

A Paradigm Shift in Batterer Intervention Programming: A Need to Address Unresolved Trauma

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Abstract

Intimate partner violence (IPV) is a significant public health problem affecting women, men, and children across the United States. Batterer intervention programs (BIPs) serve as the primary intervention for men who use violence, employing three primary modalities: psychoeducation, cognitive-behavioral therapy (CBT), and other forms of group therapy such as alcohol or drug treatment. However, research indicates that program effectiveness of the primary BIP modalities is limited, due, in part, to the theoretical underpinnings guiding intervention such as learned behavior (psychoeducation), patriarchy as the root cause (Duluth model), and “dysfunctional” thinking (CBT). Considering the mental, physical, and economic toll of IPV on families and the limited effectiveness of current intervention approaches, an assessment of the strengths and weaknesses of current modalities and an incorporation of the latest science addressing violence prevention and cessation are paramount. This article draws upon existing theories of trauma and the etiologies of violence perpetration and proposes an alternative model of care for men with IPV histories. Experiences of childhood adversity and trauma have well-established associations with a range of negative sequelae, including neurological, cognitive, behavioral, physical, and emotional outcomes. Childhood trauma is also associated with later violence and IPV perpetration. Thus, incorporating trauma-informed care principles and trauma interventions into programming for IPV perpetrators warrants further investigation. Practice and policy implications of a trauma interventions for men with IPV histories, as well as areas for future research, are discussed.

Keywords

batterer intervention program, trauma, adverse childhood experiences, trauma-informed care, trauma intervention

Intimate partner violence (IPV) remains a prominent public health concern in the United States despite decades of research and public policy efforts. Prevalence studies suggest that there are more than 4.2 million violent partner incidents against women annually and an additional 3.2 million against men (Black et al., 2011). Experiences of IPV have been shown to have long-lasting negative impacts on adult victims as well as exposed children, including physical injuries, mental health problems, substance use, and health risk behaviors (Holt, Buckley, & Whelan, 2008; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003; World Health Organization, 2012). One prominent effect of childhood exposure to IPV is an increased risk of later IPV perpetration, suggesting that traumatic experiences are central in the development of violent behaviors (Capaldi, Knoble, Shortt, & Kim, 2012).

As a response, laws have been instituted that require individuals with domestic violence-related convictions to engage in treatment, often referred to as batterer intervention programs (BIPs). However, there are serious concerns about the effectiveness of most BIPs (e.g., Corvo, Dutton, & Chen, 2008;

Feder & Wilson, 2005). In this article, we review the current status of BIPs in the United States, with a focus on the most predominant intervention modalities and their underlying theories. We then review research on trauma and IPV perpetration, drawing from multiple bodies of research to help explain the link between trauma and aggressive and violent behaviors. Finally, we present a framework that draws upon trauma principles to improve BIP effectiveness and better address the needs of men with IPV histories. This analysis focuses primarily on men, given their significantly higher representation in

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BIPs compared to women (Carney & Buttell, 2006); however, this framework is also applicable to women with histories of IPV perpetration.

The State of Batterer Intervention Programming

BIPs are the primary model of care for men who use violence. Nearly, all states in the United States have enacted legislation empowering courts to use BIPs in sentencing, and at least 45 states have created standards to certify BIPs (Price & Rosenbaum, 2009). Despite the substantial role of these programs in addressing IPV perpetration, there is little program oversight at the national level; thus, it is unclear how many programs exist in the United States. Researchers have identified between 2,100 and 2,600 programs in the United States (Dalton, 2007; Price & Rosenbaum, 2009) and over 3,200 in the United States and Canada within the last decade (Cannon, Hamel, Buttell, & Ferriera, 2016).

A national survey of BIPs ($N = 276$) across 45 states found that the majority of programs utilize an open-ended group modality with approximately 10 men per group (Price & Rosenbaum, 2009). On average, program length was 31.5 weeks with sessions lasting approximately 96 min (Price & Rosenbaum, 2009). Ninety percent of the programs utilized a one-size-fits-all model (Price & Rosenbaum, 2009), meaning that few programs tailored intervention to the varying needs of the program participants. The most recent survey of BIPs ($N = 238$) in the United States and Canada reported that 35.6% of programs primarily use the power and control Duluth model, 29.1% primarily used a cognitive-behavioral therapy (CBT) model, and 16.7% utilized a psychoeducational model (Cannon et al., 2016). Only 10.5% of programs used narrative therapy and 8.4% reported using client-centered approaches in a secondary capacity to their overall programmatic approach (Cannon et al., 2016).

Programming Dimensions

BIPs embody two primary components: understanding the definition of abuse and responsibility and teaching alternative reactions and behaviors to men or women who have used violence against their intimate partners, although the approaches across programs vary (Saunders, 2008). Saunders (2008) identified several programmatic dimensions of BIPs that are defined by the underlying assumptions of the etiology of IPV. The predominant dimensions include (1) skills training (e.g., modeling positive behavior) indicating that violence is a socially learned behavior; (2) cognitive restructuring (e.g., identifying, evaluating, and responding to dysfunctional thoughts) to address flawed patterns of thinking and subsequent negative emotions, which lead to violent behavior; (3) resocialization (e.g., considering the limiting effects of strict masculine roles); and (4) accountability awareness (e.g., use of power and control wheel) which assumes that violence is a result of a patriarchal society. Programs typically combine some form of these four dimensions. Far fewer programs employ family

systems therapy (e.g., analyzing family dynamics and communication patterns), which assumes that violence erupts from repeated cycles of conflictual interactions. This modality is most controversial as it applies responsibility to the victim as well as the perpetrator. Finally, even fewer programs employ trauma-based approaches (e.g., recognizing past victimization and building a narrative to cope with previous harm), assuming that unresolved trauma is the foundation of violent behaviors in adulthood (Saunders, 2008).

