**Trauma and Intimate Partner Violence ft. Dr. Casey Taft
June 6, 2024**

***[Scott Tirocchi]***
Well, good afternoon, and welcome to our Justice for Vets webinar.

My name is Scott Tirocchi, and I am the Division Director for All Rise’ Justice for Vets. Cindy League, our training coordinator, is assisting with technical support and webinar logistics.

The Bureau of Justice Assistance is sponsoring today's event, Dr. Casey Taft will be the guest speaker on trauma and intimate partner violence. Before Dr. Taft begins his presentation, and before I share his brief bio, I'd like to review some administrative notes.

Your microphones will be muted during this session. This presentation is 75 minutes long with 60 minutes dedicated to subject content and 15 minutes to questions and answers.

Please place all questions in the Q and A function. Please recognize that your immediate questions may be addressed throughout the webinar and that Dr. Taft will do his utmost to address all remaining questions during the Q and A period.

Please refrain from discussing anything in the Q and A function that detracts from the speaker's presentation.

Although a copy of the PowerPoint will not be available, this webinar in its entirety, including the transcript,

will be uploaded to our website during the week of July 1st, 2024.

Now that covers the administrative notes. I will now introduce Dr. Taft.

Dr. Casey Taft is an internationally recognized psychologist at the National Center for PTSD at VA Boston,

and a professor of psychiatry at Boston University School of Medicine. He has served as principal investigator on numerous funded grants, focusing on understanding and preventing partner violence. He has published over 150 academic articles and an American Psychological Association book on trauma-informed Partner Violence Intervention.

Justice for Vets is so very honored to have Dr. Taft speaking today. Dr. Taft, please take it away.

***[Dr. Casey Taft]***
Thank you, Scott. Hi everyone. Uh, welcome. Thanks for joining us.

So, uh, what I'm gonna talk about today is a little bit on etiology of intimate partner violence with a particular focus on the role of trauma. Um, I'm the developer of the Strength at Home Program, so I'm also gonna be talking about our program and the role that trauma plays. And I'll talk a little, also talk a little bit about, um, the program itself and evidence for the program. So this is an overview of what I'll be discussing.

First, I'm gonna talk about etiology of intimate partner violence, again with a focus on models that take trauma into account. Um, now I'm gonna talk about intimate partner violence intervention a little more broadly. And lastly, I'm gonna go into, uh, Strength at Home, or specifically to give an example of a trauma-informed intimate, um, intimate partner violence intervention.

So let's start with etiology and thinking about why does trauma play such a strong role with respect to intimate partner violence? A lot of the early work and the early, uh, theory that's been done in, um, with, in intimate partner violence, really trying to understand trauma and trauma related problems such as PTSD has been done in military veterans and service members.

Uh, so one of the early kind of ideas which really highlighted the role of trauma and its relationship with aggressive behavior was called the survival mode model. And this survival mode model in the beginning was used to describe, um, reactions that service members had combat veterans, uh, service members in particular

who were deployed to a war zone, who are exposed to combat-related trauma. And the idea was that when a service member is in a warzone, they need to be in this survival mode.

They need to be constantly vigilant to any potential threats in their environment. They need to notice things and see things that other people don't really see. So, their threat response is constantly activated. Um, and it's adaptive when you're in a dangerous area such as a war zone where you see threats that other people might not see. When you're highly vigilant to any potential of anybody doing any kind of harm to you, it may help them stay alive and perform their function in, in the military and keep other people alive.

Um, unfortunately, what sometimes happens with combat veterans when they return home is that it's difficult to turn off these survival mode reactions. So, they tend to go into survival mode in instances where it's not necessarily indicated, it's not necessarily appropriate.

So they might perceive threats that aren't truly realistic threats. They might make negative assumptions about others have an overly hostile attribution bias where they assume that others are trying to do harm to them, uh,

or represent a threat to them. So, they perceive unrealistic threats. They may exhibit an overly hostile appraisal of events and overvalue aggressive responses to those threats.

And unfortunately, also this can carry over into intimate relationships where they make negative assumptions about their partners. They assume their partners aren't on, aren't on their side, or are trying to do harm to them, or are cheating on them, or, uh, otherwise are, are try, are threatening them in some way in terms of their wellbeing or their safety, uh, et cetera.

Um, and this is an idea that was originally developed with service members in mind, but it's also a concept that since we've applied to all different other kinds of populations that have been exposed to trauma. So this idea of being in survival mode actually resonates very well with civilian clients that we work with in Strength at Home, who are living, you know, maybe living, uh, in trauma, trauma kind of exposed areas, right? Areas where there's a lot of violence, inner cities where they're exposed to constant trauma, violence, and potential life threat.

