# *Intersectional Trauma-Informed Intimate Partner Violence (IPV) Services: Narrowing the Gap between IPV Service Delivery and Survivor Needs*

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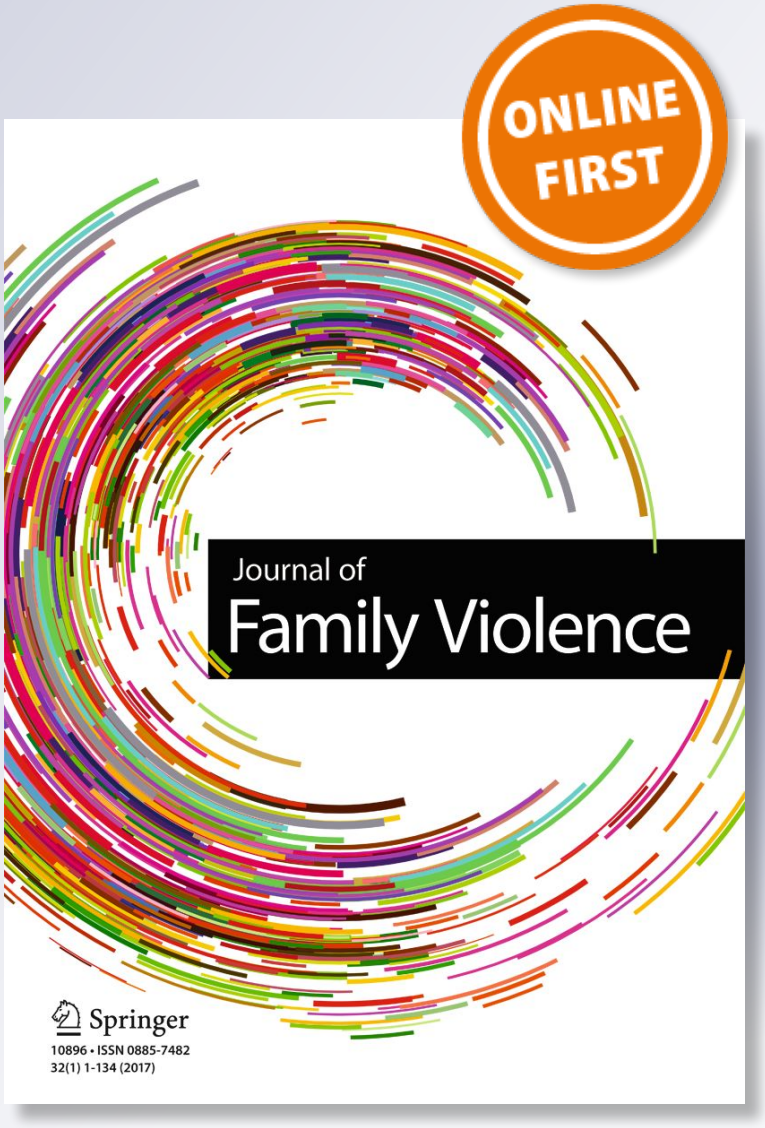


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ORIGINAL ARTICLE

# Intersectional Trauma-Informed Intimate Partner Violence (IPV) Services: Narrowing the Gap between IPV Service Delivery and Survivor Needs

Shanti Kulkarni[1]



**Abstract**
Over the past 50 years, programs serving intimate partner violence (IPV) survivors have expanded nationally. However, despite IPV program growth service gaps remain, particularly for the most marginalized and vulnerable survivor populations. Emerging practice models call for reimagining current IPV service delivery within an intersectional feminist, trauma-informed framework. An overview of intersectional (e.g. survivor-centered, full-frame, culturally specific) and trauma-informed IPV service approaches will be presented highlighting their shared emphasis on power sharing, authentic survivor-advocate relationships, individualized services, and robust systems advocacy. These approaches have the potential to transform IPV services and narrow service gaps if organizations can embed key elements into program design, implementation and evaluation processes. Recommendations for moving the IPV field forward include: 1) expanding survivors' roles/input; 2) strengthening funding streams and organizational commitment to anti-oppressive, survivor-defined, trauma-informed services; 3) forging cross-sector advocacy relationships; and 4) building knowledge through research and evaluation.

**Keywords** Domestic violence · Intimate partner violence · Service delivery · Survivor-centered · Trauma-informed · Full-frame · Culturally specific

Intimate partner violence (IPV) impacts 1 in 3 women in the U.S. and exacts tremendous social, psychological, and financial costs for individuals, families, and communities (Black et al. 2011). Over the past 50 years, programs serving IPV survivors have expanded nationally. Despite IPV program growth, service gaps remain, particularly for the most marginalized and vulnerable survivor populations. Emerging service models call for a reimagined IPV service delivery rooted in the philosophical values of intersectional feminism, a movement that strives to more broadly address the unique experiences of diverse populations, and trauma-informed care. Taken together these approaches can narrow gaps between current mainstream IPV services and the unmet needs of diverse survivors and communities.

This commentary begins by tracing IPV program development over time. An overview of survivor-centered, full-frame, culturally specific, and trauma-informed IPV service approaches, defined by four key elements–power sharing, authentic survivor-advocate relationships, individualized services, and robust systems advocacy, will be provided. The commentary then illustrates how IPV programs using an intersectional trauma-informed approach can embed these key elements into program design, implementation and evaluation processes and concludes with strategic recommendations to help the field in move forward.

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## From Self-Help to Specialized Professional Services–the Evolution of IPV Programs

Current day IPV services are directly connected to early feminist activist efforts (Goodman and Epstein 2008; Schechter 1982). During the 1970's as women shared personal stories of physical, emotional, sexual, and economic partner abuse, feminists declared IPV a social problem that required public

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response (Arnold and Ake 2013; Schechter 1982). At the time, most IPV victims lived in communities where there were no IPV services and where criminal and civil laws favored abusers (Goodmark 2012). Rather than waiting for formal social service providers to respond to IPV survivors' needs, activists created their own services (Arnold and Ake 2013). They established emergency battered women's shelters, victim advocacy, and crisis hotline programs (Goodman and Epstein 2008). These early services were deeply rooted in a mutual self-help philosophy often provided by formerly battered women within a framework that de-emphasized hierarchies (Goodman and Epstein 2008; Lehrner and Allen 2009).

