SYNERGY

RCDV:CPC The Newsletter of the Resource Center on Domestic Violence: Child Protection & Custody

A Project of the National Council of Juvenile and Family Court Judges

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The Family Violence Prevention and Services Program's National Center on Domestic Violence, Trauma & Mental Health

What does it mean to employ an accessible and trauma-informed framework when working with survivors and their children in the context of legal proceedings? We hope that this issue of Synergy, guest written by staff of the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH), provides readers with a brief introduction and insights to answer that question.

In 1999, the Domestic Violence & Mental Health Policy Initiative (DVHMPI) was founded in Chicago to address the unmet mental health needs of domestic violence survivors and their children and the traumatic effects of abuse across the lifespan. In 2005, the NCDVTMH was established as a national resource center through a grant to DVMHPI provided by the Family Violence Prevention and Services Program (FVPSA); Administration on Children, Youth and Families; U.S. Department of Health and Human Services. Since then, NCDVTMH has provided training, consultation, and resources to advocates, mental health and substance abuse providers, legal professionals, and policymakers as they work to improve agency and systems-level responses to survivors and their children.

Our mission is to develop and promote accessible, culturally relevant, and trauma-informed responses to DV and other lifetime trauma so that survivors and their children can access the resources that are essential to their safety and well-being. The articles in this issue lay out this framework and begin to explore some of the ways that this approach is relevant for those working with survivors and their families involved in family court proceedings and child welfare systems. As interest in doing trauma-informed work in these contexts continues to grow, we look forward to how these changes will complement and build on prior (and ongoing) work within the legal system to better understand and respond to the dynamics of domestic violence and the safety needs of survivors and their children.

My article, *Trauma in the Context of Domestic Violence: An Integrated Framework* provides both the historical context of trauma theory and its intersection with domestic violence advocacy work. It presents an introduction to the overarching framework that has been developed by NCDVTMH, in partnership with the DV field, over the past 20 years. *An Interview with Susan Blumenfeld, MSW, LCSW,* nationally recognized child trauma and parenting expert, discusses the ways that supporting children and the child-survivor relationship can positively impact the child's long-term development following exposure to domestic violence in the home. In *Building Trauma-Informed Capacity for Programs Serving Domestic Violence Survivors and their Children*, Ms. Blumenfeld provides an overview of a project that has been building trauma-informed staff capacity in community-based organizations in the Chicago area that serve families impacted by domestic violence and other trauma since 2004. In *Trauma and Substance Abuse: A Common Thread*, Patricia J. Bland, M.A., CDP, Director of Substance Abuse Training and Technical Assistance at NCDVTMH, provides a summary of the ways that survivors may use substances to cope, the ways that survivors may be forced or coerced into using substances, and other ways that these issues may interact.

We hope that you will find these articles helpful and interesting, and that you will be inspired to contribute to the dialogue as we continue to explore the ways that an accessible, culturally relevant, and domestic violence- and trauma-informed approach will help us to improve the legal system's responses to survivors and their children.

Carole Warshaw, MD

Director

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Thinking About Trauma in the Context of Domestic Violence: An Integrated Framework

Adapted from an article by Carole Warshaw, MD
Director, National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH)

INTRODUCTION

As the concept of "trauma-informed" becomes increasingly widespread, it is important to clarify what being trauma informed means in the context of domestic violence and in the broader context of peoples' lives. Survivors of domestic violence and their children are often dealing with the traumatic effects of abuse. At the same time, survivors may also be experiencing ongoing coercion at the hands of an abusive partner related to mental health or substance use, and other forms of violence and oppression. The NCDVTMH has developed an integrated framework to help those working with survivors and their children to recognize and respond to these complex issues. This integrated approach combines a trauma-informed perspective with a culture, domestic violence advocacy, and social justice lens. This article will explain the need for such an approach, describe how trauma theory can serve as a bridge to assist survivors, and provide examples to put trauma-informed approaches and domestic violence advocacy and social justice principles into practice.

THE NEED FOR AN INTEGRATED FRAMEWORK

In 1999, when we first started doing work on trauma and domestic violence, the physical consequences of domestic violence had been well documented. Yet acknowledging the mental health and substance abuse effects of domestic violence was still controversial. While advocates were aware of the impact that victimization could have on the emotional well-being of domestic violence survivors and their children, they were also concerned about how these mental health and substance abuse effects were being used against survivors by their

abusive partners and by the systems where they sought help.[1]

A lack of knowledge about domestic violence and the stigma associated with mental health and substance abuse reduced the likelihood that women dealing with these experiences would have access to safety, resources, and support. Women experiencing the traumatic mental health effects of abuse and/or psychiatric disabilities did not always feel welcome in shelter. At the same time, when survivors sought help in other systems, they often encountered providers who did not understand the dynamics of domestic violence. This, in turn, increased abusers' control over their lives and placed survivors and their children in further jeopardy.[2]

As advocacy, legal, and social service providers learned from survivors about how experiencing the traumatic effects of abuse could affect their ability to access help and resources, the need for a combined domestic violence- and trauma-informed approach became clearer. For example:

- The repeated betrayal of trust survivors may have experienced over the course of their lives, including in their relationship with an abusive partner, can make it harder to reach out and engage with service providers.
- Living in communal shelter environments, listening to other people's stories in support groups, and being in crowded, chaotic environments can evoke memories of survivors' own traumatic experiences, along with the intense distress they may have felt at the time.
- Trauma symptoms can affect survivors' ability to retell their stories and engage in the legal process. For example, since trauma affects memory, it may impact a survivor's ability to remember details as part of a linear narrative. Furthermore, recounting the abuse can cause survivors to re-experience aspects of the trauma, making it difficult to tell their stories or stay emotionally present.
- Trauma-related responses during legal proceedings can impact how survivors are perceived. For example, if a survivor dissociates (i.e., disengages emotionally as a way to protect herself in threatening situation) and avoids making eye contact or has a flashback (i.e., relives the experience of abuse as if it were happening in the present) and is unable to describe what happened in a clear, intelligible way, she may not be taken seriously or believed.
- Trauma-related symptoms can sap the energy needed to mobilize resources, and can affect a person's ability to process information and make complicated decisions.
- For many survivors, the "trauma" is ongoing and "symptoms," such as hyper-vigilance (continually being on alert for potential threats), may actually be responses to ongoing danger and coercive control that are keeping them safe.