So, they too will describe being in survival mode, whether it's just staying, staying safe in their own kind

of neighborhood or where they live, or they may be in survival mode in different ways. For example, just trying to survive financially or trying to get through their legal situation or, um, custody situation or visitation situation. Seeing kids dealing with courts, uh, all there are all different kinds of reasons why somebody would describe being in that survival mode and being constantly on edge and constantly vigilant to any potential threat and more likely to assume the worst in other people. So this survival mode is really, we can really think of it more broadly beyond just combat veterans in terms of how they react in their relationships and even outside of their relationships with other people.

And how this survival mode idea is relevant is that it really fits in to another model that's been out there for also for many years, looking at intimate partner violence and the role that social information processing plays.

Social information processing models have been used to explain aggressive behavior in children for, for many years. And there's many interventions for kids that are based on the social information processing model. And the basic idea behind the social information processing model is that we take in and we interpret our social world through a series of different stages and trauma can disrupt this, this kind of processing of social information. And people who have problems with violence tend to be more likely to have biases or deficits at each stage of how they're taking in their social world and responding to their social world.

Um, so there's three stages to this social information processing model. The first stage is the decoding stage, and here is where the individual is trying to interpret a conflict situation, or they're trying to interpret a situation that they're dealing with out in the world. And there's a lot of evidence that people who use violence in relationships tend to have biases in terms of how they're decoding situations. They may be more likely to assume the worst in their partners having an overly hostile attribution bias, um, and are therefore more at risk for engaging in partner aggression.

Again, this applies to children too. A lot of research has shown that when children are exposed to violence and abuse growing up, if they grow up in abusive homes when they go to school, for example, they're more likely to assume their peers aren't on their side and may respond aggressively towards their peers or have behavior problems in part because of their trauma and how it impacts their social information processing, more specifically their decoding of social situations.

So how we deal with this in Strength at Home is we try to help our clients better recognize these kind of survival mode reactions they might have, or their negative interpretations of situations that might not be entirely accurate. So, we really want to try to help our clients decode situations and less hostile, uh, less threatening kind of ways.

The next stage of social information processing is the decision skill stage. And here is where the individual is generating responses to deal with a conflict situation. And again, there's evidence that those who have problems with partner aggression tend to have difficulties generating assertive responses to dealing with conflict situations. They, they, they generate more aggressive responses to deal with conflict.

So what we do in Strength at Home is we do a lot of assertiveness training, try to teach them to other alternatives, to aggressive responses with a heavy focus on being more assertive, setting limits and boundaries with other people, uh, communicating their feelings in more forthright but also respectful ways, and also where they're being respectful to themselves by not letting other people mistreat them as well.

The last stage of social information processing, the social information processing model is the enactment stage.

And here is where the individual is enacting the behavior that they've chosen during their decision skills stage.

And here again, people who engage in partner regression tend to have a number of skills deficits and difficulties enacting competent responses to deal with conflict situations.

So here we do a lot of the skills training that, you know, virtually every other program kind of teaches, right?

How to deescalate conflict situations, how to take timeouts, how to express feelings, how to be more assertive, how to handle stress, how to recognize early cues for anger, um, among other kind of skills that we teach how to co how to, um, use relaxation kind of strategies. So, a big focus of our program, as well as most other programs out there are to teach some basic skills to have our clients better, um, better handle conflict situations and enact more competent responses.

So, this is the social information processing model in a nutshell, that has been the basis for a lot of other interventions for children as well as for adults. Um, and our contribution to this model is we've tried to talk more about trauma and bring trauma into the model a bit more.

So, this next diagram shows how this social information processing model is really, you can really think of it as an integrative model, that it brings together a number of different risk factors. So, we know that intimate partner violence perpetration is, uh, multi determined. There's a multifactor factorial, right? There's not only one risk factor that's important for, uh, understanding, uh, intimate partner violence. There's a lot of different risk factors for, for partner aggression.

Uh, and this model really, I think brings together a lot of these different risk factors in an integrative kind

of way, rather than just saying, well, all violence is because of this one core issue or this one theme, or this one reason. We think there are multiple risk factors that are relevant for understanding partner aggression. And of course, everybody's different, different risk factors may be relevant for them.

Um, so this kind of bring this model brings it together in kind of one, one kind of underlying theory that brings together all these risk factors together. So, for example, when we're thinking of decoding skills, uh, if, if the individual has PTSD or problems with anger or a history of traumatic brain injury, substance use, depression, all of these risk factors can influence how we're interpreting situations. The, the our decoding abilities and skills in our relationships. It's gonna affect how we, the assumptions we make, the interpretations we have in terms of our relationship partners.

Similarly, as I'll talk in a little bit more detail in a little while, if you, your client has these core issues related to guilt and shame or power and control, or difficulties trusting other people because of their trauma experiences

or low self-esteem, those also will affect their interpretations. So, part of our goal and part of our role in the IPV intervention work that we do is trying to help our clients better understand which of these risk factors are important for them and how is that affecting their interpretations in their relationships? How is it affecting their thought processes?

And the better they're able to recognize these things, the better they're able to catch themselves. Um, when they're going into kind of a aggressive kind of episode, they, the better they understand themselves, the better they can unlearn some of the problematic things that they've learned. Um, so again, this model helps bring together a lot of ideas that are out there in order to better understand partner aggression.