Subsequently, federal funding for IPV services became available through the Family Violence Prevention and Services Act (FVPS) in 1984 and a decade later with the 1994 authorization of the Violence Against Women Act (VAWA) (Laney 2011). Funding has increased availability of IPV services greatly and contributed to stabilization and growth for many IPV programs (Macy et al. 2010). Over time most IPV programs became more formal than informal, more professional than grassroots, and often more social service than social change oriented (Lehrner and Allen 2009; Wies 2008). These trends appear to have had mixed consequences for IPV services (Arnold and Ake 2013). On one hand, many organizations enhanced their capacity to serve survivors, children, and families with IPV specialized services (Fleck-Henderson 2017). At the same time, critics suggest that many IPV services are not consistently responsive to the diverse needs of survivors and marginalized communities (Mehrotra et al. 2016; Sokoloff and Dupont 2005).

Simultaneously the IPV service environment was being reshaped by socio-political and economic trends unfolding over the past four decades. Broad structural changes created new challenges for IPV survivors and the service providers charged to assist them, including: reduced availability of affordable housing; "fewer sources of income for women without advanced training and with children"; changing immigrant populations with unique linguistic and cultural needs; and "erosion of community mental health services" (Fleck-Henderson 2017, pp. 482–483). A multiple state shelter study found IPV survivors' most frequently unmet needs primarily related to economic concerns, such as housing, cash assistance/vouchers, transportation, and employment or training (Lyon et al. 2008). IPV survivors, especially those with young children, criminal convictions, limited education or job skills, and mental health or substance abuse challenges, often face insurmountable barriers as they attempt to transition from emergency shelter to independence (Goodman and Epstein 2008; Goodmark forthcoming).

## Current IPV Service Landscape

IPV programs vary greatly in size, mission, and community contexts which translates into wide practice differences across programs (Bennett et al. 2004; Lyon et al. 2008). Typically, IPV services, such as emergency shelter, court advocacy and arrest/prosecution, focus on survivor concerns in the immediate aftermath of IPV incidents as well as offer longer term support through hotlines, advocacy/case management, counseling, and other supportive services (Bennett et al. 2004). Nationally IPV programs report a persistent gap between IPV service requests and available services (Kulkarni et al. 2010; Lyon et al. 2008).

The relationship between IPV programs and criminal justice systems tasked with enforcing domestic violence laws has long been complex (Goodmark 2012). Many times, IPV advocates work effectively with law enforcement to ensure survivors' needs and wishes are acknowledged within legal proceedings (Goodman and Epstein 2008; Nichols 2013). According to one study, when IPV victims reported empowering court experiences, in which they understood their legal rights and choices, they also report higher levels of well-being than victims with less empowering court experiences up to 6 months later (Cattaneo and Goodman 2010). Conversely, law enforcement involvement can introduce potential risks and uncertainties for many survivors, particularly those from marginalized communities (Mehrotra et al. 2016). LGBTQ, immigrant, low-income, and survivors from communities of color are more likely to have negative law enforcement experiences, which result in survivors fearing possible deportation, arrest, housing loss, or child welfare involvement when they seek help (Fugate et al. 2005; Goodmark forthcoming). Frequently IPV survivors do not wish, or in the case of shared children are unable, to fully sever relationships with abusive partners (Davies and Lyon 2013; Fugate et al. 2005; Goodman and Epstein 2008). IPV service providers typically have little to offer survivors interested in family or couples' counseling despite the fact that survivors have been requesting such services for decades (Goodmark 2012; Stith and McCollum 2011).

Notwithstanding the paucity of services nationally, research suggests that survivors are satisfied with and appear to benefit from IPV services (Bennett et al. 2004; Lyon et al. 2008). However, as a recent study indicates IPV survivors and service providers may bring different expectations about what kind of help is most useful and what constitutes success (Melbin et al. 2014). For example, survivor service recipients defined their most meaningful successes in terms of social connections and personal accomplishments that supported a positive identity unrelated to IPV. In contrast, IPV service providers in the same study were much more likely to define success as being related to "changes in survivors' perspectives about the abusive relationship" (Melbin et al. 2014, p. 7). The study highlights what some IPV experts have identified as a common discrepancy between survivors' expressed values, preferences, and needs and typical IPV service delivery assumptions (Davies and Lyon 2013; Smyth et al. 2006).

## Narrowing the Gap between Survivors' Needs and IPV Services

Recent IPV service approaches are seeking to reduce the gap between IPV survivors' expressed needs and the services that IPV programs most typically offer. Broadly these approaches shift practice towards a more intersectional service delivery orientation, as well as encourage the integration trauma-informed care principles. Survivor-centered advocacy, the full-frame initiative, and many culturally specific program models represent approaches that consider survivors' multiple identities and priorities beyond victimization and safety. In contrast, trauma-informed service delivery organizes services around core trauma-informed values with the goal of facilitating healing from traumatic injury. Collectively all approaches seek to expand the array of survivors' needs addressed by IPV programs.

## Intersectional IPV Approaches

Intersectional feminist theory emerged to make the unique experiences and vulnerabilities of marginalized women more visible (Crenshaw, 1991). Intersectional approaches underscore the ways in which social categories, including but not limited to race, class, ability, gender, and sexuality, interact to shape IPV experiences (Potter 2013; Sokoloff and Dupont 2005). As a result, individuals contending with multiple oppressions encounter challenges that may or may not be adequately addressed with mainstream IPV services. Three IPV service frameworks respond to the intersectional needs of survivors: survivor-centered advocacy, the full-frame approach, and culturally specific IPV programs.

**Survivor-Centered Advocacy** The survivor-centered advocacy approach emerged from the domestic violence field in order to address the problem of narrowly safety-focused IPV advocacy practices (Davies and Lyon 2013). Survivor-centered advocacy broadens the definition of survivor safety stating survivors "are safe when there is no violence, their basic human needs are met, and they experience social and emotional well-being" (Davies and Lyon 2013, p. 6). Survivor-centered advocacy practices are guided by survivors' knowledge, expertise, and preferences rather than service-defined advocacy practices that tend to fit survivors into existing services regardless of their needs.

