood, and an extensive research base indicates that both childhood and adult trauma are linked with abusive and violent behavior in intimate relationships.

This book is intended to assist clinicians in understanding the relationship between trauma exposure and IPV in adulthood and to provide the knowledge and skills to deliver effective trauma-informed intervention services to individuals who engage in IPV. As we discuss in the following sections, decades of research have demonstrated high rates of trauma exposure, most notably abuse in childhood, among individuals who engage in IPV. There is an increasing recognition that models of IPV that do not take trauma into consideration are incomplete and may impede the success of prevention and treatment of violent behavior. The notion that we must give greater weight to trauma has been highlighted recently, not only through work with returning military veterans who have experienced significant trauma and exhibit IPV but also by our own recent clinical studies that have demonstrated the effectiveness of trauma-focused interventions. As we will discuss, research also demonstrates that models of IPV that incorporate trauma are relevant for both military and civilian populations. There has been a movement in the general IPV intervention field to better train counselors on trauma and its impacts, although at the time this book is being written there is no singular resource that focuses on this important issue.

This book will benefit any provider who works with violent or partner-abusive individuals. This includes those who work with civilian and military populations who exhibit problems with IPV, forensic populations, and both men and women. We believe that no abusive client is without any prior trauma or other prior life event (or events) that has shaped the way he or she views others and that influences his or her behavior in interpersonal relationships. Thus, this book is not intended to be used only with a specific subgroup of traumatized individuals who engage in IPV; instead, it is meant to be used for work with anyone who has engaged in IPV or is at risk for engaging in IPV. Although the grouping of abusive individuals into

subtypes has received considerable attention previously in the IPV literature (Holtzworth-Munroe & Stuart, 1994), these typologies have not lent themselves to effective treatment-matching strategies. Given the current state of knowledge in this area, we do not recommend dividing those who use IPV into different categories and providing different interventions, with the possible exception, as we discuss in Chapter 9, of couples therapy approaches, for safety reasons.

Training activities for individuals who provide services to persons who engage in IPV rarely focus on trauma, its impact on relationship functioning, or strategies to address its effects. This book constitutes an important resource for individual providers and program heads who would like to expand their training and clinical skill set in light of the increasing recognition of the salience of trauma in abusive behavior.

We believe this book is timely because the link between trauma and IPV is increasingly recognized in the IPV community and because even the most ardent supporters of models of IPV intervention that historically have not accounted for trauma are coming to realize that we cannot continue to ignore the elephant in the room. Trauma-informed intervention for those who engage in IPV is indeed an idea whose time has come; in fact, it is long overdue.

We want to make clear at the outset that taking a trauma-informed perspective does not minimize IPV, attempt to excuse it, or hold those who use IPV any less accountable. We can acknowledge the effects of one's prior trauma and other negative life experiences, and work to better understand the impact of these experiences on relationships and IPV behaviors, while working with clients to be accountable for their behavior. In fact, both elements are critical for successful IPV intervention, and those who engage in IPV will be far more likely to accept responsibility for their abusive behavior if they feel heard, and understood, by their provider.

## DEFINING INTIMATE PARTNER VIOLENCE

IPV behaviors take many forms. Our focus is on physical and psychological IPV because these two forms of abuse have considerable topographical and functional overlap and are the primary targets for intervention. Furthermore, trauma and posttraumatic stress disorder (PTSD) seem to be particularly strongly linked to these forms of IPV, though not as strongly linked to sex abuse (Teten, Schumacher, Bailey, & Kent, 2009). Physical IPV is perhaps the more observable of the two forms and includes all forms of physical aggression, with abusive behaviors ranging in severity from pushing and grabbing to punching, kicking, or using a weapon on a partner.

Psychological IPV is typically less obvious than physical IPV, but research shows that it can have an equal or greater negative impact on the physical and psychological health of the recipient (Coker, Smith, McKeown, & King, 2000; O’Leary, Heyman, & Neidig, 1999). Furthermore, psychological IPV early in relationships often escalates to physical IPV later (Murphy & O’Leary, 1989). Murphy and Hoover (1999) described four groupings of psychologically abusive behaviors that are based on the functions that the abuse might serve:

- *Behaviors that make the other person afraid.* Examples include threats to harm the other person; threats to harm oneself; threats to harm friends or relatives; intimidating looks or gestures; destruction of objects or personal belongings; driving recklessly to frighten the other person; aggression towards walls, doors, furniture, and so on.
- *Behaviors that attack the partner’s self-esteem.* Examples include put-downs, such as calling the other person stupid, crazy, ugly, or worthless; forcing the other person to do humiliating things; treating the other person like a child; and other such actions.
- *Behaviors that limit the other person’s basic rights and freedoms.* Examples include trying to stop the other person from going places, trying to stop the other person from seeing certain friends or family members, trying to stop him or her from getting a job or going to school, controlling the family finances, making important family decisions without consulting the other person, acting like the other person is a servant, and similar behaviors.
- *Behaviors intended to punish the other person or make him or her feel insecure in the relationship.* Examples include refusing to have any discussion regarding a problem or relationship issue, withholding affection to get back at the other person, refusing to acknowledge a problem that the other person feels is important, leaving and angrily refusing to tell the other person where you are going, and so forth.