So I wanna talk a little bit about PTSD specifically. So, it was one of those risk factors in the model that I just showed you. Um, because when we're talking about trauma and risk for I-P-V-P-T-S-D is a pretty important risk factor. Study after study shows PTSD to be very strongly predictive of risk for partner aggression.

Um, when we're thinking of service members in particular, it's interesting that the evidence shows that service members who don't have PTSD are not any more aggressive than civilians. Uh, which is interesting, I think, because sometimes people will ask, you know, how do we know that when we're talking about service members and veterans, that they aren't just more aggressive in general, and that's why they're drawn to the military. Um, but the evidence seems to suggest when a service member or a veteran does not have PTSD, they look pretty much exactly like a civilian looks in terms of their risk for engaging in aggression. However, when they do have PTSD, their risk for partner aggression increases almost threefold.

Um, when we're talking about military veterans in particular, and there hasn't been great research in civilians that's looked at this, but in a, in a nationally representative survey of military veterans that is representative of the general population of, of this was a study of Vietnam veterans. They found that when the veteran had PTSD, that 33% of veterans that were surveyed had engaged in physical aggression towards their partner over the PRI previous year. Um, this was a study conducted back, you know, quite a while ago, published in 1990, um, uh, and when the, the veterans did not have PTSD, their risk for aggression was 13.5%. So, the rates of violence are considerably higher, almost three times higher, if the veteran has PTSD versus if the veteran doesn't have PTSD.

Uh, some years now, my colleagues and I published a meta-analysis that basically summarized all of the research that's ever been con, conducted on this topic, that that has looked at PTSD and it's relationship to partner aggression perpetration. And we've generally found strong relationships between PTSD and risk for both physical aggression as well as psychological aggression. And we found that this relationship is essentially universal. So regardless of whether we're talking about civilians or service members, men or women, essentially any group that you can think of, the relationship is there.

So, I think that's important to keep in mind that when we talk about trauma and violence, this is not just an issue

for military veterans. This is an issue for everyone. You know, anyone who's at risk for trauma, and virtually everyone we see in IPP intervention programs has some form of trauma, virtually just about everybody we see has trauma in, in their past. And so there's this very strong link between PTSD and aggression, regardless of who we're talking about.

So the question then becomes, you know, why is, why, why is PTSD such a strong risk factor for partner aggression? And one way of kind of testing that question really to see, well, why is, you know, why is PTSD such a strong risk factor is to actually look at the symptoms of PTSD. You could kind of get a better idea of what it, what is it about PTSD that leads to risk for partner aggression by looking at the different symptoms and linking them with aggres, aggression. And what we see is when we disaggregate the symptoms of PTSD, there's one set of symptoms that seem to really drive this relationship.

So, um, so looking at the slide here, so there's re-experiencing symptoms of PTSD where the individual is reliving their trauma through intrusive thoughts or, or, um, other memories or nightmares, flashbacks, reliving the trauma, which is, can be very distressing for the individual. And while it is distressing for the individual, it doesn't tend to be a very strong risk factor for aggressive behavior.

Similarly, avoidance and numbing symptoms are also very distressing for the individual. Uh, so symptoms such as avoiding any kind of traumatic reminders, avoiding discussing, uh, trauma related events, um, emotional numbing where the individual feels emotionally kind of cut off from other people, they have difficulties experiencing any kind of feelings, um, which is very devastating for relationships. It's a strong predictor of divorce and unhappiness in relationships when the individual's emotionally numb from their trauma. But again, it's not a very strong predictor of aggression in relationships. It seems to be those hyper arousal symptoms of PTSD, which refer, which reflect an overactive fight or flight response that the individual may have.

Um, hyper vigilance where the person is constantly on guard, constantly on edge. Again, these symptoms that reflect that survival mode, um, that I described earlier, where the person feels constantly on edge, constantly on guard, they're gonna be more likely to make more negative assumptions in conflict situations, assume the worst than other people, and have a more hostile attribution bias. So, this is, this is some evidence to suggest that this

survival mode idea, the social information processing idea may be what's driving this relationship between PTSD and that risk for violence.

To further test this idea, uh, my team and I have done a number of different studies in the VA with, with veterans, with combat veterans in particular, where we looked at lab procedures to try to get at some of these biased ways of thinking that may be affected by PTSD. So, we used a paradigm that's called the articulated thoughts and simulated situations paradigm. It's just a lab paradigm that's commonly used, and historically it's been mostly used with college students to access some of those social information processing biases, those negative ways of thinking that tend to be predictive of violent behavior.

And how this works is you have the individual come into a lab setting, you play different recordings of couples who are in conflict situations that are, it's intended to provoke anger in the person who's listening. And then you ask them to verbalize their thoughts out loud. Then the thoughts that they verbalize are then coded according to this social information processing scheme. And what research has shown, especially in under undergraduates, is that when these thoughts are verbalized, and then they're coded, um, that these social information processing biases that come out of these verbalizations and the coding of these verbalizations are directly predictive of partner aggression outside of the lab setting.