**Full-Frame Model** The full-frame model emerged through the analysis of the needs of women contending with both IPV and homelessness. This approach seeks to more comprehensively address the complex and competing challenges associated with IPV and poverty (Smyth et al. 2006). Over time, the full frame model has been elaborated to encompass five empirically based domains associated with well-being–mastery, safety, social connectedness, stability, and meaningful access to resources (Full Frame Initiative n.d.). From this holistic perspective, safety cannot be understood in isolation from other domains of wellbeing. For example, survivors who enter confidential emergency shelters may experience increased well-being in the domain of physical safety while simultaneously experiencing significant decreases in their social connectedness and meaningful access to resources because they have been uprooted from important social networks (Goodman and Smyth 2011).

**Culturally Specific Programs** In contrast to mainstream IPV programs working to align their work within an intersectional framework, many culturally specific IPV programs were founded on intersectional principles. These programs were often established to meet the needs of survivors and communities not well-served within in mainstream IPV programs (Casa de Esperanza n.d.; Asian Pacific Institute on Gender-based Violence [API] n.d.). According to the Asian Pacific Institute on Gender-based Violence (API):

> Asian and Pacific Islander advocates, many of whom had already been involved in the national anti-domestic violence movement, questioned the lack of accesses to mainstream programs API women encountered. Many founded API specific programs, adapting existing models, designing a variety of programmatic responses, incorporating cultural contexts, and developing innovative practices and policies out of design and necessity.

A number of culturally specific organizations codified expertise working with specific survivor populations into intersectional frameworks that allowed them to address survivors' needs holistically. For example, Case de Esperanza defines the cultural context of Latinx survivors as multi-layered, including daily experiences, social norms, and internalized values (Casa de Esperanza n.d.). IPV advocates within this program appreciate the nuanced and dynamic interchange between all three levels of cultural context and use this to guide their collaborative work with survivors. Finally, culturally specific programs often seek to reflect their broader community cultural values and priorities. As a result, culturally specific programs are more likely than mainstream IPV programs to work with all family members, including partners who have used violence. For example, Caminar Latino, an IPV service organization in Georgia, describes their mission as creating "creating safe spaces for each family member to begin their journey towards non-violence" (Caminar Latino n.d.).

## Trauma-Informed Care

Contemporaneously the mental health and substance abuse disciplines have begun promoting trauma-informed care

philosophies, which have in turn influenced IPV programs Harris and Fallot 2001; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Trauma-informed care principles emerged amidst growing acceptance that traumatic experiences, such as child abuse, sexual assault, and war experiences, are often implicated in the development of behavioral health disorders. Trauma-informed care addresses the role of psychological trauma within the diagnosis and treatment of such disorders (SAMSHA 2014). Importantly trauma-informed care thinkers recognized that service delivery system reforms were also necessary to provide an appropriate healing environment for trauma survivors (Bloom 2013).

Trauma-informed practices are grounded in the belief that traumatic experiences affect the types of services needed, as well as the ways in which IPV survivors will experience formal helping systems (Harris and Fallot 2001; SAMHSA 2014). Trauma-informed programs are expected to integrate knowledge about the effects of trauma into all aspects of service. Staff are trained in the neurobiology of trauma in order to appropriately normalize survivors' information processing abilities and coping behaviors so helpers can support survivors in managing and healing at their own pace (Wilson et al. 2015). For example, IPV survivors may self-medicate physiologically uncomfortable trauma symptoms with substance use in a manner that interferes with their safety or ability to parent effectively. Trauma survivors may also have difficulty fully trusting staff's helping motivations and are often highly attuned to uses (or misuses) of staff authority (Herman 2015; Warshaw et al. 2018).

## Commonalities across Approaches

Though each approach emphasizes different dimensions of IPV practice, there is significant substantive overlap across approaches with regard to four common elements—*power sharing, authenticity, individualized services, and systems advocacy* (See Fig. 1). Survivor-centered advocacy highlights the importance of survivor expertise and agency. The full-frame approach provides a clear framework for supporting survivors across multiple dimensions of wellbeing. Culturally specific IPV programs center services in the cultural values, identities, and contexts of diverse survivors and communities. Finally, trauma-informed care calls attention to the subtle and wide-ranging influence of trauma exposure upon survivor coping and relational functioning.

Despite differences, intersectional trauma-informed approaches all view *power sharing within service delivery, authentic survivor-advocate relationships, individualized service plans,* and *systems advocacy* as instrumental for strengthening IPV practice. Power-sharing and authenticity are reflected in the relational processes of service delivery; while individualized services and systems advocacy underscore important service delivery practice domains. Survivor-defined, culturally relevant and empowering practice are intricately linked and involve interacting with survivors in ways that increase their power in personal, interpersonal and political arenas. Thus, some IPV programs include community engagement as an important empowerment strategy.

**Power-Sharing** Power sharing occurs by prioritizing survivor/victim decision making (Davies and Lyon 2013), creating opportunities for survivors to take the lead in framing their narratives, intentions, and concerns (Smyth et al. 2006), and ensuring as much survivor autonomy as possible within the treatment process (Harris and Fallot 2001; SAMHSA 2014). From a culturally specific perspective, IPV advocates are encouraged to be humble and to reflect upon their own power, privilege, values, history, beliefs, and trauma experiences to avoid recreating abusive dynamics and structures (Serrata and Notorio n.d.).

**Authenticity** Authentic helping relationships are viewed as essential to effective safety planning (Davies and Lyon 2013); described as "enduring" and "flexible" (Smyth et al. 2006, p. 496); and grounded in trust achieved through consistent staff responses both "inside and outside the treatment" (SAMHSA 2014, p. 144). Culturally specific programs may encourage IPV advocates to use their own cultural knowledge of social, political, cultural, and gender issues within their advocacy work (API n.d.).

**Individualized Services** Individualized service plans are central to all models whether the focus is improving survivor-defined safety, understanding cultural influences, addressing internal and external needs, or providing trauma-specific care. All approaches eschew 'one-size-fits-all' service delivery and argue for services and service delivery rooted in each survivor's goals, priorities, needs, and preferences.