## DEFINING TRAUMA AND POSTTRAUMATIC STRESS DISORDER

There are myriad terms with varying definitions and connotations in this area of mental health practice. For the present purposes, the common diagnostic definition of *traumatic stress* captures many of the life events and experiences that increase risk for IPV. As defined in the *Diagnostic and Statistical Manual of Mental Disorders* (fifth edition [DSM–5]; American Psychiatric Association, 2013), traumatic stress involves “exposure to actual or threatened death, serious injury, or sexual violence” (p. 271). Although trauma usually is conceptualized

in terms of direct exposure to such events, the *DSM-5* diagnostic criterion also allows for exposure through witnessing such events in person, finding out that a traumatic event has occurred to a close family member or friend, or being exposed in a repeated or extreme fashion to the unpleasant details of a traumatic event (vicarious traumatization). The World Health Organization's (1992) *International Classification of Diseases, 10th Edition (ICD-10)*, describes a *traumatic stressor* as exposure to a situation that is exceptionally threatening or catastrophic in nature and likely to cause pervasive distress. Examples include exposure to military combat, war, physical assault, sexual assault, being kidnapped or taken hostage, terrorist attacks, natural disasters, and motor vehicle accidents.

In understanding and treating IPV, it may be helpful to expand the definition of traumatic stress to include adverse experiences that can dramatically alter the development of interpersonal and emotional functioning but may not fit precisely within the diagnostic formulation of traumatic stress. Most notable are persistent experiences of emotional abuse, in which a child or adult is denigrated, humiliated, devalued, or intimidated; significant abandonment and detachment experiences; emotional neglect; and physical neglect. Even if not accompanied by trauma exposures consistent with the *DSM-5* or *ICD-10* definitions, such as physical or sexual abuse, these other adversities can alter one's core beliefs and emotions regarding safety, closeness, trust, power, and control. The results are often manifested as serious problems in intimate relationships.

Similar to the definition of traumatic stress, the common diagnostic formulation of PTSD has important implications for understanding and treating IPV, but it also provides an incomplete framework. Although the *ICD-10* includes PTSD under the stress-related disorders category, until the publication of *DSM-5*, which contains a separate category for traumatic stress disorders, PTSD was considered an anxiety disorder. This is not surprising given that the diagnostic definition of PTSD focuses primarily on the anxiety-related consequences of trauma exposure, specifically the tendency to be troubled by recollections and reminders of the trauma; avoidance of thoughts, feelings, memories, and situations associated with the trauma; and symptoms of anxious arousal, such as insomnia and hypervigilance. As we discuss throughout this book, these symptoms enhance sensitivity to danger and threat, thereby altering key aspects of social information processing that contribute to relationship problems and IPV.

Particularly relevant to our focus on IPV are changes to the *DSM-5* PTSD symptom cluster formerly known as *hyperarousal* and now renamed "alterations in arousal and reactivity that are associated with the traumatic event(s)," falling within Cluster E. One of the symptoms in this cluster has been changed from "irritability/anger" to "irritability or aggressive behavior."

The reasons cited for this change were to reduce overlap between this symptom and the new Criterion D (“Negative alterations in cognitions and mood that are associated with the traumatic event”) symptom “persistent negative emotional state” and to reflect consistent findings, discussed throughout this book, that aggression is a common manifestation of PTSD (M. W. Miller, Wolf, & Keane, 2014). It is important to note, however, that irritability and outbursts of anger remain part of the hyperarousal symptom cluster in *ICD-10* and that aggression is not specifically included.

Acknowledgment of the link between PTSD and aggression in the revised DSM-5 criteria appears to represent a positive development, but it also raises considerations in our work with trauma-exposed individuals who use IPV and those who experience the IPV. It is important that our clients and those who experience the abuse do not come to view IPV as an unavoidable psychological manifestation of trauma exposure. We caution partners in couples with whom we work to avoid the interpretation that the abusive behavior they experience is simply a component of PTSD and just goes along with the diagnosis. Similarly, we promote the view with our clients that they have learned to be aggressive and to view others in a negative way but that this can be unlearned despite one’s PTSD status.