So, um, before we did this research, this has primarily been done exclusively in undergrads, and we wanted to look at this in combat veterans who had PTSD symptoms. And what we found was essentially what we had predicted, and based on the model that I've been describing, when the combat veterans had these higher levels

of hyper arousal symptoms. So, when they tended to be in that survival mode, they had these, uh, social information processing biases, overly negative, overly hostile assumptions and attributions about their relationship partners that predicted their aggression towards their partners outside of the lab.

So, this is just kind of a, a long way of saying we have some lab evidence that this, this model really holds up, that there really is some evidence that this model is, is kind of a, a good, uh, it does help us understand aggressive behavior and why trauma and especially PTSD may lead to that greater risk for aggressive behavior.

Also, many, many years ago now, um, my team and I, we teamed up with a researcher whose name was Amy Holsworth Monroe. Uh, some of you may recognize that name. You know, years ago, she was really the top researcher in the IPV, um, perpetrator area. And she had this large data set that she had gathered for court ordered domestic abusers in Indiana. Um, and I, I asked her if we could partner with her and look at some of her data because I was aware that she had looked at social information processing in her study as well as PTSD. And, uh, I asked if we could look at some of these relationships among some of these variables that we had shown to be relevant in veterans. If we could look at these things in civilians to see if we find the same pattern.

And of course, this model here is way too, um, there's way too many circles and arrows. It's, it's really hard to make heads or tails when you look at this, you know, the, the, the whole model together. Um, but what we, we really focused on primarily is what we circled in orange. And the way the way this study worked was the way these kind of analyses work is we used what's called structural equation modeling that helps you statistically look at interrelationships among different kind of constructs.

So really what's relevant here is what's circled in orange, is that in this study, we found that these civilian abusers, when they had higher levels of PTSD symptoms, they had greater social information processing deficits. And these social information processing deficits predicted their physical and psychological abuse. So again, this is just some evidence that everything that I've been talking about for veterans and service members applies equally well to civilians. So, this is kind of a, again, a universal model. It's been used to explain aggression in children, in veterans, in civilians. So, this is, again, is all to say that this model seems to hold up well, whe, whether we're talking about veterans or civilians.

So, the last thing I wanna talk about when we're talking about etiology of, of intimate partner violence, and especially with the, with respect to the role of trauma, um, many or even most of the clients work with do not necessarily have PTSD. They may not have any diagnosable problem, any diagnosable psych psychiatric issue at all. But virtually everybody we work with has experienced trauma.

Um, in one of one study we did where we, um, did a clinical trial of 120 veterans, every single one of them reported prior trauma, and we didn't screen them in or out if they had trauma or not. It just so happened every single one of the, the clients referred to our program had some reported trauma. So, trauma is ubiquitous, you know, in this population, virtually everybody has trauma and pretty much anybody who's been through significant trauma, you know, for example, if you ask again, a combat veteran who's been deployed to a war zone, if they experienced, you know, has changed them in any way, they'll pretty much all tell you that it has, right? That, that they're not the same person after exposure to violence and trauma as they were before they come back different in some ways. Um, and not everybody who, who experiences trauma, um, not everybody, uh, experiences the same issues, right?

And, and of course there's also something called post-traumatic growth where people who go through trauma may grow from their experience, you know, through overcoming traumatic situations. But sometimes trauma can lead to some problems in folks who are exposed to it in terms of how they view other people, how they view themselves, how they view the world that can underlie not only trauma reactions, but also conflict in their relationships.

So I'm gonna go over a handful of these core themes, which I think is important to consider when we're doing work with OCU violence, because virtually everybody we work with probably has some trauma in their background and probably at least one of these core themes that it would be helpful if they understood it a little better so they can understand how they learn their own abusive behavior, and then we can help them unlearn it.

So, I'm just gonna talk a little bit about issues related to trust, self-esteem, uh, power conflicts and guilt and shame. Um, and for those of you who are familiar with treatments for PTSD, for example, these core themes may look familiar to you. Um, these are all core themes that are often targeted when we're doing trauma-related work. Um, when we're talking about, for example, cognitive processing therapy, one of the most popular interventions for PTSD.

Um, and that's really no mistake because, uh, when I was developing Strength at Home, I was working with some of the leading PTSD, um, program developers, including Patricia Reik, who developed cognitive processing therapy. So, we kind of talked a lot about these ideas about how some of these trauma-related problems can really lead to conflict in problems in relationships. So, I'm just gonna touch on each of them.

So first, with respect to, uh, trust. So for our, our clients, their trauma may have been caused by someone who was supposed to be trustworthy, somebody they thought they could trust. Um, maybe somebody let them down or they felt betrayed by that person. And they, and after that experience, they may feel that they can't trust anyone or that others are out to hurt or betray them. And of course, there's different levels to this.