**Systems Advocacy** All approaches emphasize the importance of systems change advocacy. Survivor-centered approaches call for advocacy aimed at improving survivor choices within their communities. Full-frame approaches suggest that engaging in social action may be necessary to help survivors overcome structural and resource barriers associated with poverty. Culturally specific IPV programs are involved in systems advocacy to positively affect those policies or community issues that most affect their populations whether that be affordable housing, economic development, police violence, or immigration policies. Finally, trauma-informed care approaches invest in changing service delivery systems to become less triggering and more responsive to survivor needs.

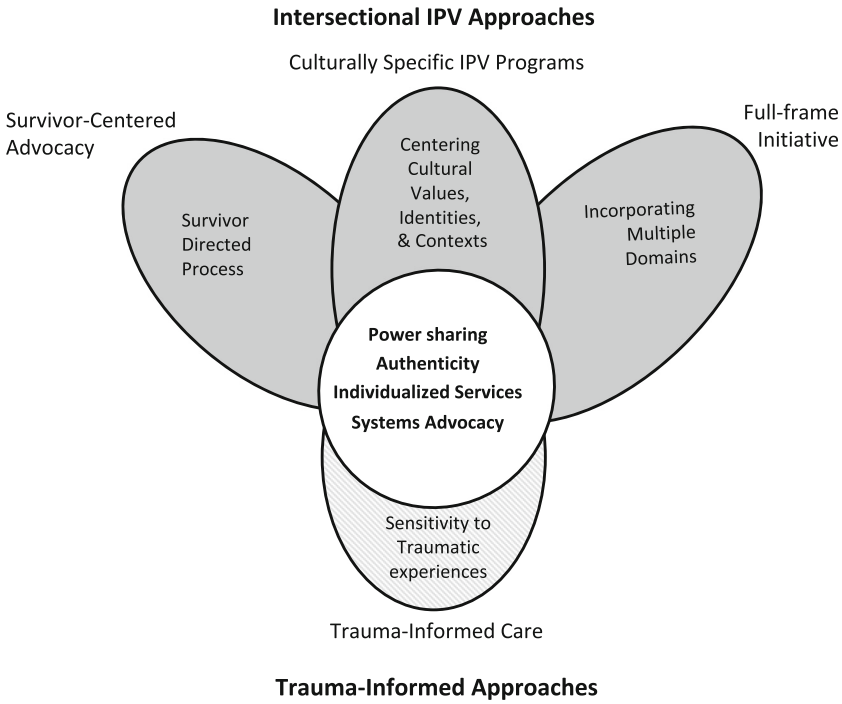


**Fig. 1** Intersectional trauma-informed IPV approaches

## Delivering Intersectional Trauma-Informed IPV Services

Intersectional trauma-informed approaches all challenge IPV service providers and programs to more closely realign with survivors' expressed needs, preferences and community contexts. Some IPV programs achieve this realignment by enhancing current practices; other programs may explore returning to historical practices or creating entirely new practices (Arnold and Ake 2013). Delivering intersectional trauma-informed IPV approaches requires sustained practitioner, organizational, and community commitment (Kulkarni et al. in review). The key elements of these approaches–*power-sharing, authenticity, individualized services, and systems advocacy*—can and should be integrated through program design, implementation, and evaluation (See Table 1).

**Program Design** Intersectional trauma-informed approaches require programs to critically examine IPV services and service delivery (Wood 2015) which can be achieved through thoughtful needs assessment. IPV programs should explore avenues to creatively pursue input from survivors not always well served by mainstream IPV services. Programs can learn a great deal from survivors who are 'unsuccessful' within their programs, and perhaps even more so from survivors who never make it to their program doors. The Interaction Institute for Social Change (IISC) recommends assembling action teams to guide service planning (IISC 2016). Actions teams should include individuals who are: 1) directly impacted by services or lack of services; 2) marginalized from mainstream service delivery; 3) connectors in or across sectors/fields; 4) able to implement change; 5) potential barriers to change implementation; 6) knowledgeable with regard to needed expertise; 7) informal authorities; and 8) decision makers. The action team model illustrates power sharing as optimally integrated into program planning processes; however even smaller steps towards inclusion can help to reduce power imbalances. Authenticity between IPV program leadership, staff, service recipients, and community leaders is related to yet distinct from power sharing. For example, transparency is an important strategy for equalizing power differences and at the same time reflects authentic engagement. IPV organizations can commit to authenticity by striving for openness and transparency about their missions, values, struggles, and decision-making processes with program staff, service recipients, and community partners.

Service delivery should also be planned around principles of individualized services and systems advocacy. IPV programs can embrace flexible, voluntary service models that includes an appropriate range of services. Indeed, as federal funders (e.g. Office of Violence Against Women [OVW] and FVPSA) have implemented voluntary services model requirements, more programs have begun to understand and adopt this service philosophy. Due to resource limitations, community partnerships are essential, especially for addressing survivor priorities not be related to victimization or safety. Through these partnerships, IPV programs are well-positioned to support the adoption of trauma-informed survivor-centered practices across other systems.

**Table 1** Delivering intersectional trauma-informed IPV services

| | Program Design Goals | Program Implementation Goals | Program Evaluation Goals |
|---|---|---|---|
| Power sharing | Diverse stakeholder input to determine service priorities | Staff composition reflects client population | Diverse stakeholders determine whether services are successful |
| Authenticity | Honesty about tensions between organizational philosophy and mission and resource limitations and other external constraints | Transparency in service delivery decisions | Successes, challenges, and unanticipated consequences shared |
| Individualized Services | Commitment to a flexible, voluntary service model that includes an appropriate range of services | Sufficient autonomy to work with survivors in ways that best meet each survivor's needs | Outcome measures reflect changes related to survivors' service plan |
| Systems Advocacy | Survivors needs met across multiple systems (e.g. criminal justice, child welfare, health care) | Productive relationships with other systems leaders that are rooted in advocacy and problem-solving | Survivors' experiences assessed across multiple systems, as well as the quality and effectiveness of cross-system partnerships |