In some instances, trauma responses may be misinterpreted as signs of denial, dishonesty, or unwillingness to engage. If not understood, they can adversely affect survivors' safety, access to services, credibility in court, and legal outcomes. For these

TRAUMA AND THE ABUSER

- Domestic violence can have significant trauma-related health, mental health, and substance abuse consequences.
- Abusers actively undermine their partners' sanity, sobriety, and parenting, which also impacts their children's well-being.
- Abusers use trauma-related health, mental health, and substance abuse issues to further control their partners, particularly in relation to custody, credibility, and recovery.
- Women who develop trauma, mental health, or substance abuse conditions in the context of domestic violence are at greater risk for coercive control.
- Stigma associated with substance abuse and mental illness compounds risks for survivors and their children.

reasons, we need an integrated approach that addresses all of these complexities: the impact of trauma and the potential for retraumatization in service systems, the ongoing danger and coercion, and the stigma that enables abusers to successfully use mental health and substance abuse issues against survivors.

TRAUMA THEORY AS A BRIDGE

The evolution of trauma theory over the past three decades has helped to bridge clinical and advocacy perspectives. As knowledge about trauma has grown, there has been a profound shift in our understanding of the impact of trauma on individuals, families, and society. Trauma theory also shifted the ways that we conceptualized mental health "symptoms," reframing them as survival strategies—adaptations to potentially life-threatening situations that are made when real protection is unavailable and usual coping mechanisms are overwhelmed. Posttraumatic Stress Disorder (PTSD) was the first diagnosis to recognize that external events can play a significant role in the development of mental health symptoms. This recognition has also helped to destigmatize the mental health and substance use-related consequences of domestic violence by identifying the common physical and psychological effects of abuse and normalizing human responses to interpersonal trauma.

> *"Trauma theory also shifted the ways that we conceptualized mental health "symptoms," reframing them as survival strategies—adaptations to potentially life-threatening situations that are made when real protection is unavailable and usual coping mechanisms are overwhelmed."*

The concept of Complex Trauma, introduced by Judith Herman in her book, *Trauma & Recovery: The Aftermath of Abuse—From Domestic Abuse to Political Terror* (1997), refers to the multiple ways that exposure to ongoing interpersonal trauma, particularly in childhood, can impact us in the short and long term. This concept offers a more holistic and nuanced way of understanding the effects of interpersonal trauma across the lifespan. The coming together of the trauma and child development fields has also provided important insights into the critical role that early caregiving relationships play in how we manage stress; regulate emotions; and feel about ourselves, other people, and the world. Emotional dysregulation (disruption in our internal capacity to manage feelings in a safe and balanced way) is a hallmark of complex trauma. Understanding the neurobiological underpinnings of emotional dysregulation helps make sense of some of the coping strategies people use to manage their feelings through external means (e.g., self-injury, substance use). Similarly, understanding how betrayal of trust in childhood can affect our ability to trust as adults helps make sense of the challenges survivors may face in their interactions with service providers.

These ideas have helped to reframe previously misunderstood behaviors as understandable responses to overwhelming trauma. When service providers have a greater appreciation of survivors' resilience, strength, and survival skills, they are more likely to respond in ways that are empathic, non-judgmental, and ultimately, more trauma informed - ways that are also more likely to increase survivor safety.

Trauma-informed approaches recognize that supporting children's healthy attachment to the survivor-parent is crucial to their development and resiliency following exposure to domestic violence in the home. This understanding has many implications for how a child's best interests are understood, particularly in the context of dependency and family court proceedings. New scientific findings have also begun to elucidate the mechanisms through which early experience shapes brain architecture, as well as the ways that our brains are able to continually learn and

grow throughout our lives, a concept known as neuroplasticity.[3] Furthermore, research on trauma and resilience, combined with lessons learned from the experiences of survivors, advocates, and clinicians, have taught us many lessons about how to respond in helpful ways. In sum, these advances in understanding trauma have led to a more holistic approach to thinking about the biological, emotional, cognitive, and interpersonal effects of abuse, and to more complex and nuanced approaches to healing.

PUTTING IT INTO PRACTICE
A TRAUMA-INFORMED APPROACH[4]

Trauma-informed social justice work 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. Becoming trauma-informed does not mean defining all experiences through a trauma lens. It means adding an additional layer of perspective to the work we do. That perspective is informed by what people find helpful in reducing further traumatization, and it can inform the creation of services and environments that support the resilience and well-being of survivors and their children. In the legal context, such as within custody or child welfare proceedings, adopting a trauma-informed approach would also mean accounting for the effects of both trauma and domestic violence in our understanding of survivors' responses and in decision-making processes.[5]

Creating trauma-informed services means taking time to think about how trauma might affect survivors' experience of services and what we can do to reduce further traumatization at every level of our organizations. When we understand trauma responses as adaptations to being under siege, then part of our work is to do everything we can to reduce the likelihood that survivors will feel discounted and disempowered in our programs and systems. This includes doing what we can to reduce further harm, support strengths, and facilitate healing, resilience, and well-being. It also means being thoughtful in how we relate to other people within the broader context of their lives, culture, and experiences.

> *"When we understand trauma responses as adaptations to being under siege, then part of our work is to do everything we can to reduce the likelihood that survivors will feel discounted and disempowered in our programs and systems."*

While this might involve offering access to trauma treatment or other healing modalities, at heart, trauma-informed practice is about creating environments and relationships that offer an atmosphere of safety, connection, and hope. This includes supporting survivors to feel more connected and empowered as they prepare for situations in which responses to trauma may be evoked such as going to a court hearing, job interview or custody evaluation.