Um, so again, if we're talking about veterans, we'll, you'll have some veterans who will say, um, you know, I don't, I don't trust anybody. You'll have others who will say, I only trust other veterans. I don't trust civilians and others who will, you know, may trust their partners, but not others. Um, so there's different levels to how this mistrust can generalize, but sometimes it can carry over into relationships. When somebody's experienced trauma, they have difficulties trusting other people, and almost all of our clients will describe difficulties trusting other people.

I'll ask our group, you know, raise your hand if you, you know, have trust issues. And just about everybody will raise their hand just about every time. Uh, and obviously that can lead to problems in relationships. So, if there's severe mistrust in the relationship, our clients may engage in more coercive and controlling kind of behaviors, trying to prevent their partner from betraying them or, or from harming them in some way.

Um, so here we see more coercive control that can escalate to other forms of psychological and physical aggression as well. So, it's very helpful to help our clients understand their own trust, uh, behaviors as it relates to power and control issues. Self-esteem is also very relevant for many of our clients who've, who've experienced trauma. They may blame themselves for trauma that they've experienced, that they were exposed to, uh, if they were abused growing up.

Um, and most of our clients have experienced abuse or witnessed abuse growing up as children. Um, and it does affect the way they feel about themselves. They internalize these messages that they received, and they witnessed and observed growing up. Um, so many of our clients struggle with low self-esteem, and we know that when clients have low self-esteem, they tend to be less secure in their relationship, and they engage in more controlling behavior, again, because they may fear their partner is going to leave them, their partner is gonna find somebody better than them, their partner's gonna realize that they're a failure. Um, so they'll engage in more controlling behavior to keep their partners close and to prevent their partners from leaving them or hurting them in some way.

Or they might engage in more denigrating kind of psychologically abusive behavior. So, their partner isn't feeling better about themselves than the client feels about themselves, right? They might try, if they feel terrible about themselves, they don't want their partner to be feeling good about themselves either.

So, low self-esteem can really manifest, um, in, in abusive behavior in a lot of different kinds of ways. Power conflicts, we know power and control models are really important, um, historically for understanding partner aggression. We also think power and control is obviously a very important core kind of idea.

You know, for our own program and for understanding partner aggression, uh, from a trauma perspective, exposure to trauma may contribute to a profound sense of powerlessness. Uh, when our clients are exposed to significant trauma, they feel powerless about the situation they're dealing with. Oftentimes, they will compensate for these feelings of powerlessness by trying to control those who are closest to them, including family members and relationship partners, which can contribute to power conflicts in relationships.

Uh, if we're talking about, uh, military populations, sometimes there's issues related to, um, power and control messages that are taught with respect to military communication. For example, the idea that one person's giving the orders, one person's always following the orders, you know, where there's a rank and you know, one person may outrank the other person. And of course, in relationships it doesn't work like that, where, where neither one outranks the other person, uh, hopefully.

So sometimes when we're dealing with a military population, we have to talk about military communication, kind of how, what that teaches in terms of, of power conflicts. I also want to talk about, um, the issue of shame. So, our client, many of our clients often experience trauma related shame, um, kind of related to what we were just talking about through, uh, trauma experiences they've had, um, victimization experiences they may have had, things they may have done, um, et cetera. And there's some theorists, anger and aggression theorists and researchers who have long argued that aggression may represent a maladaptive effort to avoid shame and associated feelings of weakness, inferiority, and worthlessness.

So, because shame is such a negative emotion, shame is one of the most aversive feelings there is. And our clients will do anything to avoid feeling that shame and those associated feelings of weakness, inferiority, and worthlessness. So, they may kind of turn it around and project that those feelings outwards in the form of aggression towards other people. Uh, and we also know with this population that shame is, um, often a hindrance to our clients taking responsibility for their abusive behavior, right?

So, anybody who engages and works with those who engage in intimate partner violence knows that this is a population that often doesn't take responsibility for their behavior. They engage in denial and minimization and victim blaming with respect to their abuse. Um, and oftentimes shame is really at the heart of a lot of those kinds of behaviors, right? They feel a lot profound shame for their abusive behavior. So, it makes it hard for them to actually take responsibility for it.

And the more that we shame our clients and the more we label them as batterers or, um, engage in oth, other kind of shaming, you know, confrontational behaviors, often our clients get even more resistant and they take less responsibility and really try to try to convince us that they're not a bad person, right? Like, I'm not really like that. I'm not really a bad person, you know, it's really, it was really her fault, right? Or really what I did wasn't a big deal, or it's really the system's fault, I don't belong here, et cetera. So, a lot of times, you know, I think it's really helpful to think of that from a shame perspective, that shame is at the heart of a lot of that denial and minimization.