**Program Implementation** As noted, IPV programs operate in vastly different contexts with different levels of financial and non-financial resources (Kulkarni et al. 2010; Macy et al. 2010). Resource constraints impact service delivery, staff wellness, and organizational culture in ways that should be acknowledged (Bell et al. 2003). However, IPV programs still successfully leverage existing resources to innovatively respond to survivors' needs by building strong organizational culture (Kulkarni et al. in review). Trauma-informed care approaches explicitly identify organizational culture as the vehicle for transforming program practices (Harris and Fallot 2001; SAMHSA 2014). An IPV program's organizational culture can support staff creativity and survivor-centered practices or stifle such responses (Kulkarni and Bell 2013). For example, supervision can help overcome staff concerns, such as assuming responsibility for IPV survivors' safety in ways that prevent more fully sharing power (Logan and Walker 2018; Wood 2015) or adopting professional boundaries or emotional distance that impedes authentic survivor-advocate relationships (Kulkarni et al. 2012; Logan and Walker 2018). Staff are challenged with holding each other accountable for adhering to trauma-informed principles in their work while also normalizing and supporting the real occupational impacts of secondary trauma and burnout, (Kulkarni et al. in review).

Training is also useful to help staff intentionally integrate micro (individual/relationship) and macro (organizational/societal) perspectives when working with IPV survivors regardless of their educational background (Nichols 2013). IPV advocates should be prepared with a thoughtful understanding of trauma and IPV, as well as survivors' experiences of poverty, racism, and other forms of oppressions (Kulkarni et al. in review). Within their day-to-day work, program staff must rely on shared values and language to navigate difficult choices about service delivery (Nichols 2013). Anti-racist efforts currently promoted by domestic violence coalitions, IPV programs, and national advocacy groups are important for the field (e.g. Racial & Economic Equity for Survivors Project (REEP), Center for Survivor Agency and Justice). Just as diverse action teams are beneficial for program planning, IPV program staff who demographically correspond to the racial/ethnic, economic, and linguistic make-up the community served are also essential. Staff equipped with an intersectional, anti-oppressive framework can avoid the tendency of IPV programs to normalize the majority heterosexual, cisgender, able-bodied, U.S. born, English-speaking, white experience (Donnelly et al. 2005; Nnawulezi and Sullivan 2014).

**Program Evaluation** While design, implementation, and evaluation activities occur sequentially, they should also be understood as interconnected in nature through a series of planning, action, and reflection cycles. Too often evaluation has been presented as funder requirement, thus experienced as a form of 'hoop jumping' for IPV programs (Goodman et al. 2015; Macy et al. 2010). However, program evaluation can be a meaningful strategy to ensure organizational self-accountability and quality improvement related to intersectional trauma-informed approaches. Programs can collect information independently or they can partner with IPV researchers in mutually beneficial ways (e.g. Thomas et al. 2018a).

Evaluation data can help determine successes, challenges, and unintended consequences. IPV evaluation efforts should provide multiple opportunities for survivor feedback over time. IPV programs will want to make efforts to understand survivors' experiences across multiple systems, as well as assess the quality and effectiveness of cross-system partnerships. Survivor feedback can also help IPV programs ensure that clients are experiencing services in line with intersectional trauma-informed organizational values (Nnawulezi 2016). To the degree possible, programs should utilize outcome measures that capture survivors' progress and barriers to change. The MOVERS (Measure of Victim Empowerment Related to

Safety) Scale was developed through an IPV researcher-practitioner collaboration (Goodman et al. 2015). This 9-item scale has 3 subscales—internal tools, expectation of support, and trade-offs. IPV programs are using MOVERS to track survivors' reported improvements in internal resources (e.g. survivor coping strategies, safety planning knowledge, and self-efficacy) and social support (e.g. family, friends, advocates). Importantly though MOVERS can also be used to track those barriers to change that the program may not be able to address (e.g. affordable housing, employment, child care; Thomas et al. 2015).

## Imagining a New IPV Service Landscape

Fully embracing intersectional trauma-informed practice challenges IPV programs to constructively contend with the here-to-for unmet needs of survivors who do not want to press charges against or even physically separate from their partners yet desperately want to achieve some measure of safety and dignity in their lives (Goodmark 2012). As IPV programs become more guided by survivors' expressed needs as opposed to currently available services (Davies and Lyon 2013), some programs may begin to cautiously explore criminal justice and therapeutic alternatives, such as restorative or transformational justice (End Domestic Abuse 2017) and IPV informed couples counseling (Stith and McCollum 2011)., that better meet the needs of more marginalized survivors (Arnold and Ake 2013; Goodmark forthcoming). IPV programs may contemplate the intergenerational, historical, and insidious trauma that abusers may have experienced (Siegel 2013). Ironically, some adult abusers exposed to IPV as children would have previously been considered victims by IPV programs that are now reluctant to work with them (Mehrotra et al. 2016). A trauma-informed approach to batterer intervention treatment may open the possibility for alternative interventions designed to disrupt the intergenerational cycle of IPV while still prioritizing survivor safety and holding individuals accountable for violent behaviors (Edleson et al. 2015; Siegel 2013). An intersectional trauma-informed IPV framework will seek to understand all family members, as multi-dimensional, complex individuals who cannot be reduced to single identities associated with victimization and perpetration (Mennicke and Kulkarni 2016). For example, prevention initiatives that help fathers understand the impact of IPV on children appear more successful in engaging men who abuse in examining violence and changing behavior (Carlson et al. 2015; Thoennes and Pearson 2015; Thomas et al. 2018b). These services may also better meet the needs of survivors who want to safely and effectively co-parent with formerly abusive partners.

## Recommendations for Moving Forward

Intersectional trauma-informed care approaches collectively require IPV service providers to share power, individualize interventions, and actively advocate for systems changes. IPV programs are thus challenged to support advocates' authentic engagement with clients and to invest in organizational cultures where advocates can exercise the professional autonomy necessary to compassionately and respectfully meet the unique needs of all survivors. At the macro level, IPV programs can ensure available services to address the comprehensive range of survivors' expressed needs through program innovation and partnerships. In doing so, programs must also continually advocate for resources and policy changes that support IPV survivors across systems community-wide.