At the organizational level, becoming trauma-informed means creating a physical and sensory environment that is accessible, welcoming, inclusive, healing, and attentive to potential trauma triggers, as well as a relational environment that is caring, respectful, empowering, transparent, and attentive to both physical and emotional safety. It also means ensuring that programs and services are flexible and responsive to both individual and collective needs, linguistically appropriate, and attuned to the people and communities being served. Involving people who access services in the agency's evaluation, planning, and oversight is another key element of trauma-informed work.

Lastly, a trauma-informed approach fosters the recognition of what we bring to our interactions with others, including our own experiences of trauma as well as the ways we are affected when we are truly open to the experiences of other people. This includes ensuring that our organizations support staff well-being and create safe opportunities for reflection and growth.

Attending to all of these elements and, ultimately, becoming a trauma-informed organization is a long-term transformative process that takes administrative commitment, a thoughtful and inclusive approach, purposeful planning, and a substantial investment of time and resources.[6]

AN ADVOCACY AND SOCIAL JUSTICE FRAMEWORK: *IMPLICATIONS FOR SERVICES AND SYSTEMS*

A trauma-informed approach can greatly inform and enhance work with survivors of domestic violence by increasing understanding of the psychological consequences of abuse and the ways that trauma can affect survivors as well as providers and systems. However, responding to trauma also requires a commitment to change the conditions that produce it. Trauma-informed approaches are not a substitute for advocacy-based approaches that help survivors achieve freedom and safety or for broader social justice efforts to address the underlying causes of oppression and abuse.

Many survivors experience collective forms of trauma such as historical trauma,[7] and the trauma of war, poverty, displacement, and persecution, in addition to trans/homophobic and gender-based violence. Culture, context, and identity can all impact a person's experience of trauma and approach to healing, including access to holistic, communal, and spiritual approaches to healing. Responses to collective trauma may involve the mobilization of entire communities to transform the continuing effects of trauma across generations and to change the ongoing social, political, and economic conditions that contribute to violence and oppression.[8] Responses to trauma are ultimately responses to socially tolerated forms of abuse, violence, and oppression and require a social justice approach.

For many survivors of domestic violence, trauma is not only in the past but is also ongoing. Thus, trauma-informed work means attending not only to the physical and psychological impact of trauma, but also the direct effects of an abusive partner's coercive and controlling behavior. This requires a focus not only on healing the traumatic effects of the abuse, but also on ensuring access to safety, resources, and support. Recognizing the ways that an abusive partner may be undermining a survivor's mental health, sobriety, and recovery—and the ways he or she may use these issues to interfere in a survivor's custody of their children—has critical implications for both family and dependency courts. Both trauma and domestic violence can impact survivors' appearance in court and, as a result, credibility and decisions about custody. Additionally, a non-custodial parent's accusations about the mental health status of a primary caregiver should raise concerns about possible mental health and substance use coercion.[9] The potential for safety and support to help resolve the traumatic effects of abuse is also critical to keep in mind.

CONCLUSION

Using a trauma-informed approach that incorporates a domestic violence advocacy and social justice lens provides an opportunity to offer a more integrated approach to the evolving discourse on trauma. This more integrated approach will help to ensure that services, programs, and court processes are fully accessible, culturally attuned, and both domestic violence- and trauma-informed. It also provides a framework for understanding how the traumatic effects of social injustice can play out in individual, social, and institutional forms, and for addressing the social, political, and psychological conditions that generate and support abuse, oppression, and violence across generations. Ideally, it will also help us to embody, in our lives and work, the world we want to create.

[i]Two recent studies on mental health and substance use coercion conducted by the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH) and the National Domestic Violence Hotline highlight the scope of this problem. An alarming percentage of hotline callers reported a current or former partner had deliberately done things to undermine their sanity, sobriety, and recovery; control their access to treatment; and/or use mental health or substance use issues to sabotage their efforts to obtain custody or protective orders. Warshaw C., Lyon E., Phillips H., Bland P. & Hooper M., *Mental Health and Substance Use Coercion Survey: Report on Findings from the National Center on Domestic Violence, Trauma & Mental Health and the National Domestic Violence Hotline* (in press).

[ii]For example, if mental health providers are not trained to address the social factors that entrap victims in abusive relationships, this can result in mistakenly interpreting survival strategies as disorders, overlooking the advocacy needs of survivors (e.g., safe housing, legal assistance, safety planning), and not understanding the risks a psychiatric diagnosis can pose for custody battles with an abusive partner. Similarly, providers often use a family member to provide collateral information during psychiatric crises, without safely ascertaining whether the informant is, in fact, the abusive partner. Obtaining information from potential abusers or those who may be allied with them or allowing abusers into the treatment or discharge planning process can be dangerous for domestic violence survivors

[iii]Felitti V.J., Anda R.F., Nordenberg D., Williamson D.F., Spitz A.M., Edwards V., Koss M.P. & Marks J.S., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults, The Adverse Childhood Experiences (ACE) Study*, AM. J. PREV. MED. 14(4):245-58 (May 1998); Classen, C.C., Pain; C., Field, N.P. & Woods P., Posttraumatic Personality Disorder: A Reformulation of Complex *Posttraumatic Stress Disorder and Borderline Personality Disorder*, PSYCHIATR. CLIN. NORTH AM. 29(1):87-112, viii-ix (March 2006); Lanius R.A., Bluhm R., Lanius U. & Pain C., *A Review of Neuroimaging Studies in PTSD: Heterogeneity of Response to Symptom Provocation*, J. PSYCHIATR. RES. 40(8):709-29 (Dec. 2006); Lyons-Ruth, K., Dutra, L., Schuder M. & Bianchi, I., *From Infant Attachment Disorganization to Adult Dissociation: Relational Adaptations or Traumatic Experiences?* 29(1): 63-viii (March 2006); McEwen, B.S., *Protective and Damaging Effects of Stress Mediators: Central Role of the Brain*; DIALOGUES CLIN. NEUROSCI. 8(4): 367–381 (Dec 2006); Nemeroff C., Neurobiological Consequences of Childhood Trauma, J. CLIN. PSYCHIATRY 65 Suppl 1:18-28 (2004); Van der Kolk, B.A.; Roth, S.;Pelcovitz, D.;Sunday, S.; Spinazzola, J., *Disorders of Extreme Stress: The Empirical Foundation of a Complex Adapation to Trauma*, J. OF TRAUMATIC STRESS 18 (5): 389-99 (Oct. 2005); Yehuda, R., *Advances in Understanding Neuroendocrine Alterations in PTSD and their Therapeutic Implications*, ANN. N Y ACAD. SCI. 1071:137-66 (July 2006).