So a question that I often ask my clients, especially clients who are engaging in a lot of this denial and minimization, is I'll say, you know, I'll ask, what makes it hard for you to talk about your abuse? What makes it hard to talk about what you did in your relationship? And what I'm hoping for is that the client will be honest and say, um, you know, I grew up with a, an abusive father, right? My father was abusive to me, my father was abusive towards my mother, and I always told myself I wasn't gonna be like him, right? I wasn't gonna be like that. I wasn't gonna be abusive. And here I am, you know, court ordered to this program.

Um, so if you can have them openly talk about how they actually feel really bad for what they did for actually feeling shame and acknowledging that it's hard for them to talk about it, that helps kind of break through some of that denial and minimization and helps them take greater responsibility. Anytime we have the opportunity in this kind of work to have our clients openly talk about their abuse in a way where we're not shaming them, where they feel open to be honest about their abuse and the impacts that it's had, that's gonna really help in increase that responsibility taken.

So, from a trauma-informed perspective, that's a big goal of our program. Strength at Home and other trauma-informed programs is to have create an environment where our clients feel like they can openly talk about their feelings of guilt and shame. They can openly talk about their abuse in a way where they're not shut down, they're not told that they're a bad person, and they're not shamed, uh, by the provider. And that leads to greater responsibility take.

So now I wanna shift gears a little bit and talk about, um, intervention for intimate partner violence. And, and then I will talk more about Strength at Home in particular. So one of the reasons we developed Strength at Home, um, was we were trying to create something that could be considered evidence-based. And initially when we developed Strength at Home, we developed it for military veterans because there had not been any prior clinical trial that had shown any treatment effects in a military population. And even still to this day, Strength at Home is the only program that's been shown through randomized control trials to be effective

for service members or veterans.

There's no other clinical trials that have been shown to be effective even beyond that, even beyond the lack

of evidence for service members and veterans. Um, the evidence suggests that those out there in the world outside of military context, those who receive abuser intervention programs average very small reduction in their recidivism, only 5% reduction in recidivism relative to untreated groups. And a more recent meta-analysis, I think they showed only a 6% reduction in recidivism. Julia Babcock just did a, a, a new Meta-analysis, uh, where she looked at this. Um, so in general, programs show very small treatment effects when they're examined through randomized controlled trials, which is the gold standard for determining if something is effective or not.

And when studies actually use Survivor reports of IPV, the results are even worse.

Um, so one meta-analysis that use Survivor Reports, they looked at all the published studies on the topic that actually use reports from survivors. They actually found no significant reductions in abusive behavior for those who are being ordered to abuse or intervention programs. So, the evidence for the programs that are out there is not good, um, which is not a good situation because hundreds of thousands of people every year are court ordered to these programs. So, we would like to have more confidence that these programs are effective. Uh, and that's why, that's why we develop Strength at Home and try and have been doing research on it, uh, for many years now, including randomized control trials.

Some other limitations of existing interventions is they're often not trauma-informed. Um, and I know trauma-informed is sort of a buzzword these days, and a and a lot of folks claim that what they're doing is trauma-informed. Um, but, but trauma is not necessarily baked into the intervention, you know, in ways that it, that it could be. Or they ignore psychiatric factors such as PTSD that may be relevant.

Uh, many programs are strictly psychoeducational where it's taught like a class instead of something that I think, um, is a little more penetrating, which I think is what we really need. Uh, and that's why from a trauma-informed perspective, we think it's really helpful to have our clients, um, reflect on their own experiences, their histories, their trauma experiences, not as a way to justify abuse. So, we're never justifying abusive behavior and saying, you know, you're only abusive because of your trauma or your trauma cause your abuse. Of course, we never say that, right? Everybody's responsible for their behavior.

Um, but it's very helpful for our clients to better understand their own experiences, how it contributed to problematic things that they've learned. We want them really to reflect deeply on their behavior and where it comes from and how they can unlearn these behaviors. And we don't really think you could do that just from teaching a class. We think you need something that is much more penetrating, where you have clients really think deeply about these issues, challenge each other, support each other in a, in a small group kind of context.

Um, so that's another way that Strength at Home is a little bit different than other programs. We tend to have smaller groups, not large, you know, impersonal groups of like up to 20 people in a room. It's a lot harder to get people to talk about their situations and have everybody participate in these important discussions that we have.

So next I wanna talk about, uh, a little more about the Strength at Home Program specifically. So, Strength at Home was initially developed over 15 years ago, and like I said, initially the program was developed, um, for military veterans through the Department of Defense. We also received funding from the VA. And since then, we've received funding from a lot of other agencies such as the CDC and various foundations. Um, the idea was to create a model program for, uh, partner aggression in service members and veterans. That was initially the idea. And more recently, we've expanded these evaluations to, uh, looking at civilians.

And I'm going to present some of our data where we've been using the program with civilians. Uh, right now we have three ongoing randomized control trials looking at Strength at Home with civilians. Two of them are just about to begin. One has been ongoing. Um, so in the future we're gonna have a lot more data for Strength at Home in civilians, but we do have some initial work from pilot, a pilot study, and some implementation work. Uh, we've been doing. So again, because this model has been shown to apply to every population, whether we're talking about veterans or civilians, um, the program also applies equally well regardless of who we're working with.