IPV programs might consider the following recommendations as the IPV field advances intersectional trauma-informed services (see Table 2).

1. Expand survivors' roles/input. Koss et al. (2017) recommend IPV service providers to move beyond being survivor-centered to become truly survivor-*informed.* With this in mind, IPV programs should seek survivor input in all aspects of service planning, delivery, and evaluation. Organizations can provide a variety of mechanisms to facilitate meaningful survivor participation, including establishing advisory boards, hiring peer support specialists, creating speakers' bureaus, tenant groups and organizing policy advocacy initiatives. Due to the crisis nature of IPV services, some organizations may not have ongoing contact with the survivors they serve, thus programs may need to outreach to survivors who are more stably situated and represent a wide range of identities reflective of the larger community.
2. Strengthen funding streams and organizational commitment to anti-oppressive, survivor-defined, trauma-informed services. IPV programs require adequate resources in order to provide quality services. IPV advocates must continue to educate public and private funders, philanthropists, and even small donors about survivors' diverse needs, individual preferences, and unique barriers (Mehrotra et al. 2016). IPV programs should prioritize

**Table 2** Recommendations for advancing intersectional trauma-informed IPV services

| IPV Program/Policy Action Recommendations | |
|---|---|
| #1 | Expand survivors' roles/input |
| #2 | Strengthen funding streams and organizational commitment to anti-oppressive, survivor-defined, trauma-informed services |
| #3 | Forge cross-sector advocacy relationships |
| #4 | Build knowledge through research and evaluation |

efforts to provide staff a living wage and health benefits, including access to mental health care. Organizational culture provides the necessary context and backdrop for such intersectional trauma-informed practice to occur (Kulkarni and Bell 2010). Uninformed organizational culture can also impede intersectional advocacy and service innovation. Those who lead IPV organizations should affirm their commitment to the values that underlie these practice approaches–values in which many IPV organizations were founded (Lehrner and Allen 2008; Nichols 2013). Relationships between IPV advocates and survivors are instrumental for facilitating survivor empowerment, self-determination and growth (Goodman et al. 2016). However, these relationships can only occur within organizational contexts that allow advocates to utilize their authenticity, critical thinking, and creativity (Kulkarni et al. in review; Logan and Walker 2018). Advocates need training to hone specialized knowledge and skills. Coaching, supervision, and peer support are all important to ensure on-going professional development and guard against secondary trauma responses.

3. Forge cross-sector advocacy relationships. IPV survivors have intersecting needs and identities. Though IPV advocates have developed expertise in gender-based violence and trauma, most advocates lack deep knowledge in areas such as (but not limited to) affordable housing, racial justice, education reform, immigrant and LGTQ rights, and economic development (O'Neal and Beckman 2017). Survivors' needs are more fully served in the short and long-term through non-traditional cross-sector partnerships in these and related areas. These partnerships, whether formal or informal, will yield innovative solutions and strengthen communities where survivors live.
4. Build knowledge through research and evaluation. Generally, IPV services research, including research validating intersectional trauma-informed approaches, is complicated and difficult to conduct. Over the past decade, the IPV field has made important strides in conceptualizing and evaluating IPV services (Sullivan 2018). Though still limited, research findings are beginning to document the value and effectiveness of existing programs as well as encouraging innovative IPV service approaches (e.g. DV Housing First). Nonetheless, evidence-based approaches should be critically reviewed and thoughtfully implemented to accommodate individual survivor circumstances, reflect community contexts, and avoid unintended consequences. Goodman et al. (2018a, 2018b) have cautioned against privileging scientific methods, such as randomized clinical trials, that are not only quite difficult to achieve within IPV programs but also tend to limit inclusion of study participants who struggle with multiple concerns. Community-based participatory methods (CBPR) is an alternative research approach that may be particularly amenable to IPV services (e.g. https://cbprtoolkit.org/). CBPR is highly process oriented whereby researchers and community partners engage in close collaboration to identify research questions, develop data collection strategies, interpret data, and disseminate findings (Goodman et al. 2018a, 2018b; Goodman et al. 2017). Program evaluation efforts are often driven by funder requirements rather than program development needs. IPV organizations are encouraged to consider the resources associated with evaluation as an investment in service quality. Staff at all levels can be involved in making sense of and responding to outcome and service delivery trends. Advocates can also be encouraged to embed client feedback and satisfaction questions into the service delivery process. For example, IPV advocates can conclude their meetings with survivors by asking questions that can strengthen survivor-centeredness (e.g. what were the things that we did that were most helpful to you? are there any specific things that we didn't focus on that would have been useful for you?).

## Conclusion

IPV service delivery emerged from feminist values and principles around empowerment, self-determination within a larger socio-political analysis of gender oppression. As the IPV field embraces intersectional trauma-informed service delivery models, programs should reinvigorate their commitment to underlying values of anti-oppression, intersectionality, and self-reflection. Innovative strategies can center the needs of IPV survivors who are often the most marginalized and most at risk for multiple forms of violence. IPV organizations have the duty to respond to the needs of all survivors and communities. Programs can face these challenges squarely by critically examining current services, listening deeply to diverse survivors' expressed needs, and moving to narrow the gap between the two.

## References

Arnold, G., & Ake, J. (2013). Reframing the narrative of the battered women's movement. *Violence Against Women, 19*, 557–578.

Asian Pacific Institute on Gender-Based Violence (n.d.). *Culturally specific advocacy*. Retrieved from https://www.api-gbv.org/culturally-specific-advocacy/

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society, 84*(4), 463–470.

Bennett, L., Riger, S., Schewe, P., Howard, A., & Wasco, S. (2004). Effectiveness of hotline, advocacy, counseling, and shelter services

for victims of domestic violence. *Journal of Interpersonal Violence, 19*(7), 815–829. https://doi.org/10.1177/0886260504265687.

Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., … & Stevens, M.R. (2011). The national intimate partner and sexual violence survey (NISVS): 2010 summary report. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Bloom, S. L. (2013). *Creating sanctuary: Toward the evolution of sane societies*. Routledge.