BIP Effectiveness

Researchers have attempted to answer the primary question in the field of IPV intervention, *Does batterer intervention programming work?* (e.g., Edleson & Syers, 1991; Gondolf, 1999; Saunders, 1996; Tolman & Bennett, 1990). This is a challenging question, given that the research designs used to test BIP effectiveness are plagued by the complexities common to applied research, including but not limited to high attrition rates, inability to randomly assign participants, and lack of equivalent groups (Eckhardt, Murphy, Black, & Suhr, 2006). These methodological limitations likely contribute to an underestimation of program effects. Drawing on the most rigorous studies, results from meta-analyses and reviews are equivocal; however, it is reasonable to conclude that BIP effects are not strong (Eckhardt et al., 2006; Stover, Meadows, & Kaufman, 2009). For example, one of the most favorable reports of BIP effects reported a small to medium effect size ($h = .41$) after examining five quasi-experimental and experimental studies (Davis & Taylor, 1999). Babcock, Green, and Robie (2004) conducted a meta-analysis of quasi-experimental and experimental studies and found similar small to medium effect sizes ranging from $d = .09$ – $.34$ and determined, using the conservative effect size, that men with IPV histories are only 5% less likely to be violent postintervention. Feder and Wilson (2005) conducted a meta-analysis including studies that were quasi-experimental and experimental that established initial equivalence between groups. Findings indicated that intervention had no effect on victims' reports ($d = .01$) and a small effect on police reports ($d = .26$). Overall, it appears that BIPs yield modest effect sizes, but when examining only the most rigorous study designs, the effect sizes are smallest (Eckhardt et al., 2006).

Current Models and Effectiveness

The majority of research has focused on the effectiveness of the Duluth model, the primary model within the psychoeducational framework, and CBT programs, with less research examining alternative forms of intervention. The following is a review of these primary models.

Psychoeducation

Social learning theory (SLT) emerged from observational work in which aggressive behaviors were modeled by adults and, subsequently, adopted by children (Bandura & Barab, 1971).

Stemming from SLT, IPV researchers developed the Intergenerational Transmission of Violence theory (Kalmuss, 1984). Accordingly, a child who witnesses or is directly victimized learns (1) the behavior (e.g., intimidation, physical force) and (2) the positive consequence (e.g., compliance from victim) or negative consequence (e.g., divorce, breakup) resulting from violent behavior. Violence also becomes understood as a social norm, especially within specific circumstances such as abuse of a female spouse (Neighbors et al., 2010). The frequency at which a child witnesses an action and corresponding result influences their likelihood of adopting or learning the behavior (Black et al., 2011). Therefore, it is theorized that children's exposure to family violence that resulted in a positive consequence for the perpetrator would lead them to be more likely to adopt violent behaviors in adulthood (Black et al., 2011). According to this theory, violence is learned and normalized, thus interventionists assert that violence can be unlearned in two ways: observation and negative consequences. For example, if someone observes an influential person modeling non-violence to solve interpersonal problems or uses violence with negative consequences (e.g., arrest), that person could potentially learn new forms of conflict resolution or alter existing outcome expectations, such as understanding that violence often results in negative outcomes.

Duluth model. Pence (1983) developed the Duluth model: a coordinated community response of law enforcement, criminal and civil courts, and human service providers. The core elements of the Duluth model include policies that centralize victim safety and perpetrator accountability, practices and processes that link intervening practitioners and agencies together, tracking and monitoring cases and assessing data, and a system that shifts responsibility for victim safety from the victim to the system (Pence, 1983). The Duluth model relies on basic tenets of the psychoeducational approach with one key difference. The central assumption of the Duluth model is that men with IPV histories are products of a society that teaches them that they are superior (i.e., patriarchy) and, thus, they use violence and other abusive tactics to control their partners. Following from this assumption, the primary intervention technique employed in BIP groups is an educational approach focused on teaching men about their current behaviors and thinking that subjugates women and supplanting these with gender-equitable behaviors and thinking.

Therapy objectives include increasing client responsibility for his behavior, developing alternatives to engaging in violence (e.g., time outs, empathizing, problem-solving, and tension-reducing exercises), challenging gender norms, increasing anger control, developing a personal support system, decreasing dependency on the relationship, increasing understanding of the family and the social facilitators of battering, and increasing identification and expression of all feelings (Pence, 1983). The "power and control wheel," which describes battering behaviors, and the "control log," which challenges belief systems that support those behaviors, are quintessential tools of the Duluth model (Pence, 1983). Much

research has examined the effectiveness of the Duluth model with mixed evidence (e.g., Babcock, Green, & Robie, 2004; Eckhardt et al., 2013); considering the most rigorous studies, outcomes appear modest. For example, in a randomized control trial, Feder and Dugan (2002) randomly assigned men ($N = 404$) either to the Duluth model and probation monitoring group or the probation monitoring only group. Six- and 12-month follow-ups showed similar rates of violence between groups. These results suggest that the Duluth model did not provide any additional effects beyond those derived from probation monitoring.