And in fact, we use the same exact manual with veterans as we do with civilians. We're not using different manuals for different groups, it's the same manual we use for everybody. So, Strength at Home is for clients who've engaged in physical or psychological partner aggression. These are small close groups that are trauma-informed, informed. So, this is a little bit different from the standard model for, for abuse or intervention programs, which tend to be open groups. We think it's important to have closed groups for a number of different reasons.

Uh, one is because for trauma-exposed, uh, groups such as this, uh, building comradery, building trust is very important, right? If you want folks to be completely honest about their abusive behavior, completely honest about their problems, if you want them to challenge each other, confront each other, support each other, it really helps for them to build that, these relationships over time. And if there's new people coming into the group every week, that makes it a little bit more challenging.

Also, the program is built on what's called the stages of change model, where in early on in the program, we're doing a lot of motivational exercises to get them on board with the program. And as we move through the stages of the program, the group becomes more and more motivated, and we hear less of that denial and minimization and victim blaming.

So, by the time we get to the later sessions, really that's virtually non-existent. Um, so it, it would be very kind of disconcerting, right? If we, you know, you move your folks along in terms of the readiness for change. They're actively working on things, and then somebody brand new comes in and says, I don't belong here. You know, I got a raw deal. It's all my partner's fault. And then it's almost like starting at square one, right? Um, so it really helps to have everybody begin together and end together, and the material really builds on each on itself every week.

So, we work our way up to the higher level teaching of skills, such as how to express feelings better. Um, the program is psychoeducational. So, we definitely do teach skills in the group, uh, but it's also therapeutic in that we really emphasize the importance of relationships in the group, group members supporting each other, group members feeling connected with their group leaders.

When we train providers in Strength at Home, we train them in, um, kind of some of the, the, the, the early kind of ideas and models for understanding how can you facilitate a group that's really change focused, that's really positive, that's really supportive, um, that's really motivational. So, there's a heavy emphasis on motivation and building relationships in a non-shaming environment, because we think that's what's most important, uh, for creating that environment for people wanting to, oh, be totally honest about their, their abuse and change their behavior.

And for that reason, that's why I think that's why we're able to see change in our program over a relatively short period of time, is because of that environment that we're creating. Um, the program has been informed by interventions for both intimate partner violence as well as trauma-related problems. So, when we were developing this program, we were bringing together leaders in IPV as well as trauma and kind of melding together what we thought, what I thought were the most important and impactful components of these programs that were out there, these interventions that were out there and put it together in a, in a trauma-informed and really streamlined kind of way. So that each session is very simple. There's a, and there's a lot of repetition across meetings.

Um, so we're not bombarding folks who have with too many concepts because many of our clients who have trauma histories, who have TBI and PTSD, um, it's, it's really good to have a lot of repetition and simple concepts rather than throwing the kitchen sink at them every week where they're not gonna remember every anything that we talked about by the end of the program, we reach out to the partners or the survivors of the clients in our program at the beginning of the program and at the end of the program, we think this is important as part of, part of a coordinated community effort. Uh, we do safety planning with the partners, give them hotline numbers, provide referrals for mental health services and other support. And of course, we also want to get their per perspective on abuse that may have occurred.

That's also very helpful for our research and our program evaluation. If we want, if we want, uh, accurate reports of abuse, we wanna hear from the survivors, of course, and get any kind of feedback on the program. These are the different, um, stages of the program. Um, early on, and I'll go through this in a little more detail in a moment early on, uh, it's focused mainly on psychoeducation. Some really basic concepts that we want everybody to have. There's a heavy emphasis on motivational interviewing and goal setting, getting folks ready for the program.

Then we move towards conflict management, how to deescalate situations. Then we teach higher level co coping strategies, such as, um, recognizing and correcting survival mode thinking, stress management, relaxation training. And then at the end, we focus on high level communication skills, how to listen better, how to give an assertive message better, how to express feelings. This breaks it down in a little more detail.

So early on, like I said, we use motivational interviewing strategies. So motivational interviewing strategies are a way to move people along in terms of their readiness for change. They've been shown to be effective in a lot of other areas of intervention. So, so for example, during the first session, we do a pros and cons exercise with our group. This is a commonly used motivational strategy. So how we do this is we'll ask the group, well, first we'll tell the group that part of our group philosophy is that abuse is a learned behavior, and it can be unlearned.

So, then we ask the group, how do people learn to be aggressive or abusive in relationships? How is this learned? And usually our group will tell us, uh, well, I, you know, I learned to be more aggressive from my, my, my parents. You know, my father was aggressive, my father was abusive to me, my father was abusive to my mother. And I kind of learned that this is the way to, you know, the way to be in a relationship. So, I didn't really know any better. And we'll say yes, like that is true.