In addition to anxiety-based reactions that are central to the diagnosis of PTSD, traumatic stress and childhood adversities alter other aspects of emotion regulation and interpersonal functioning that are important in understanding and treating IPV. For example, among persons seen in community treatment agencies for engaging in IPV, more than 80% report traumatic stress exposures (Hoyt, Wray, Wiggins, Gerstle, & Maclean, 2012; Semiatin, 2012), yet only 13% to 28% meet the symptomatic criteria for a probable diagnosis of PTSD. In fact, many trauma-exposed individuals who use IPV report few or none of the classic anxiety-based symptoms of PTSD (Gutjahr, Portnoy, & Murphy, 2014). Thus, concepts that go beyond the diagnostic formulation of PTSD are necessary to understand the links between trauma and IPV, in particular with respect to the role of childhood trauma exposures.

It is interesting that laboratory studies have shown that the most common emotional reaction to exposure to trauma cues among those with PTSD involves anger rather than anxiety or other emotions (Pitman, Orr, Forgue, de Jong, & Claiborn, 1987; Taft, Street, Marshall, Dowdall, & Riggs, 2007), and anger tends to increase more sharply after such exposures than anxiety (Taft, Street, et al., 2007). Despite numerous studies showing a link between anger and use of IPV (Birkley & Eckhardt, 2015), as well as research indicating that anger statistically accounts for the relationship between PTSD and IPV (Taft, Street, et al., 2007), some professionals downplay the role of anger because they believe it diminishes personal responsibility for abusive behavior. We see no reason why one should be held less accountable for their

abusive behavior if that person has problems with anger. It is far better to acknowledge rather than deny links between anger and IPV so that we can be more effective in our IPV intervention work.

Other diagnoses are informative here yet also limited in understanding how trauma exposure can lead to IPV. Most notable is that the emotional dysregulation and interpersonal turmoil associated with borderline personality disorder (BPD) appear to characterize a subgroup of individuals who engage in IPV (Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000). Although a history of childhood trauma is not a diagnostic element of BPD, it is highly prevalent among individuals with this condition (Newnham & Janca, 2014; Westphal et al., 2013), and it is thought to produce extreme emotion dysregulation and interpersonal dysfunction when combined with invalidation of emotional experiences by caregivers during development (Linehan, 1993). As with PTSD, however, it is important to note that only a modest proportion of those who engage in IPV meet the diagnostic criteria for BPD (<25% using a structured diagnostic interview; Hart, Dutton, & Newlove, 1993).

Some clinical scholars have conceptualized emotion dysregulation and interpersonal difficulties as core symptoms of complex trauma reactions, or *complex PTSD* (Cloitre, Miranda, Stovall-McClough, & Han, 2005). When linked to an extended pattern of childhood abuse exposure, however, the only thing that is truly “complex” about these symptoms is that they are not well captured by the traditional diagnosis of PTSD. Avoidance and suppression of negative emotions, perceived lack of control of one’s emotional reactions, and periodic emotional outbursts are among the most common legacies of childhood trauma. These problems are often compounded by problematic coping, including the abuse of substances, as well as impulse control problems that can impair functioning in a variety of life areas.

## STRUCTURE OF THIS BOOK

In Chapter 1, we describe a social information processing theory to explain how trauma exposure increases risk for IPV. This model is based on considerable prior research and theory and serves as the basis for clinical work to understand and address the links between trauma and IPV. In short, this model holds that the experience of trauma negatively affects how individuals process social information, which ultimately leads to a misappraisal of intimate relationship events, an overly hostile attribution bias, emotional avoidance and avoidant coping strategies, and reduced ability to generate and enact socially competent responses to normal challenges that emerge in relationships. We spell out the details of this model and provide a common-language,



nontechnical review of research studies conducted by ourselves and others that support this model. A primary goal is to highlight the cognitive, emotional, and behavioral targets for intervention and prevention of violence from a trauma-informed perspective.

Chapters 2 and 3 focus on understanding the links between trauma and IPV in both military and civilian populations. Trauma and PTSD have been associated with use of IPV across both populations (Taft, Walling, Howard, & Monson, 2011), but the magnitude of the relationship differs, and different forms of trauma and life events may be especially relevant for one group versus the other. For example, military training and exposure to unique forms of trauma (traditional combat exposure, perceptions of threat in the war zone, and exposure to atrocities) present a unique set of factors to consider in understanding military IPV, whereas childhood trauma has received a greater emphasis in the civilian literature and perhaps has greater salience for understanding IPV. We also discuss the relevance of other models of aggressive behavior and the importance of examining combinations of risk factors in understanding IPV (Finkel, 2007), as well as the literature focusing specifically on women's use of IPV.

Chapters 4 and 5 focus on strategies and safety in IPV assessment and intervention. We discuss the concept of therapeutic assessment and how to incorporate motivational interviewing to directly assess and address IPV by clients. We discuss a trauma-informed, multimethod approach to assessing potential trauma, IPV, and other common co-occurring trauma-related disorders and problems, as well as motivational issues. Strategies for providing client feedback and assisting with goal setting are also covered. The critically important role of confidential partner assessment is discussed, as are issues related to ensuring safety of partners and the provision of appropriate mental health services and other resources. We also discuss available risk assessment measures and their use and the importance of forming relationships with the larger community of providers to help ensure safety for those who experience IPV.