CBT

Cognitive-behavioral therapists assert that behavior and cognition are closely connected and that altering dysfunctional attitudes, beliefs, and thought processes will change dysfunctional behavior (Allen, MacKenzie, & Hickman, 2001). After identifying "dysfunctional" thinking, CBT-BIPs focus on restructuring one's thinking and developing coping skills to adapt to stressful situations (D. B. Wilson, Bouffard, & Mackenzie, 2005). Results from several randomized control trials indicate that CBT-oriented BIPs were no more or less effective than the other leading intervention approaches (e.g., Duluth), particularly when measuring partner report rather than police report. For example, Dunford (2000) randomly assigned 861 men to one of the following groups: 26-week CBT-BIP, 26-week couples therapy, rigorous monitoring group, or a no-intervention control group. Six- and 12-month follow-ups with their intimate partners showed no differences across groups. Smedslund and colleagues (2011) reviewed six randomized controlled trials of CBT-BIPs and found that only one study reported a statistically significant reduction in violent behavior.

An emerging variant of CBT that has been used in BIPs is moral reconnection therapy (MRT). Developed by Little and Robinson (1988), MRT's primary aim is to increase moral reasoning of offenders as a mechanism to reduce recidivism. To date, it is offered to criminal justice offenders in every state in the United States and in seven countries (Correctional Counseling, 2017). Designed in 12- and 16-step formats, MRT increases moral reasoning by way of confrontation of individual's thoughts and behaviors while participants describe, assess, and criticize their beliefs and attitudes. MRT is delivered in an institution or community setting, twice per week for approximately 1–2 hr per session. Program participants complete exercises and tasks that, for example, reinforce positive behavior and develop positive identity formation and frustration tolerance, using a workbook to help move through the stages of moral development (D. B. Wilson et al., 2005). In a meta-analysis of 33 studies including adult and juvenile criminal justice offender samples, Ferguson and Wormith (2013) examined the effects of MRT on recidivism. Effects were small at 2 ($r = .19$) to 2 years ($r = .15$) postintervention, and the effect sizes were smallest ($r = .11$) when considering only the most rigorous designs (i.e., RCTs; Ferguson & Wormith,

2013). Notably, studies of MRT include “criminal justice offenders” and are not exclusive to men with IPV histories; thus, these results must be interpreted with caution.

Other Therapeutic Approaches

Researchers have found that alcohol or drug (AOD) use is one of the most robust factors related to IPV perpetration (Capaldi et al., 2012); yet, interventions for substance abuse are integrated to varying degrees or not at all in BIPs (McCullum, Stith, Miller, & Ratcliffe, 2011). One study illustrated that AOD perpetrators are more physically violent and psychologically abusive than non-AOD perpetrators and more likely to use severe physical violence (Thomas, Bennett, & Stoops, 2013). Co-occurrence rates are consistently found to be 50% or higher among clinical samples (Kraanen, Scholing, & Emmelkamp, 2010). As a result, substance abuse programs have incorporated IPV intervention strategies or modules with individuals (Kraanen, Vedel, Scholing, & Emmelkamp, 2013) and couples (Klostermann, Kelley, Mignone, Pusateri, & Fals-Stewart, 2010). Literature examining combined AOD-IPV programming lacks rigorous study designs and is plagued with high attrition rates and/or low sample sizes (I. M. Wilson, Graham, & Taft, 2014). Drawing from the most rigorous studies, a systematic review found that combined alcohol and IPV intervention resulted in positive short-term effects compared to standard BIPs; however, these effects were not sustained (I. M. Wilson et al., 2014).

Addressing the Gaps in Batterer Intervention Programming

Despite the strengths of these approaches, there are fundamental theoretical flaws that limit these models from successfully addressing IPV. Below we highlight these flaws and related gaps in batterer intervention programming.

Psychoeducation

Violence as a learned behavior is the basic tenet of psychoeducational models; thus, logic indicates that if men can learn violence then they can “unlearn” it. However, the underlying assumptions of this approach must be qualified. First, the outcomes of children who grow up in violent homes are not determined. In other words, not all children who witness or experience violence grow up to become perpetrators or victims of violence; in fact, some children develop in a resilient fashion despite maltreatment (Cicchetti, 2013). Second, a key assumption of learned behavior is the strong influence of modeling and imitation of an important person (e.g., parent) in childhood. Resting on this assumption, psychoeducation is limited in that the modeling relationship becomes substantially less influential as children age into adulthood (Bandura & Barab, 1971). Thus, modeling new behavior to adults will be less impactful as a mechanism of change.

The Duluth model has faced much criticism over the last several decades with researchers asserting themselves in colorful debates (see Dutton & Corvo, 2006, 2007; Gondolf, 2007). Despite the controversy, two salient points have been raised about the limitations of the Duluth model that cannot be ignored. First and foremost, the central assumption, that men commit IPV as a result of a patriarchal society, has not held up to empirical evidence. A substantial body of research has shown that both men and women have the propensity for violence, and women report the use of violence as much if not more than men (Straus, 2008). Additionally, research on violence among same-sex couples stands in contrast to the central assumption (Messinger, 2014). Finally, not all men have used violence against women; this begs the question: in the same society, how can some men use violence against their partners while others do not? Notably, there is debate over gender symmetry with critics pointing to the oversimplification of rates of violence between gender without consideration of the contextual and sociopolitical experience and consequence of violence (Stark, 2010). To be clear, sex role ideology is an important consideration, however, research has demonstrated that other factors have similar or more substantial effects on IPV perpetration (Stith, Smith, Penn, Ward, & Tritt, 2004). Therefore, employing an intervention approach that reflects the assumption that patriarchy is the primary cause of violence against women undermines important findings in the field and limits advancement for intervention.

Second, Pence and Paymar (1993) conceptualized the victims as the clients, rather than the perpetrators who attend sessions, in order to hold men accountable for their behavior and to empower victimized women. Nevertheless, conceptualizing victims as the clients established adversarial relationships between men and BIP facilitators. This approach runs counter to evidenced-based practices, such as building a working therapeutic alliance with the client (i.e., perpetrator; Murphy & Eckhardt, 2005; Radatz & Wright, 2016). This alliance involves collaboration on treatment goals between the clinician and client and development of a therapeutic bond (Taft & Murphy, 2007). Research revealed the damaging effects on the therapeutic bond resulting from confrontational approaches commonly used in BIPs in the absence of strengths-based or solution-focused frameworks (Holdsworth, Bowen, Brown, & Howat, 2014).