[iv]Warshaw C. & Cave C., *Module 4 Creating Inclusive Trauma-Informed Environments, Advocacy and Supports in Warshaw*, C., Blumenfeld S., Bland P. & Cave C., Training-of Trainers Curriculum: Creating Inclusive Trauma-Informed Domestic Violence Services & Organizations (NCDVTMH September 2013).

[v]This includes, for example, recognizing that attempted reconciliations, withdrawing petitions for protective orders, failing to call the police, recanting after disclosure, not remembering chronological details of an abusive incident, etc., are not "proof" of false allegations but rather normal responses by survivors dealing with trauma, coercion, ongoing threats to safety, and a host of other concerns.

[vi]For a more comprehensive approach to creating trauma-informed services and organizations, see NCDVTMH's *Accessible, Culturally Relevant, Domestic Violence- and Trauma-Informed Agencies (ACDVTI) Tool* at http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/03/ACDVTI-Self-Reflection-Tool_NCDVTMH.pdf.

[vii]Historical trauma is the cumulative emotional, psychological, and spiritual wounding of individuals and communities across generations, emanating from massive group trauma experiences such as slavery and colonization—the experience of which are still ongoing.

[viii]Collective responses to trauma may involve the engagement and transformation of entire communities, as exemplified by the work of the Mohawk Nation at Akwesasne, which is described in the forthcoming report *Promising Practices and Model Programs: Trauma-Informed Approaches to Working with Survivors of Domestic Violence and Other Trauma*, authored by H. Phillips, M. Fabri, E. Lyon, and C. Warshaw.

[ix]See, Substance Use Coercion Study at Note i.

The Family Violence Prevention and Services Act

Domestic Violence Services Network

While not all-inclusive of all domestic violence victims' service providers, this graph reflects the average number of locations (sites) where victims can receive services that are funded by the Family Violence Prevention and Services Program of the U.S. Department of Health and Human Services. The numbers listed reflect the average of local programs funded from 2011-2013, and the average number of tribal programs funded from 2010-2012. Each of the national, tribal, state, and local victim service providers work collaboratively to promote practices and strategies to improve our nation's response to domestic and dating violence to make safety and justice not just a priority, but also a reality. (Updated April 2014)

Local

1,505 Domestic violence shelter sites

1,129 Non-shelter service sites

Tribal

83 Tribal domestic violence shelter sites

179 Tribal non-shelter sites

State/Territory

56 State/Territory domestic violence coalitions, many of these are dual domestic and sexual violence programs

National

2 NATIONAL HOTLINES

National Domestic Violence Hotline
1-800-799-7233 (SAFE)
1-800-787-3224 TTY for the D/deaf
www.ndvh.org

National Dating Abuse Helpline
1-866-331-9474 or
1-866-331-8453 TTY for the D/deaf
Text: "loveis" to 77054
www.loveisrespect.org

2 NATIONAL RESOURCE CENTERS

National Resource Center on Domestic Violence
1-800-537-2238
1-800-553-2508 TTY for the D/deaf
nrcdvta@nrcdv.orgwww.nrcdv.org

National Indigenous Women's Resource Center
1-406-477-3896
1-855-649-7299 Toll free
www.niwrc.org

5 SPECIAL ISSUE RESOURCE CENTERS

Battered Women's Justice Project
1-800-903-0111, ext. 1 Criminal and Civil Justice Center
www.bwjp.org

National Clearinghouse for Defense of Battered Women
1-800-903-0111, ext. 3
www.ncdbw.org

National Center on Domestic Violence, Trauma and Mental Health
1-312-726-7020
www.nationalcenterdvtraumamh.org

National Health Resource Center on Domestic Violence
1-888-792-2873
www.futureswithoutviolence.org

Resource Center on Child Protection and Custody
1-800-527-3223
www.ncjfcj.org

3 CULTURALLY SPECIFIC RESOURCE CENTERS

Asian Pacific Islander Institute on Domestic Violence
1-415-568-3315
www.apiidv.org

Casa de Esperanza
1-651-646-5553
www.casadeesperanza.org

Institute on Domestic Violence in the African-American Community
1-877-643-8222
www.dvinstitute.org

1 CHILDREN EXPOSED TO DOMESTIC VIOLENCE TA PROJECT

Futures Without Violence
1-617-702-2004
http://promising.futureswithout violence.org

1 LGBTQ LEARNING CENTER

NW Network for Bisexual, Trans, Lesbian and Gay Survivors of Abuse
1-206-568-7777
http://nwnetwork.org

Celebrating **30 Years** of the *Family Violence Prevention and Services Act!*

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Trauma and Substance Abuse: A Common Thread*

Patricia J. Bland, M.A., CDP

Trauma is often the common thread running through the life experiences of many survivors of domestic violence and sexual assault. Trauma, which can include the experience of violence, abuse, and oppression by an intimate partner, may also be accompanied by a substance use disorder, other disabilities, and societal oppression. The experience of a substance use disorder for survivors of domestic violence and sexual assault, while not universal, is pervasive. Survivors often express concerns about their substance use in the context of power and control dynamics and exploitation by their intimate partners.