Caminar Latino (n.d.). *About our programs.* Retrieved from http://caminarlatino.org/programs/

Carlson, J., Casey, E., Edleson, J., Tolman, R., Walsh, T., & Kimball, E. (2015). Strategies to engage men and boys in violence prevention. *Violence Against Women, 21*(11), 1406–1425. https://doi.org/10.1177/1077801215594888.

Casa de Esperanza (n.d.). *What we do.* Retrieved from https://casadeesperanza.org/en/what-we-do/

Cattaneo, L., & Goodman, L. A. (2010). Through the lens of therapeutic jurisprudence: The relationship between empowerment in the court system and well-being for intimate partner violence victims. *Journal of Interpersonal Violence, 25*(3), 481–502.

Crenshaw, K. (1991). Mapping the margins: Identity politics, intersectionality, and violence against women. Stanford Law Review, 43(6), 1241–1299.

Davies, J., & Lyon, E. (2013). *Domestic violence advocacy: Complex lives/difficult choices* (2nd ed.). Thousand Oaks: Sage Publications.

Donnelly, D. A., Cook, K. J., Van Ausdale, D., & Foley, L. (2005). White privilege, color blindness, and services to battered women. *Violence Against Women, 11*(1), 6–37.

Edleson, J. L., Lindhorst, T., & Kanuha, V. K. (2015). *Ending gender-based violence: A grand challenge for social work (Grand Challenges for Social Work Initiative Working Paper No. 15)*. Cleveland: American Academy of Social Work and Social Welfare.

End Domestic Abuse, W. I. (2017). Transformative justice. *Coalition Chronicles, 36*(2), 1–23.

Fleck-Henderson, A. (2017). From movement to mainstream: A battered women's shelter evolves (1976–2017). *Affilia, 32*(4), 476–490.

Fugate, M., Landis, L., Riordan, K., Naureckas, S., & Engel, B. (2005). Barriers to domestic violence help seeking. *Violence Against Women, 11*(3), 290–310. https://doi.org/10.1177/1077801204271959.

Full Frame Initiative (n.d.). *The five domains of wellbeing (fact sheet).* Retrieved from: http://fullframeinitiative.org/resources/about-the-full-frame-approach-and-five-domains/#video on 3/20/2018.

Goodman, L. A., & Epstein, D. (2008). Listening to battered women: A survivor-centered approach to advocacy, mental health, and justice. American Psychological Association.

Goodman, L. A., & Smyth, K. (2011). A call for a social network-oriented approach to services for survivors of intimate partner violence. *Psychology of Violence, 1*, 79–92. https://doi.org/10.1037/a0022977.

Goodman, L. A., Cattaneo, L. B., Thomas, K., Woulfe, J., Chong, S. K., & Smyth, K. F. (2015). Advancing domestic violence program evaluation: Development and validation of the measure of victim empowerment related to safety (MOVERS). *Psychology of Violence, 5*(4), 355.

Goodman, L. A., Fauci, J. E., Sullivan, C. M., DiGiovanni, C. D., & Wilson, J. M. (2016). Domestic violence survivors' empowerment and mental health: Exploring the role of the alliance with advocates. *Journal of Orthopsychiatry, 86*(3), 286–296.

Goodman, L., Thomas, K., Serrata, J., Lippy, C., Nnawulezi, N., Ghanbapour, S., Sullivan, C., & Bair-Merritt, M. (2017). *Power through partnerships: A CBPR toolkit for domestic violence researchers*. Available at: https://cbprtoolkit.org/authors.

Goodman, L. A., Epstein, D., & Sullivan, C. M. (2018a). Beyond the RCT: Integrating rigor and relevance to evaluate the outcomes of domestic violence programs. *American Journal of Evaluation, 39*(1), 58–70.

Goodman, L., Thomas, K., Nnawulezi, N., Lippy, C., Serrata, J., Ghanbarpour, S., Sullivan, C., & Bair-Merritt, M. (2018b). Bringing community based participatory research to domestic violence scholarship: An online toolkit. *Journal of Family Violence, 33*(2), 103–107.

Goodmark, L. (2012). *A troubled marriage: Domestic violence and the legal system*. New York: NYU Press.

Goodmark, L. (forthcoming). *Decriminalizing domestic violence: A balanced policy approach to intimate partner violence.* University of California Press.

Harris, M., & Fallot, R. D. (2001). *New directions for mental health services. Using trauma theory to design service systems*. San Francisco: Jossey-Bass.

Herman, J. L. (2015). Trauma and recovery: The aftermath of violence–from domestic abuse to political terror. Hachette UK.

Interaction Institute for Social Change. (2016). *Facilitative leadership for social change training resource: What is a stakeholder?* Boston: Interaction Institute for Social Change.

Koss, M. P., White, J. W., & Lopez, E. C. (2017). Victim voice in reenvisioning responses to sexual and physical violence nationally and internationally. *American Psychologist, 72*(9), 1019–1030.

Kulkarni, S. J., & Bell, H. (2013). Trauma and the organization: Understanding and addressing burnout and secondary trauma in a trauma-informed system. In B. Doolittle (Ed.), *Psychology of Burnout: New Research. Haupage*. New York: Nova Publications.

Kulkarni, S. J., Bell, H., & Wylie, L. (2010). Why don't they follow through?: Intimate partner survivors' challenges in accessing health and social services. *Family & Community Health, 33*(2), 94–105.

Kulkarni, S. J., Bell, H., & Rhodes, D. (2012). Back to basics: Essential qualities of services for survivors of intimate partner violence. *Violence Against Women, 18*(1), 85–101. https://doi.org/10.1177/1077801212437137.

Kulkarni, S.J., Stylianou, A.M., & Wood, L.G. (in review). Successful rules reduction implementation process in domestic violence shelters from vision to practice. Social Work.

Laney, G. (2011). *Violence Against Women Act: History and Federal Funding*. (CRS Report No. RL33539). Retrieved from: http://library.niwap.org/wcontent/uploads/2015/VAWA-Tkit-CRSReport2.26.10.pdf

Lehrner, A., & Allen, N. E. (2009). Still a movement after all these years? Current tensions in the domestic violence movement. Violence Against Women, 15(6), 656–677.

Lehrner, A., & Allen, N. E. (2008). Social change movements and the struggle over meaning making: A case study of domestic violence narratives. *American Journal of Community Psychology, 42*, 220–234.