CBT

CBT is founded on the assumptions that cognitions affect behavior, that we can monitor and alter our cognitions, and that if we change our cognitions we can change our behavior (D. B. Wilson et al., 2005). In essence, it is designed to address flawed, “dysfunctional,” or exaggerated thinking that results in undesirable behavior (Allen et al., 2001). Studies in the general population have found that CBT has positive effects on emotion regulation, a higher brain or frontal lobe function (Davidson & McEwen, 2012); however, CBT may not be as effective for areas of the lower brain, particularly the limbic

system that contributes to learned emotional associations. It is the latter point that illuminates the limitation of using solely CBT with men who use violence—it does not address the source of the “dysfunctional” thinking.

Considering the latest research on the developmental effects of early childhood adversity and community violence, cumulative trauma and toxic stress can alter the architecture of the brain and levels of brain chemicals, or neurotransmitters, which can hinder the development of key skills such as emotion regulation and feeling recognition needed to successfully navigate interpersonal relationships (Mitchell et al., 2014; Shonkoff et al., 2012). Unless the underlying issues prompting dysfunctional thinking (such as child abuse or parental abandonment) are addressed, restructuring cognition will remain a superficial intervention. Additionally, MRT, which focuses specifically on moral development, has been criticized based on its limited cultural scope and its heavy reliance on individualism, without taking into consideration poverty, racism, underresourced communities, familial challenges, or problematic relationships with drugs and alcohol (Ferguson & Wormith, 2013).

Other Therapeutic Approaches

Addressing AOD and IPV concurrently has encouraging outcomes (Stover et al., 2009); however, researchers assert that other factors, namely, trauma, may mute the positive effects of these programs, resulting in impermanent effects (Thomas et al., 2013). In a study comparing 247 men with AOD and IPV histories with 524 men with only IPV histories, researchers found that men with both AOD and IPV histories have significantly higher trauma symptoms compared to men without AOD histories (Thomas et al., 2013). Researchers have suggested that addressing underlying trauma with men who have used violence against women, particularly those presenting with histories of substance abuse, is necessary in order for alcohol or IPV interventions to take effect (Thomas et al., 2013).

One-size-fits-all Models

Finally, an ongoing challenge to the implementation of BIPs remains, namely, the lack of amenable program components tailored to the unique profile of the participants (Aaron & Beaulaurier, 2017). In a recent survey of U.S.- and Canada-based BIPs, the majority of the respondents indicated that a one-size-fits-all approach was a limitation of their current state standards and program delivery (Cannon et al., 2016). Furthermore, researchers have argued that the one-size-fits-all approach of arrest and mandated BIPs does not center victim-survivors who want to remain with their partners despite the abuse (Messing, Ward-Lasher, Thaller, & Bagwell-Gray, 2015). Empirically based behavioral and psychological typologies have emerged from the IPV literature, with reports illustrating low-, moderate-, and high-risk profiles (Cavanaugh & Gelles, 2005) and variability in men’s readiness to change (Levesque, Gelles, & Velicer, 2000). Together, this research

suggests that policies and programming have not yet adapted to these empirical findings in the field and represent a significant limitation in program delivery.

Considering the mixed evidence on BIP effectiveness, stemming in part from the limited theoretical underpinnings, and evidence of the profound effects of adverse childhood experiences and trauma, it may be more appropriate to view batterer intervention using a trauma lens. To address the gaps in current interventions, we propose a paradigm shift of batterer intervention programming to a model of care employing trauma principles with men.

Links Between Trauma and IPV

Trauma is defined as an extreme event that overwhelms an individual’s coping skills and threatens their well-being. Traumatic events were traditionally conceptualized to include events “outside of the range of usual human experience,” such as natural disasters, violence, war, or major accidents (American Psychiatric Association, 2013; American Psychological Association, 2017). As this area of study evolved, researchers recognized chronic conditions such as child neglect and poverty as potentially traumatizing (Collins et al., 2010; De Bellis, Hooper, Spratt, & Woolley, 2009). A relatively common assessment of exposure to traumatic and negative events is the Adverse Childhood Experiences (ACE) Scale (Felitti et al., 1998), which has been used among diverse populations to predict health problems, health risk behaviors, and aggressive and violent behaviors (Duke, Pettingell, McMorris, & Borowsky, 2010; Felitti et al., 1998; Nurius, Green, Logan-Greene, & Borja, 2015). ACEs include traumatic events, such as childhood abuse, but also include events that may be difficult and stressful, such as parental substance use, living with a person with mental illness, or divorce. Recent extensions of ACEs include exposures to poverty, community violence, and bullying (Cronholm et al., 2015; Logan-Greene, Kim, & Nurius, 2016).

In most studies, ACE exposures have yielded a predictable “dose response” pattern such that each additional adverse experience yields worsening of outcomes (Kalmakis & Chandler, 2015). Moreover, ACEs are interrelated; experiencing one ACE makes experiencing another more likely, which is also known as cumulative trauma (Felitti et al., 1998). Complex trauma involves individuals who are exposed to repetitive, prolonged, or cumulative traumatic events of an invasive interpersonal nature (e.g., physical or sexual abuse, witnessing domestic violence) occurring during key developmental periods such as childhood or adolescence (Courtois, 2008).