Many women have disclosed their intimate partner has coerced or forced them into using alcohol or other drugs or denied access to medications, (e.g., methadone, asthma inhalers, insulin, etc.). Many describe both induced debility and the threat of exposure as a form of coercion or mechanism of control that increases fear, safety risks, and reluctance to seek assistance from legal or other service providers.[1]

In addition, survivors of abuse may turn to alcohol or other drugs to help them survive and cope with the abuse and its traumatic effects. Abusive partners, in turn, can rely on stigma associated with substance abuse to undermine and control partners. They often actively introduce their partners to alcohol and other drugs; undermine their partners' efforts to get sober; and manufacture, exaggerate, or threaten to expose their partners' history of substance abuse to prevent them from seeking custody, child support, or other services.[2]

Statistics demonstrate how trauma and substance abuse intersect for people seeking help from legal and social services:

A National Institute on Drug Abuse study found that 90% of women in drug treatment had experienced domestic violence from a partner during their lifetime (Miller, 1994). More recent studies confirm between 55 and 99% of women who have substance abuse problems have also been victimized at some point in their lives.[3] and between 67 and 80% of women in substance abuse treatment are domestic violence victims.[4]

- In a 2012 review of the literature, 22–72% of DV shelter residents have current or past problems with alcohol or other substances.[5] A study of Illinois DV shelters revealed 42% of service recipients abused alcohol or other drugs (Bennett & Lawson, 1994). One in four women in an Iowa shelter/safe home sample had a lifetime diagnosis of alcohol dependence; another one in four women in the study had alcohol or other drug problems.[6]
- As many as 74% of women in substance abuse treatment have experienced sexual abuse.[7]

*** Adapted from "Trauma: A Common Denominator" in Real Tools:** *Responding to Multi-Abuse Trauma Violence and Sexual Assault* **(2011) by Debi S. Edmund and Patricia J. Bland**

- A person with a disability (including a substance use disorder)—regardless of age, socioeconomic status, race, ethnicity, or sexual orientation—is twice as likely to be a victim of abuse than a person without a disability.[8] Among adults with developmental disabilities, as many as 83% of women and 32% of men have been victims of sexual assault.[9]

The National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH) has developed numerous resources that would be of interest to juvenile and family court judges and other system professionals who would like to build their skills to respond to the effects of trauma and substance abuse experienced by survivors of domestic violence and sexual assault. Resources available on the website include webinars, technical assistance, research, and training available to address the intersection of domestic violence and other forms of trauma in the context of substance abuse. These resources, including Real Tools: Responding to Multi-Abuse Trauma, can be easily accessed at the NCDVTMH web site: http://www.nationalcenterdvtraumamh.org/.

Other useful resources on the website include *The Attorney's Handbook, The Trauma-Informed Legal Advocacy Project* materials, as well as other tip sheets, policy guidelines, webinars, and practical information including an extensive literature review and a special collection of resources.

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Pioneers in our Backyard

An Interview with Susan Blumenfeld, MSW, LCSW

Susan Blumenfeld, MSW, LCSW, is the Child Trauma Training Director at the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH). She is an experienced clinician, supervisor, and nationally recognized expert in working with children exposed to domestic violence and other trauma and supporting parent-child relationships. Her work has focused on building the capacity of advocates, clinicians, and supervisors to work with children and families. In this interview, Ms. Blumenfeld provides insight into how custody and child welfare professionals can identify and respond to the needs of children and families who have experienced the traumatic effects of domestic violence.

What are some of the ways that children exposed to domestic violence may be impacted by trauma?

Many children who come into contact with the child welfare and family court systems have experienced domestic violence. The nature of their exposure and their responses vary greatly and are, of course, individual and unique. Many children do well as they develop and grow into adulthood and may not need additional supports or interventions. To understand the traumatic effects, we have to consider the totality of protective factors that might buffer and lessen the impact on children, including their relationships with caregivers and the family's cultural and spiritual beliefs and traditions.

Children may experience higher rates of traumatic stress based on proximity, severity, and ongoing exposure to domestic violence as well as the cumulative effects of multiple kinds of exposure (such as being a direct victim of child abuse and witnessing community violence). Younger children are at greater risk of developing post-traumatic stress responses because they are more reliant on their parents and adult caregivers for protection and safety. The abusive partner's behavior and actions can also disrupt the quality of the caregiving environment for children and may affect their healthy growth and development over time.

Children's responses may be similar to adults experiencing Posttraumatic Stress Disorder in that they typically involve hyper-arousal, re-experiencing, numbing, and avoidance. Babies may manifest this through persistent crying, irritability, and negative mood. Toddlers may be clingy and have trouble separating from their

caregivers, or on the other hand, may explore without regard to safety. Pre-schoolers may hit and bite other children and have intractable temper tantrums. School-age children may have somatic symptoms, such as headaches and stomachaches or trouble concentrating in school and difficulty relating to peers. Adolescents may engage in high-risk behaviors, numb out, retreat socially, and get failing grades in school.

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However, we should be cautious about lists of signs and symptoms and instead consider each child's responses within the context of current and past experiences and gather information from parents and other adults. Children's responses may be due to issues unrelated to trauma.

Are there basic guidelines to keep in mind when responding to the needs of children impacted by domestic violence?

It's important to use both a trauma-informed and a developmentally sensitive lens in considering children's needs. Always try to understand the child's behavior and responses in the context of their unique experiences. Without a trauma lens, children's behavior can be misunderstood. For example, school age children exposed to domestic violence and other trauma at the same time are often labeled as "hyperactive." They may have trouble concentrating in school and getting their work done. If we think about this same child using a trauma lens, we may find that he is flooded by worry about his mother who is being abused (survivor-parent), has intrusive thoughts and memories about a recent traumatic incident at home, and as a result, is having difficulty paying attention and sitting still when experiencing hyper-arousal. Using a developmentally sensitive lens may help us to identify age-related tasks that may be stalled or disrupted by traumatic experiences. For example, toddlers and young children, who would otherwise explore more independently, may suddenly have trouble separating from their caregivers, and become anxious and clingy after witnessing a frightening incident at home.

Are children impacted by trauma even if their non-violent parent separates from an abusive partner?

Safety risks to survivor-parents and their children may escalate after separation or when court arrangements are being determined. Abusive partners often try to undermine the bond between survivors and their children as well as survivors' parenting role. In many cases, abusive partners use protracted custody and other legal proceedings as a means to control and punish their former partner for separating, and while the case is ongoing, they may

threaten harm to both their former partners and their children. Post-separation visitation arrangements are often used by abusive partners to continue to harass and control their former partners through their children (e.g., abusive partners may ask for information that they then use to stalk the non-violent parent).