In Chapter 6, we discuss process considerations in IPV intervention. We discuss *process factors*, or nonspecific factors, that exert a powerful impact on treatment outcomes regardless of the form of intervention we provide. This topic is particularly important for IPV intervention given that the field has largely downplayed the significance of process factors despite the fact that clients who use IPV often present to treatment with trauma histories and interpersonal features that make the development of a positive therapy process challenging. We review the literature on process factors, namely, the therapeutic alliance and motivational readiness for change, with respect to IPV intervention. We also discuss core themes that may underlie trauma and IPV, including guilt and shame, power and control conflicts, trust difficulties,



and low self-esteem, and we address how to uncover and address these themes and their impact on the therapeutic process.

In Chapters 7 and 8, we address group interventions and techniques for facilitating a positive group atmosphere and effective IPV preventing and intervention. Group intervention is the standard format for IPV programs. We discuss the literature on the importance of group cohesion in IPV intervention and focus on why enhancing cohesion may be particularly important among trauma-exposed clients, who often have few sources of social support. With an emphasis on the work of Yalom (1995), we present specific techniques that providers can use to facilitate greater cohesion in IPV intervention. We then describe a specific example of a group IPV intervention, the Strength at Home Men's Program, which we developed and tested via pilot studies and a randomized controlled trial. We discuss session content for this intervention, provide (in the Appendixes) some handouts and materials that highlight trauma-informed elements of the program, and review the available research evidence that attests to its effectiveness.

We discuss couples interventions for preventing and treating IPV in trauma-exposed individuals in Chapters 9 and 10. We describe the controversy regarding the ethics and safety of treating IPV in the couples context as well as the evidence suggesting that dyadic intervention is most helpful for couples who display low-level situational couple violence. We also discuss how trauma may influence couple dynamics and hinder communication, emotional expression, and intimacy. Differences in treatment needs between single- and dual-trauma couples are described, as are advantages of addressing core themes in work with couples. We describe safety issues and steps to enhance safety in work with couples and review several dyadic interventions that may prevent or end IPV. We provide an example of a trauma-informed couples-based IPV group intervention program that we have developed and evaluated, the Strength at Home Couples' Program. We review session content and the evidence suggesting the effectiveness of the program.

Chapters 11 and 12 present individual therapy strategies and examples, a topic that has received relatively little attention in the clinical and research literatures. We discuss sequential treatment models in which individual sessions are delivered before or after a standard group intervention. For example, these interventions can involve pregroup preparation to enhance motivation, or they can be used postintervention to prevent relapse of problem behaviors or to address PTSD or other trauma-related problems that the group may not have fully addressed. Simultaneous models in which clients receive supportive individual intervention to address safety issues or imminent concerns while also engaging in group intervention for IPV also are discussed. We address individual treatment as an alternative to group intervention as well as the practical and clinical concerns worth considering when deciding on

group versus individual approaches. We also detail case formulation strategies that allow for flexible selection and implementation of individually focused intervention strategies based on the client's needs.

In Chapter 13 we focus on adjunctive interventions that may be particularly indicated in a trauma-exposed population who uses IPV. We note the importance of examining the client's full diagnostic picture, which may include housing status, occupational status, literacy and education, parenting status, injury and physical health status, and psychiatric status. Whether the comorbid problems may impede IPV intervention is considered and then illustrated by how one of us handles substance abuse issues in a general IPV clinic. Finally, we consider adjunctive or concomitant interventions for some of the most common comorbid issues in persons who present for IPV intervention, including PTSD, depression, substance use problems, and traumatic brain injury.

We conclude the book with an Afterword in which we summarize the material covered in the chapters and offer our insights into what is needed to implement trauma-informed IPV intervention on a large scale. We discuss potential barriers to instituting trauma-informed IPV interventions, such as challenges in the coordination of care, state IPV intervention standards, a reliance on a system of court-mandated intervention, and an incorrect view that trauma-informed care means holding one's clients less responsible for their abusive behavior.

## SUMMARY

Trauma and its impacts are often recognized and addressed among children, although when these traumatized children reach adulthood recognition of the effects of their trauma appears to fade among some treatment providers. In this book, we address how trauma in both childhood and adulthood may increase risk for IPV, discuss some potential reasons for this relationship with a focus on social information processing, present intervention strategies and examples for addressing trauma and IPV, and provide a summary of research findings demonstrating the efficacy of trauma-informed interventions for IPV in military veterans. This book is particularly needed at this time given the increasing recognition of the potential effects of trauma on relationships, and on IPV specifically, and the limitations of existing interventions that address such trauma.