A few studies have examined ACEs among men with IPV histories, with the expected finding of elevated exposures to childhood adversities (e.g., Voith, Anderson, & Cahill, 2017). Whitfield, Anda, Dube, and Felitti (2003) examined the prevalence of childhood exposure to domestic violence, physical abuse, and sexual abuse, finding that exposure to any of these adversities approximately doubled the chances of both IPV perpetration and victimization in adulthood. Another recent

study compared ACEs among men with IPV, nonpartner violence, or nonviolent histories. Researchers found that those with an IPV history had the highest average ACE score than the other two groups as well as the highest risk levels of criminal propensity (Hilton, Ham, & Green, 2016). A tremendous amount of research has linked childhood exposures to abuse and domestic violence with later perpetration of IPV among men (see Capaldi et al., 2012). A smaller body of research has emerged examining more proximal trauma-related variables, particularly post-traumatic stress disorder (PTSD) symptomology, finding an increased risk of IPV perpetration (Hahn, Aldarondo, Silverman, McCormick, & Koenen, 2015), though this research has focused predominately on military or veteran populations (Creech et al., 2017; Taft, Watkins, Stafford, Street, & Monson, 2011). Despite early calls for trauma treatment for men in BIPs (Bell & Orcutt, 2009), the ACE framework has not yet been fully integrated into the IPV practice and research fields with men in the general population.

Effects of Trauma on Men in BIPs

Individual responses to traumatic events can vary widely, with some post-traumatic stress symptomology understood to be normative in the short-term, albeit dysfunctional if unresolved after a few months (van der Kolk, 2003). Symptoms can include intrusive memories or dreams, avoidance of reminders of the trauma, cognitive alternations (such as negative thoughts about the self and the world), and increased physiological arousal (American Psychiatric Association, 2013). These symptoms are understood to have both neurological and psychological etiologies (Shonkoff et al., 2012). Importantly, individuals exposed to cumulative and complex trauma are more vulnerable to toxic stress (prolonged or extreme activation of the body's stress response), which can result in fundamental changes in the brain that can alter cognition and behavior (Briere & Scott, 2015; Martin, Cromer, DePrince, & Freyd, 2013; Shonkoff et al., 2012).

Physical Health: Body and Brain

Recent neurological research has elucidated the processes by which trauma affects the brain. These include changes to the "middle" part of the brain, known as the limbic system, specifically the hippocampus and amygdala, and the "higher" part of the brain involved with executive functioning, known as the prefrontal cortex (Yehuda & LeDoux, 2007). The hippocampus function involves memory and learning, including the differentiation of past and present (Whitlock, Heynen, Shuler, & Bear, 2006). Experiences of trauma appear to reduce both hippocampal volume and activity that can prevent traumatic memories from being effectively processed, which may lead to intrusive thoughts and reexperiencing symptoms (Carrion & Wong, 2012). For men in BIPs, this may materialize as a lack of concentration or short attention spans due to trauma reminders, resulting in low abilities to process and encode new information, and if gone unaddressed, acquire new skills.

The amygdala is also part of the limbic system and serves as an alarm system for the body via mechanisms such as stress and fear. Studies of trauma-exposed individuals found increased amygdala activity in their brains, resulting in heightened fear and hyperarousal (Arnsten, Raskind, Taylor, & Conner, 2015). Should someone be in danger, the amygdala's response is effective; however, extreme or prolonged arousal found with traumatized individuals will challenge their ability to regulate affective states such as anger, anxiety, and sexuality (van der Kolk, 2007) and can lead to an increase in aggressive responses, especially in the context of conflict and stress (Siever, 2008). Thus, men in BIPs may be more vigilant and guarded in their interactions, especially with those of a close and personal nature, due to hyperarousal of stress and fear.

The prefrontal cortex, part of the "higher brain," regulates behavior and emotions, including impulse control and concentration (Arnsten et al., 2015). Traumatic experiences have been linked to diminished prefrontal cortex activity, potentially contributing to impaired cognitive abilities and emotional reasoning (Carrion & Wong, 2012). Men with histories of IPV are likely to have difficulty identifying, expressing, and managing emotions and can become easily overwhelmed in relationships and other domains (e.g., work, school). Lacking impulse control, men in BIPs may have diminished capacities to think through consequences before acting. A constellation of intrusive thoughts, reduced impulse control, impaired cognitive abilities and emotional reasoning, and enhanced fear and arousal enhances the likelihood of an aggressive response. This may be especially true in interpersonal conflicts, such as emotional fights with a romantic partner (Sayers, Farrow, Ross, & Oslin, 2009).

Self-concept

Neurobiological changes as a result of trauma manifest in observable differences in conceptions of self. Early models of trauma responses emphasized changes in schemata, which are broad paradigms that organize views on the self, the world, and others (Piaget, 1971). Horowitz (1986) posited that traumatic events present difficulties in processing because they conflict with preexisting schemata. For example, an individual who has experienced abuse may need to integrate that experience with their assumptive schema that the world is inherently safe (Foa & Rothbaum, 2001), resulting in cognitive conflict as the individual determines whether that initial schema is inherently false. One common resolution to this internal conflict is blaming oneself for the traumatic event, introducing or affirming beliefs that the self is "bad" or "unworthy"; these beliefs are common among individuals who have experienced childhood abuse (McCann & Pearlman, 1990).