Transitions for "drop off" and "pick up" are often scary times for children, especially when the abusive partner threatens violence, says "you'll never see your children again," engages in acts of property destruction, or uses verbal or physical violence during these encounters. This

can also stimulate children's memories about frightening past incidents. In these situations, the trauma is not past but re-lived in the present. These incidents can also make it harder for the survivor-parent to regain their parental authority, which may have been undermined by the abusive partner.

Even when transitions for visits go relatively well, children may experience trauma-related responses during contact with the abusive partner-parent. They may feel unsafe, experience trauma reminders of past abuse, and unfairly hold the survivor-parent responsible for "making them go on visits" if she is court ordered to do so as a custodial parent. Children may also have mixed loyalties to both of their parents, and there may be aspects of children's relationships with the abusive partner-parent that are positive. The abusive partner-parent may be fun, buy them things, and let them stay up late and do things that are not permitted at home. At the same time, the abusive partner-parent may be frightening to the child or the child may identify with the parent's aggression as a way of feeling less helpless and powerless.

In situations where the pattern of domestic abuse is more severe (with threats or use of weapons, ongoing assault to a new partner, or child maltreatment by the abusive parent) children may not have words to express their fear about being alone with the abusive partner-parent. However, we may be able to observe it through their behavior (e.g., being "shut down," depressed or irritable, and protesting against visits).

How can we support the emotional safety and well-being of children around custody and visitation?

We can support healing and resiliency and lay the foundation for the child's healthy development by supporting the safety of both the survivor-parent and the child and by finding ways to strengthen their relationship. Using a developmentally sensitive, trauma-informed approach, we can offer survivor-parents and their children suggestions for navigating custody arrangements and visitation, such as the following:

- Talking together about the visit to prepare children for contact, and safety planning in anticipation of the visit.
- Providing an emotional "safety link" for the child such as by having the child take a favorite small toy or token from the survivor-parent, or arranging for a phone contact during the visit.
- Creating a safe place for survivors to reflect on their own feelings of anger and helplessness that get evoked during this process.
- Offering validation, perspective, and support to help survivors feel calmer in the face of ongoing threats and reminders of previous trauma so they are better able to continue supporting their children emotionally.
- Supporting survivor-parents in their attempts to (1) understand their children's trauma-related responses to visitation; (2) recognize when their children's volatile or regressed behavior is part of a transition process back; and (3) re-establish their authority, limits, and structure, and adopt routines that promote reconnection once children return home.

Using a trauma-informed approach can help survivor-parents regain a sense of competence and control in their parenting role and help children to feel more secure and supported during these times.

How can we support children in the child welfare system who have experienced trauma?

Children in care may experience multiple transitions or changes. When they are placed in out-of-home care by child protective services, the transition itself can be traumatic. New environments may be challenging in predictable and unpredictable ways. Children may respond to trauma reminders, based on prior experiences that are unknown to their adult caregivers. For example, a child might start screaming when she sees someone with red hair and is reminded of the lady who came to remove the child from her home. When caregivers are informed about children's traumatic experiences prior to their coming into care, they can be better prepared to understand children's reactions and responses while they are in care.

When children are removed from their homes, placement in kinship care is considered a best practice. There are instances, however, when children are placed with their fathers, who formerly abused their mothers, or with paternal relatives. This can be frightening and retraumatizing for survivor-parents and their children who may recall past abuse. Without understanding that the survivor-parent may be responding to both current dangers and memories of past abuse, the survivor-parent may appear unreasonable or "resistant," which can derail her plan for getting the children home. It's critical to have a full understanding of safety risks and trauma before making these kinds of placement choices.

Multiple placements are sometimes inevitable, but can be detrimental to children's well-being. Young children may have difficulty attaching to new caregivers with repeated placements. Placement disruptions may cause children of all ages to re-experience feelings of loss and abandonment and reinforce a sense of being unworthy of love and care.

Even when children have placement stability, they benefit from being prepared for the transitions made during visits with biological caregivers and returning back to the foster home. Survivor-parents and their children can better manage transitions when there is room to talk about their feelings. Child welfare case managers and other professionals can support biological parents and foster caregivers to understand what these repeated reunions and separations during visits may evoke in children. It also helps to anticipate visits, establish routines for "coming" and "going," explain to children what's going to happen in the future, and reassure them that they are safe.

How can we best support recovery and resilience in children and youth who have experienced domestic violence?

Research on resilience tells us that a consistently loving, nurturing relationship with a non-abusive parent or an adult caregiver who is involved in a child's life over time is the single greatest resource for children's healthy development and recovery from exposure to domestic violence and other trauma. The SASS framework, that I developed as part of my work with NCDVTMH, builds on that understanding and belief. The acronym SASS stands for safety, attachment, self-regulation, and self-esteem/self-agency. These components are interrelated and fluid.

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Safety refers to both physical and emotional safety. Service providers and survivor-parents often need to help children reestablish a sense of safety and security over and over again.

Attachment, connected to reestablishing a sense of safety, comes from knowing that the survivor-parent is available to the child to help organize feelings that may arise when the child feels frightened, and can take actions to protect their child (within the limits of their control).

Self-regulation is an important part of the healing process, as children and teens (and survivor-parents) learn to cope with overwhelming, frightening, and powerful feelings, thoughts, memories, and sensations in adaptive ways and to place traumatic experience "in the past." Parents help scaffold our ability to self-soothe and regulate when we're young, and relaxation skills can be taught to help us feel calmer and self-soothe when stressed.

Self-esteem/self-agency may falter as a result of the harm done; however, the survivor-parent and other important adults can help children overcome self-esteem issues by positively mirroring who they (the children) are and what they are capable of doing. Through relationships with parents and other caring adults, we learn how to articulate what we want and need, to trust others to help meet our needs, and to gain skills in negotiating and problem-solving when we have conflicts. Having a sense of self-agency grows out of feeling that we matter and are capable of mastering age-appropriate tasks.