Logan, T. K., & Walker, R. (2018). Advocate safety planning training, feedback, and personal challenges. *Journal of Family Violence, 33*(3), 213–225. https://doi.org/10.1007/s10896-017-9949-9.

Lyon, E., Lane, S., & Menard, A. (2008). Meeting survivors' needs: A multi-state study of domestic violence shelter experiences, executive summary. *National Institute of Justice. Retrieved from VAWNET: http://www.vawnet.org/AssocFilesVAWnet/MeetingSurvivorsNeeds-ExSummary.pdf.*

Macy, R., Giattina, M., Parish, S., & Crosby, C. (2010). Domestic violence and sexual assault services: Historical concerns and contemporary challenges. *Journal of Interpersonal Violence, 25*(1), 3–32. https://doi.org/10.1177/0886260508329128.

Mehrotra, G., Kimball, E., & Wahab, S. (2016). The braid that binds us: The impact of neoliberalism, criminalization, and professionalization on domestic violence work. *Affilia Journal of Women and Social Work, 31*(2), 153–163. https://doi.org/10.1177/0886109916643871.

Melbin, A., Jordan, A. & Fels Smyth, K. (2014). How do survivors define success? A new project to address an overlooked question. Full Frame Initiative: Greenfield.

Mennicke, A., & Kulkarni, S. J. (2016). Understanding gender symmetry within an expanded partner violence typology. *Special Issue of Journal of Family Violence., 33*(8), 1013–1018. https://doi.org/10.1007/s10896-016-9867-2.

Nichols, A. (2013). Meaning-making and domestic violence victim advocacy. *Feminist Criminology, 8*(3), 177–201. https://doi.org/10.1177/1557085113482727.

Nnawulezi, N.A. (2016). From organizational culture to survivor outcomes: A process and outcome evaluation of the district alliance for safe housing. Washington, D.C.: District Alliance for Safe Housing, Inc. Available at: https://safehousingpartnerships.org/sites/default/files/2017-01/DASH%20Model%20Report_2016.pdf

Nnawulezi, N. A., & Sullivan, C. M. (2014). Oppression within safe spaces: Exploring racial microaggressions within domestic violence shelters. *Journal of Black Psychology, 40*(6), 563–591.

O'Neal, E. N., & Beckman, L. O. (2017). Intersections of race, ethnicity, and gender: Reframing knowledge surrounding barriers to social services among Latina intimate partner violence victims. *Violence Against Women, 23*(5), 643–665.

Potter, H. (2013). Intersectionality and criminology: Gender, race, class and crime. London:Routledge.

Schechter, S. (1982). *Women and male violence: The visions and struggles of the battered women's movement*. Boston: South End.

Serrata, J. & Notario, H. (n.d.). *Trauma-informed principles through a culturally specific lens*. Available for download at: http://nationallatinonetwork.org/images/Trauma-Informed-Principles-through-a-Culturally-Specific-Lens_FINAL.pdf .

Siegel, J. (2013). An expanded approach to batterer intervention programs incorporating neuroscience research. *Trauma, Violence & Abuse, 14*(4), 295–304. https://doi.org/10.1177/1524838013495982.

Smyth, K., Goodman, L., & Glenn, C. (2006). The full-frame approach: A new response to marginalized women left behind by specialized services. *American Journal of Orthopsychiatry, 76*(4), 489–502. https://doi.org/10.1037/0002-9432.76.4.489.

Sokoloff, N. J., & Dupont, I. (2005). Domestic violence at the intersections of race, class, and gender: Challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence Against Women, 11*, 38–64. https://doi.org/10.1177/1077801204271476.

Stith, S., & McCollum, E. (2011). Conjoint treatment of couples who have experienced intimate partner violence. *Aggression and Violent Behavior, 16*(4), 312–318. https://doi.org/10.1016/j.avb.2011.04.012.

Substance Abuse and Mental Health Services Administration (2014). *Trauma- Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57*. HHS Publication No. (SMA) 13–4801. Rockville: Substance Abuse and Mental Health Services Administration.

Sullivan, C. M. (2018). Understanding how domestic violence support services promote survivor well-being: A conceptual model. *Journal of Family Violence, 33*, 123–131.

Thoennes, N., & Pearson, J. (2015). *Fatherhood programs and intimate partner violence*. Philadelphia: Fatherhood Research and Practice Network, Temple University.

Thomas, K. A., Goodman, L., & Putnins, S. (2015). "I have lost everything": Trade-offs of seeking safety from intimate partner violence. *American Journal of Orthopsychiatry, 85*(2), 170–181.

Thomas, K. A., Goodman, L. A., Vainer, E. S., Heimel, D., Barkai, R., & Collins-Gousby, D. (2018a). "No Sacred Cows or Bulls": The Story of the Domestic Violence Program Evaluation and Research Collaborative (DVPERC). *Journal of Family Violence*, 1–13.

Thomas, K. A., Mederos, F., & Rodriguez, G. (2018b). "It shakes you for the rest of your life": Low-income fathers' understanding of domestic violence and its impact on children. *Psychology of Violence*. Advance online publication. https://doi.org/10.1037/vio0000196.

Warshaw, C., Tinnon, E., & Cave, C. (2018). Tools for transformation: Becoming accessible, culturally responsive, and trauma-informed organizations. Washington, D.C.: National Center on Domestic Violence, Trauma & Mental Health. Available for download at: https://www.nationalcenterdvtraumamh.org/2018/04/new-resource-tools-for-transformation-becomingaccessible-culturally-responsive-and-trauma-informed-organizations/. Accessed 1 Sep 2018.

Wies, J. R. (2008). Professionalizing human services: A case of domestic violence shelter advocates. *Human Organization*, 221–233.

Wilson, J. M., Fauci, J. E., & Goodman, L. A. (2015). Bringing trauma-informed practice to domestic violence programs: A qualitative analysis of current approaches. *American Journal of Orthopsychiatry, 85*(6), 586.

Wood, L. (2015). Hoping, empowering, strengthening: Theories used in intimate partner violence advocacy. *Affilia, 30*(3), 286–301. https://doi.org/10.1177/0886109914563157.