More recently, researchers have recognized that children growing up in chaotic and unsafe environments (e.g., abusive or neglectful households) at young ages and for prolonged periods may not initially adopt a schema that the world is inherently safe. Instead, children who develop in the context of ongoing danger, maltreatment, and inadequate caregiving

systems develop schemas that the world is unsafe and that those who care for you are untrustworthy and unreliable (Crittenden, 2006). Nevertheless, at young ages, children are dependent on their caregivers and must develop strategies to adapt to their environment (Crittenden, 2006), which if gone unresolved will continue to evolve with each developmental stage. Martin, Cromer, DePrince, and Freyd (2013) found that children who had higher ACE scores and appraised these experiences as significant betrayals developed negative self-concepts that manifested as symptoms of depression, disassociation, and PTSD in adulthood. Men in BIPs who developed this schema as children in order to survive may grow up feeling powerless and, thus, use violence to feel in control and empowered in their intimate relationships.

Behavior

“Triggers” are defined as stimuli that remind individuals of an earlier trauma and that prompts extreme responses more associated with the traumatic memory than present circumstances (van der Kolk, 1994). A trigger can be a sensory experience, such as a smell, music, or a similar setting to the prior trauma, but it may also be situational. For example, an argument between spouses may be appraised as threatening, triggering physiological symptoms of panic and fear disproportionate to the actual situation (Ehlers & Clark, 2000). Individuals with unprocessed traumatic memories are more likely to respond to ambiguous situations aggressively based on a habituated response to protect the self from further trauma (Chemtob, Roitblat, Hamada, Carlson, & Twentyman, 1988; Hartman & Burgess, 1993). Thus, due to unresolved trauma, men in BIPs may react intensely to seemingly unremarkable stimuli.

Enhancing BIPs to Recognize and Treat Trauma With Men

Due to the prevalence of ACEs among high-risk populations and the resultant negative social, emotional, behavioral, and cognitive sequelae, a trauma lens has been applied to interventions for substance use disorders (Najavits, 2002), sex offenders (J. S. Levenson, Willis, & Prescott, 2015), mental health disorders (Morrissey et al., 2005), incarcerated and formerly incarcerated persons (Miller & Najavits, 2012), among others. Despite the critical shift toward trauma responsiveness in a number of other fields, BIPs have yet to pivot in this direction. Clearly, there is ample research to suggest that trauma and toxic stress are central in the etiology of the perpetration of domestic violence; yet, the deep emotional, physiological, and psychological toll that men carry with them may be difficult to address with solely psychoeducation or cognitive restructuring. In this section, we identify several steps to adapt BIPs that will address this fundamental disconnect. First, we present trauma-informed care (TIC) as a necessary but insufficient guiding principle. We then present two evidenced-based elements of trauma intervention that are vital to fundamentally change violent behaviors with men.

TIC

Elements of TIC stem from the knowledge of (1) the prevalence of childhood adversity among the general population and (2) how these experiences shape an individual’s worldview, themselves, and their relationship to others (Substance Abuse and Mental Health Services Administration, 2015). TIC components include safety, trust, collaboration, choice, and empowerment (J. Levenson, 2017). Each component is necessary to develop a strong therapeutic alliance, a critical factor in treatment progress (J. Levenson, 2017). Also, researchers recommend the provision of comprehensive services, including substance use and mental health treatment for incarcerated or formerly incarcerated persons, urging practitioners that TIC must be tailored to the needs of a given person, demonstrating sensitivity to individual histories of trauma and presenting concerns (Miller & Najavits, 2012; Wallace, Conner, & Dass-Brailsford, 2011).

TIC is a necessary first step for agencies and practitioners working with men in BIPs. TIC involves an organization and treatment plan that understands, recognizes, and responds to the effects of trauma. In other words, with the goal of understanding the etiology of the problematic behavior, TIC transforms the intervention question from *what’s wrong with you?* to *what happened to you?* For example, BIP practitioners could draw from models used with other populations such as sex offenders (e.g., J. Levenson, 2014) and include (1) a trauma-informed comprehensive assessment of a person’s life history and current experience, (2) the development of person-centered treatments based on that trauma-informed life assessment, (3) provision of choice and autonomy on elements of their treatment plan, (4) the use of trauma-informed interviewing techniques such as those embodied by motivational interviewing for all interactions (e.g., intake, group sessions) with men, and (5) a consideration of the role of maladaptive coping mechanisms through a trauma perspective (see Table 1).

Trauma Interventions

It is insufficient to make lasting change with men in BIPs to solely adopt TIC principles. Practitioners must move beyond TIC and shift the paradigm to address unresolved trauma (Siegel, 2013); in essence, moving from the question *what happened to you?* to *what is right about you?* (Harris & Fallott, 2001). Trauma intervention engages the “middle brain” and the “higher brain” using a bottom-up and top-down approach. The current use of solely top-down approaches, such as Duluth (psychoeducation) and CBT, is insufficient (Roberts, McLaughlin, Conron, & Koenen, 2011).

Bottom-up approach. Engaging only the “higher brain” during intervention does not address physiological adaptations to trauma, leaving men vulnerable to continued explosive and aggressive responses when exposed to stimuli their lower brain deems dangerous. The bottom-up approach involves biologically informed interventions that address the physiological

Table 1. Trauma Effects on Men With Histories of Violence and Implications for Trauma Intervention.