The beauty of this resilience-based approach is that it applies to ALL children and can be tremendously supportive in helping children impacted by violence to build richer self-capacities, stronger interpersonal relationships, and more adaptive ways of coping with the traumatic effects of domestic violence and other trauma.

For the tip sheet *Tips for Supporting Children and Youth Exposed to Domestic Violence: What You Might See and What You Can Do*, additional resources, or more information on SASS or NCDVTMH please visit www.nationalcenterdvtraumamh.org. You can also register for a 10-part webinar series entitled, "Building Trauma-Informed Services for Children, Youth and Parents Impacted by Domestic Violence."

Other websites of interest:

Promising Futures at http://promising.futureswithoutviolence.org/ provides best practices for serving children, youth, and parents experiencing domestic violence.

The National Child Traumatic Stress Network at www.nctsn.org provides resources for parents, foster caregivers, and professionals in the child welfare system

The Safe Start Initiative at www.safestartcenter.org provides information on children's exposure to violence and resources on promising practices and evidence-informed approaches.

Promoting Promising and Evidence Based Practices

Building Trauma-Informed Capacity for Programs Serving Domestic Violence Survivors and their Children

The **Child Trauma Capacity Building Project** (Child Trauma Project) has been building trauma-informed staff capacity in community-based organizations in the Chicago area that serve families impacted by domestic violence and other trauma since 2004. The Child Trauma Project is an initiative of the National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH). The goal is to promote well-being, resilience, and healthy growth and development for children experiencing domestic violence by supporting the relationship between survivors and their children and by fostering healing and recovery from the traumatic effects of interpersonal violence and abuse. The Child Trauma Project has partnered with national experts and built local collaborations with community programs to create trauma-informed, developmentally sensitive services for parents and children impacted by domestic violence.

According to preliminary data, the Child Trauma Project's unique approach has significantly enhanced the trauma-informed capacities of frontline staff and their supervisors in community-based programs. Some results also suggest improvements in the well-being of survivors and their children, and increased resilience and recovery from the immediate and ongoing effects of interpersonal violence. In the past four years, the Child Trauma Project has expanded beyond Chicago, as NCDVTMH has begun mentoring and training advocates and professionals across the country to use this promising approach. Child Trauma Project staff have worked with domestic violence and dual domestic violence and sexual assault coalitions (coalitions) and member programs of the coalitions who serve families living in both rural and urban areas.

The project is supported by the Irving Harris Foundation, a private philanthropic foundation dedicated to promoting services and initiatives that support families with young children to grow and thrive. The Child Trauma Project is currently looking for ways to increase sustainability of this promising approach beyond the individuals and agencies involved to reach collaborative partners (such as child welfare agencies and early child care programs).

VISION & APPROACH

The vision of the Child Trauma Project is to (1) promote prevention and earlier intervention for children and families, (2) strengthen parent-child relationships to support recovery and healing from the traumatic effects of interpersonal violence and abuse, (3) work with collaborative partners to influence policy-level efforts to affect social change, and, ultimately, (4) eradicate interpersonal violence in future generations. The project incorporates the wisdom of the domestic violence community, including the principles of survivor-defined advocacy, as well as an understanding of trauma-informed principles, and a developmentally sensitive lens.

The Child Trauma Project draws on established relationships with local programs and between local agencies and coalitions. A first step in this capacity-building approach is to identify the gaps in knowledge and skills of frontline staff and supervisors at community-based programs. Participants then receive training based on one or both of two core curricula that were developed for this project in partnership with national experts. The curricula provide information about the traumatic impact of domestic violence on children and their non-violent caregivers and translate trauma-informed practice from academic-based research settings to the community. Both curricula were successfully field-tested with local domestic violence and mental health agencies in the Chicago area. *Children Exposed to Domestic Violence* is a foundational training curriculum written by Patricia Van Horn, JD, PhD, in collaboration with NCDVTMH. It prepares domestic violence frontline staff to use the advocacy relationship to support the parent-child relationship to restore a sense of safety and protection. It also prepares staff to support resilience and healing from the traumatic effects of experiencing domestic violence. The second curriculum, *Children and Trauma*, was developed for clinicians and clinical supervisors delivering services in community-based domestic violence, mental health, and other family service settings. It is co-authored by Betsy Groves, MSW, LICSW, from the Child Witness to Violence Project in Boston, and Susan Blumenfeld, MSW, LCSW, Child Trauma Training Director, NCDVTMH. This curriculum introduces mental health clinicians to two evidence-based, trauma-specific treatment models: Child Parent Psychotherapy, for children up to age six and their non-violent parents, and Trauma-Focused Cognitive Behavioral Therapy.

Both curricula emphasize a relationship-based approach that "How you are is as important as what you do."[1] Skills taught through the curricula include the following:

- Sharing information with survivors about how domestic violence and other trauma might affect their children's behavior and ongoing development
- Providing information on traumatic stress and how stress may impact children's neurodevelopment and stress response system
- Helping parents better understand and support their children's resilience by normalizing trauma-related responses, feelings, and behavior
- Offering strategies to help survivors and their children cope with the effects of traumatic stress and trauma reminders and to manage feelings in the moment when stressful situations arise.

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The curricula also describe evidence-informed approaches to strengthening parent-child relationships impacted by domestic violence and other interpersonal trauma. They summarize findings on resilience, attachment relationships, risks to children's ongoing development, and what promotes healing and recovery. Throughout the training curricula, the user will also find practical tools, language, and guidance relevant to both domestic violence advocates and mental health clinicians working in domestic violence program settings.

After receiving training, participants join an inter-agency group that meets in person to continue building their knowledge and skills. NCDVTMH staff or consultants trained and mentored by NCDVTMH facilitate these groups, providing ongoing consultation continuously for one year after completion of the training. NCDVTMH also offers quarterly meetings for supervisors and managers to build reflective supervisory skills and enhance trauma-informed services and supports within their programs and agencies.

In sum, the Child Trauma Project combines foundational training, extended consultation, and technical assistance to enable frontline staff and supervisors to integrate key elements of a trauma-informed approach into practice. The consultation helps

advocates develop skills and find ways to engage and support parents to strengthen and support the parent-child relationship as a key resource for healing and recovery. This might include helping survivors and children talk together about their traumatic experiences; label feelings that come up, such as sadness, loss, anger, and mixed loyalty to the domestic violence survivor and the parent who has perpetrated violence; and engage in activities that are fun and promote bonding. One important part of the inter-agency groups is that, using reflective practice principles (a core element of trauma-informed services), frontline staff and supervisors have the opportunity to reflect on their own responses that arise in doing this work, explore ways to reduce burnout and secondary trauma effects, and to remain hopeful while supporting children and families.

Several coalitions have adapted and replicated the Child Trauma Project model, including Idaho and New Hampshire. It will expand into New Mexico in the coming year.

PROMISING OUTCOMES

The Child Trauma Project uses qualitative and quantitative measures for gauging progress in integrating core competencies into practice. Data from self-administered surveys for frontline staff in the Chicago-based groups show significant progress in key indices of core competency. Although the data set for child- and family-level outcomes is limited, formal measures suggest improved child functioning, reduced trauma-related behaviors and responses for children and adolescents, and reduced stress for parents. Feedback from advocates and mental health clinicians also suggests that parent-child relationships have strengthened.

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Qualitative observations from frontline staff and supervisors confirm that training and extended consultation help providers integrate a common understanding about how domestic violence and other lifetime trauma impact survivors and their children, and parent-child relationships. Women's advocates, children's advocates, and mental health clinicians have reported feeling increased empathy and greater attunement for both adults and children impacted by domestic violence. They are able to take the perspective of the other (i.e., the child, if they are working primarily with adults and vice versa) and to hold both the parent and child in mind at the same time.

A group member who completed the consultation experience stated, "Being able to reflect is one of the biggest ways I have changed. I didn't used to give myself time to do that. I just used to jump right to the list of referrals and resources. Stepping back and slowing down a little has helped me stay focused on my role." Another stated, "I feel more comfortable and confident working with moms, since I've only ever worked with kids. My perspective was always, 'child first'… I do try to see the broader perspective [now], think about what might be going on for mom or why mom and I might see things so differently or disagree, or think about why my idea of 'child first' might not work right now."

The inter-agency group provides an opportunity to help peers come together with others doing similar work, which decreases isolation and becomes a form of self-care and renewal. They are able to share their painful, frustrating, or unresolved feelings about families who are receiving or have received services and gain fresh ideas, a new perspective, and renewed hope. A notable outcome is that when frontline staff and program supervisors have a reflective, safe space, a parallel process takes place: because there is room to feel accepted and supported by each other, in turn, they are more able to create this for survivors and their children. One peer group member gave this example: "[I] know in my head that it's okay that I don't have all the answers, and I also think [this] helps me understand my clients. They feel guilty about so many things, but we're supporting and encouraging them. They think they should have all the answers and know everything, too…and we tell them it's okay."

Quarterly meetings for program supervisors and managers help build on the foundational training and infuse reflective supervision within their programs. Participating supervisors and program managers have observed that their relationship with staff that they supervise has changed. One domestic violence program manager who supervises more than 12 staff began to apply reflective supervision practices and initiated individual supervisory meetings that were open and collaborative. The impact was immediate. Staff members were more focused and

energized, and related to survivor families in a more caring and collaborative way.

Another program supervisor remarked, "Being able to 'step back' instead of quickly stepping in has made a difference. It's taken a weight off of me, because I don't have to come up with a solution [but we can figure it out together]." Supervisors are better able to hold the "not knowing" and complexity in a parallel way to peer group members and can share responsibility for problem-solving with their team. Supervisors and managers note that coming together in a "safe space" with peers from other agencies has decreased their sense of isolation, increased their sense of competence as supervisors, and helped with the recognition that "my agency isn't the only one" with these kinds of challenges and issues.

CONCLUSION

Over the past decade, NCDVTMH has learned that frontline staff, supervisors, and agency programs can benefit greatly from capacity-building efforts to sustain trauma-informed practice that includes training and ongoing, facilitated consultation. Survivor families have complex needs that are often compounded by the lack of domestic violence-sensitive mental health resources within the community. This approach enhances resources at the community level and leads to better outcomes for children and parents impacted by domestic violence. NCDVTMH will continue to partner locally in Chicago and with coalitions to explore strategies for building internal capacity within agency programs while supporting external consultation relationships by disseminating this promising approach more widely. For more information contact Susan Blumenfeld at sblumenfeld@ncdvtmh.org.

[1] Jeree Pawl and Maria St. John, Zero to Three Press, 1998.

New NCJFCJ Family Violence and Domestic Relations (FVDR) Program Employees

Brenda Beltramo joins the FVDR Program as a Web Developer. Brenda is an IT professional with many years of experience in web design and development in both the public and private sectors. She is a graduate of the University of Minnesota, Minneapolis.

Amanda Kay, JD, joins the FVDR Program as a Program Attorney. Prior to joining the NCJFCJ, Amanda represented domestic violence victims in family law and protection order matters at the Volunteer Attorneys for Rural Nevadans and was a supervisory staff attorney for the Nevada Supreme Court, where she spearheaded efforts to improve the court's handling of pro se appeals. She received her J.D. from the University of Cincinnati College of Law and a B.S. in mathematics from the College of William & Mary.

Kelly Ranasinghe, JD, joins the FVDR Program as a Program Attorney. He is a graduate of California Western School of Law and is a nationally certified Child Welfare Law Specialist. Before joining the NCJFCJ, Kelly worked with the San Diego Public Defender's Office as a Juvenile Dependency attorney, and with the Imperial County Public Defender's Office as a minor's counsel and court-appointed guardian *ad litem.*

Sarah Smith, JD, joins the FVDR Program as a Program Attorney. Prior to joining NCJFCJ, she spent six years as a public defender in Bronx Family Court, representing indigent parents whose children were in the child welfare system. Before pursuing a law degree, Sarah worked as a journalist and editor in New York, and as a grassroots organizer in the Washington State labor movement. She received her B.A. in Political Science from Brown University and her J.D. from Georgetown Law Center.

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