Trauma	Effects on Men With Histories of Violence	Trauma-Informed Principles	Trauma Intervention
Childhood exposures to adversity and violence (e.g., child abuse, community violence exposure, and divorce)	Increased likelihood of multiple experiences of childhood trauma and adversity	Conduct an adversity assessment and trauma screening during intake process	Provide person-centered, strengths-based intervention through consideration of individual trauma histories
Neurological and physiological effects of trauma	Increased likelihood of aggression in response to stress due to increased amygdala and decreased prefrontal cortex activities	Create a safe treatment environment via personal space, authentic partnership, and physical space	Address trauma symptoms on neurological and physiological levels through mindfulness practices such as meditation, yoga, and breathing exercises
Cognitive effects of trauma	Increased likelihood of negative schemata related to self, relationships, and others	Offer psychoeducation about the effects of trauma on cognitions associated with violence perpetration	Identify and process unresolved trauma and formerly adaptive thought patterns related to violence perpetration
Emotional and behavioral effects of trauma	Potential to have “triggers” that result in extreme emotional and behavioral responses, such as violence perpetration	Explore and discuss situational or sensory triggers associated with violence perpetration	Develop and practice coping skills to manage emotional and behavioral responses to triggers

elements involved with trauma triggers and hyperarousal (Solomon & Heidi, 2005). This approach will help men connect with what their bodies are feeling and gain a sense of control over their biological rhythms (van der Kolk, 2014). BIPs could incorporate mindfulness, eye movement desensitization and reprocessing (EMDR), yoga, breathing exercises, among other calming techniques. Once men learn to regulate their nervous system activation and address trauma related somatic symptoms, they will be more receptive to top-down approaches.

Although not explicitly using an ACEs framework, several BIPs employing mindfulness have emerged in recent years (e.g., Tollefson & Phillips, 2015; Zarling, Bannon, & Berta, 2017). These programs are grounded in previous research indicating that individuals who engage in aggression have a low awareness of their internal states (Umberson, Anderson, Williams, & Chen, 2003), low tolerance for emotional arousal (Jakupcak, 2003), and underdeveloped skills needed to identify emotions in oneself and others (Gratz, Paulson, Jakupcak, & Tull, 2009; Marshall & Holtzworth-Munroe, 2010). For example, acceptance and commitment therapy (ACT) aims to increase psychological flexibility through present moment awareness, acceptance of difficult emotions or thoughts, decreased attachment to thoughts, perspective-taking, identification of values, and committed action to those values (Zarling et al., 2017). Results from a randomized control trial suggest that men in the ACT treatment group showed significant declines in psychological and physical IPV perpetration compared to the support-and-discussion control group (Zarling, Lawrence, & Marchman, 2015). Although still early, this mindfulness-based program shows promising results.

Top-down approach. Current top-down approaches that engage the “higher brain” must be adapted to help men understand how trauma has affected their self-concept and view of the world

and how that manifests in their behaviors and attitudes. For example, an inherent flaw in CBT techniques used in BIPs will remain without a trauma adaptation. CBT is designed to address flawed, “dysfunctional,” or exaggerated thinking (Allen et al., 2001). However, men exposed to cumulative and complex trauma as children are less likely to develop a safe worldview and to have corresponding adaptive behaviors as a result of untrustworthy caregivers and unsafe environments (Crittenden, 2006), which is indeed “functional” thinking. When a sense of safety and security fails to be established, then children develop feelings of shame and self-hatred and have challenges with self-efficacy and working through interpersonal conflict (van der Kolk, 2007). Thus, CBT practitioners are not correcting “dysfunctional” thinking with men; instead, practitioners must recognize the lack of safety experienced by men and frame their current behaviors as adaptive responses to extremely stressful environments in childhood. Perhaps even more important is that practitioners must recognize that with men who have grown up in toxic environments, there are no preexisting schemata that the world is a safe place and people are inherently trustworthy for men to recall or build upon. Practitioners must work, instead, with the client to establish an entirely new schema from which the client can begin to recover from the harm inflicted upon them as children.

Several fundamental needs must be established in order to address men’s trauma histories: (1) a sense of safety, (2) mutual trust and healthy relational attachment, (3) a capacity for self-reflection and critical thinking, (4) a narrative incorporating past trauma exposure, and (5) a sense of purpose and direction (Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005). These needs can be established by expressing compassion and genuine acceptance of that individual via empathy, positive affirmations, validation of their autonomy, and recognition of their absolute self-worth (Taft & Murphy, 2007). Trauma

intervention calls upon practitioners to bridge trust, demonstrate authentic partnership via shared goal development and prioritization, and employ strengths-based techniques and treatment plans with men (Radatz & Wright, 2016).

Discussion

As the primary model to address IPV cessation, aside from arrest, BIPs play one of the most important roles in ending violence against women. However, the evidence of BIP effectiveness is underwhelming, given the high stakes. Shifting the paradigm to integrate the ACEs and trauma framework will enhance our theoretical understanding of why men use violence and, in turn, change how we intervene (i.e., TIC and trauma intervention). Given the robust body of research and implementation with other populations, applying a trauma lens with men in BIPs shows promise to help end violence against women (see Critical Findings section).

Paradigm shifts are challenging. The IPV field is entrenched in the original conceptualizations of why men use violence, namely, that it is learned and that it is a product of being men in a patriarchal society (Kalmuss, 1984; Pence, 1983). Due to the immense effort and sacrifice required to recognize violence against women legally and culturally (Htun & Weldon, 2012), new discoveries that may advance the field have been cautiously adopted, if at all. In part, this limitation is due to the separation of BIPs from victim and advocate services, which have evolved with the needs of their population. Nevertheless, the slow progress with men who use violence ultimately endangers the lives of women. Shifting the lens through which we understand men's use of violence must happen, but only with careful attention to continued victim protection and advocacy.

Although this article focused primarily on men in BIPs, it is certainly true that boys *and* girls are exposed to cumulative and complex trauma that can lead to victimization and perpetration in adulthood. In homes with strong patriarchal norms, boys and girls learn different adaptive behaviors to survive. For example, research indicates that boys are socialized to express a narrower emotional range than girls, emphasizing mostly anger (Garside & Klimes-Dougan, 2002; Jakupcak, Tull, & Roemer, 2005; Kret & De Gelder, 2012), while girls are socialized to please other people (Gilligan, 1982; Impett, Sorsoli, Schooler, Henson, & Tolman, 2008). These early gender scripts can translate into different adaptive behaviors in childhood and adulthood and may explain why girls/women have higher rates of depression (Pratt & Brody, 2008) and victimization in adolescence (Vagi, Olsen, Basile, & Vivolo-Kantor, 2015) and adulthood (Breiding, Chen, & Black, 2014) compared to boys/men. In homes where gender scripts are less rigid, boys and girls may learn a wider range of adaptive behaviors that they employ for survival, for example, by developing greater verbal capacity in boys, which may protect against aggression; conversely, girls who are exposed to female perpetration may adopt a wider range of aggressive adaptive behaviors for survival (Bennett, Farrington, & Huesmann, 2005). The moderating effect of gender on trauma must be incorporated into the treatment model when working with men and women who perpetrate IPV.

Research Directions

IPV researchers should examine the needs of this population, including mental health (e.g., depression, PTSD), physical health and wellness (e.g., cortisol levels, perceived physical wellness), and conceptualizations of the self (e.g., self-worth) and the world (e.g., attitudes) in order to identify areas of need within this population and explore patterns among men in BIPs. Researcher should also test mechanisms of evidenced-based trauma interventions, such as hippocampal and amygdala activity, with men in BIPs using evidenced-based practices (e.g., mindfulness, EMDR) with rigorous methods, including quasi-experimental designs and randomized controlled trials. Although there are practical barriers to randomized designs in real-world settings, such as those in the criminal justice setting, the field should look to methodological approaches employed in public health that draw from basic and applied research, resulting in successful prevention programs for a number of health issues (Eckhardt et al., 2006). The Medical Research Council has provided a strong framework for developing and evaluating complex interventions, including random and nonrandomized designs using mixed methods that would enhance the rigor of BIP research (Craig et al., 2008; Moore et al., 2015). Trauma-informed practices in BIPs, including organizational changes, knowledge and skill acquisition, and manifestations of trauma intervention (e.g., development of a therapeutic alliance), should be evaluated (see Practice, Policy, and Research Implications of Incorporating Trauma Interventions into BIPs section). Finally, further investigation into underlying pathways leading from childhood trauma to adulthood perpetration of IPV, including environmental factors (e.g., community violence, gang involvement, and prosocial activities) and health factors (e.g., substance abuse), could provide valuable insights for earlier intervention.

Practice and Policy Implications

BIPs providers can begin with a basic awareness of trauma via training and education for program staff and other affiliates, such as probation or parole officers. Training should include information on the prevalence of ACEs in the general and IPV populations; how ACEs then effect men's physiological, cognitive, and behavioral presentations; and how practitioners' own experience with ACEs inform their work in BIPs. Additionally, BIP providers should develop practice standards for assessing and addressing trauma symptoms. For example, existing assessments that could be employed are the Trauma Symptom Inventory (Briere, Elliot, Harris, & Cotman, 1995), ACEs checklist (Felitti et al., 1998), or an extended ACEs checklist (Cronholm et al., 2015; Logan-Greene et al., 2016). To improve upon the significant limitation of the "one-size-fits-all" model, ubiquitous in BIPs (Price & Rosebaum, 2009), programs should utilize these universal screening tools to tailor treatment to the needs of the clients served. For men who screen positively for trauma, trauma treatments with established evidence bases, such as EMDR (Chen, Zhang,

Hu, & Liang, 2015; Shapiro, 1999), mindfulness (Kearney, McDermott, Malte, Martinez, & Simpson, 2013; King et al., 2013), and yoga (Gallegos, Crean, Pigeon, & Heffner, 2017), should be used to guide practice standards (see Practice, Policy, and Research Implications of Incorporating Trauma Interventions into BIPs section). BIPs should employ evidenced-informed, strengths-based techniques such as building a therapeutic alliance (Taft & Murphy, 2007) and motivational interviewing techniques (Stuart et al., 2013). Additionally, national leadership should be convened, such as the roundtable hosted by U.S. Department of Justice Office for Victims of Crime and Office on Violence Against Women in early 2017, to develop BIP curricula using best practices and evidenced-based practices that should be disseminated. Finally, IPV providers, researchers, and policy makers should work with state legislators to incentivize BIPs receiving state funding to seek trauma training, develop TIC practices, and institute trauma intervention into curricula.

Critical Findings

- Batterer intervention programs (BIPs) are the primary interventions for men with histories of intimate partner violence (IPV) in the United States
- Nationally, BIPs implement a variety of group intervention approaches, including psychoeducation, cognitive-behavioral therapy, and other therapy models such as alcohol or drug interventions
- Research on the leading BIP models suggests limited effectiveness in reducing or preventing violence perpetration
- Childhood trauma is associated with a range of negative outcomes, including neurological, cognitive, and emotional changes and later IPV perpetration
- Utilizing trauma-informed care principles and trauma interventions in BIPs may improve program effectiveness and better address needs of men who use violence

Practice, Policy, and Research Implications of Incorporating Trauma Interventions Into BIPs

Practice Implications

- Training and education for batterer intervention program (BIP) providers on trauma among men who use violence
- Developing practice standards for universal screening of and intervention for trauma symptoms among men who use violence

Policy Implications

- Develop standards on trauma-informed practices and trauma intervention curricula in BIPs
- Revise state legislation to incentivize trauma-informed practices and trauma intervention for BIPs receiving state funding

Research Implications

- Test mechanisms of evidenced-based trauma interventions and evaluate trauma-informed practices in BIPs
- Refine understandings of existing associations and underlying pathways between childhood trauma and later violence perpetration

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