That's one way that people learn to be aggressive or abusive, is by observing it, by experiencing it,

 by it being kind of taught as a normative kind of thing. But another way we learn to be aggressive in relationships is we get rewarded for it, whether we realize it or not, that behavior gets reinforced in some way. And if we weren't getting, if we weren't getting anything from being aggressive in the relationship, we wouldn't be doing it. And we certainly wouldn't continue to do it.

So, we want you to think about what are you actually getting from being aggressive in your relationship? And we'll write this on the board, a pros or benefits side, and a cons or cost side. And I'll actually ask the group, what do you get from being aggressive in your relationship? What are the benefits you receive from that? And usually, at first, the group thinks it's a trick question, right? And they're, they're kind of scared and they'll say, well, there's nothing good about it. You know, they're, they're giving me the response. They think I wanna hear. Like, there's nothing good about being aggressive in a relationship or abusive.

It's, it's, it's all bad. And they'll say, well, I, yeah, like I, yeah, of course you're right. It, it is, it, there's nothing, you know, it's not a good thing. But I want you to really think about what do you get from it. I want you to be totally honest, like with yourself and with the group. And usually the group will come up with a handful of things they'll say in the moment, it's the only way I know how to get my partner to listen to me. Or it's the only way I know how to get my partner to leave me alone is by yelling or hitting something or acting out or lashing out in some way. And usually it's power and control benefits they get from it. Um, I get, I get my way, I get my partner to leave me alone. I feel more powerful. I feel more in control of the situation. Uh, it's the only way I know how to assert myself.

And then we'll ask, what are the negative consequences of being aggressive in your relationship? And that list is of course, much, much longer. And there they'll talk about, um, legal consequences, financial consequences, losing their relationship, becoming homeless, losing custody of their kids, losing visitation of their kids, their kids having problems in school, um, being stigmatized as a batterer. The list goes on and on, and I'm writing down all these responses and having them look at this. And at the end I have them reflect on it. And I ask them, you know, what do you, what do you think? You know, looking at what we wrote down, what you all came up with, what, what, what are your thoughts? And usually they'll say, well, obviously it's not working for us, right? Because there's a lot more constant pros. And the pros are only a handful of things, and they're all short term. So, in the moment you feel more in control, you feel more powerful, you end an argument temporarily, you get your way, but long term, you lose everything, right? You lose all, you know, you lose your marriage, your kids, your relationship, your money, your freedom.

Um, so some of our group members when we're doing this exercise, really seem to have an aha moment. And they realize, okay, well this makes sense. This is why I continue to do it because I'm getting something from it whether I realize it or not, but it's not working for me, right? Uh, because of all, 'cause I'm not getting much and 'cause there's all these negative costs.

So, it's helpful for them to really realize the contingencies that are at play and how their behavior is getting reinforced. And, and then we make the point that in this program, the goal here is to help you get the benefits without the, the cost, without the cons. We can help you feel more in control of yourself, your situation, to get out your feelings better, um, to assert yourself, to set limits and boundaries with other people, um, to communicate your feelings. We can help you get all of these things without being aggressive, without the cons. And that that helps set the stage for the group members being open to hearing about what we have to offer. And we're gonna find a better way for them to handle situations that doesn't have all the costs.

Another, another benefit of this exercise is it helps to set the stage for the group environment that I described earlier, where group members are seeing this is a place where I can be honest and I can openly talk about my own abusive behavior without being shut down, without being labeled, without being, um, kinda shamed in some way. So it's, it's good, it's a good icebreaker exercise for group members to really connect with each other around their problems their abuse has caused. And also to see that this is a place where they can talk about this, where they're not gonna be kind of shamed further than they already feel. So that's just an example of one motivational kind of exercise we use early on.

We also do a lot of goal setting. We ask the group, you know, what do you wanna get outta the group? What are your personal goals? We ask them that a few times during these early meetings. 'cause it's really important for them to have a clear idea of what they want to get outta the group. Um, during these early meetings, we also educate the group about what abuse actually is. You know, different forms of abuse, um, physical, psychological, sexual abuse.

Uh, we go into a lot of detail about psychological abuse, all the different forms of psychological abuse, have our clients acknowledge and talk about what they've done in their relationships. Um, and then we also talk about trauma and those core themes that I mentioned earlier, trust, power and control, guilt and shame, uh, self-esteem, uh, et cetera, to have them really think about for themselves, uh, which themes are relevant for them.

Then we move into conflict management, management stage. We have clients better understand their conflict situations. What are the thoughts and feelings and physical kind of warning signs for their anger and aggression. Um, there's a heavy focus on assertiveness training, how to be more assertive with other people, um, to set limits and boundaries with other people to express how they feel in a more forthright way without keeping in and stuffing all their feelings, which, you know, eventually they will explode and become more aggressive.

Um, we also teach them timeouts during these early sessions to learn how to deescalate a situation to get out of a situation before it gets outta control. Um, the next stage we go over coping strategies, including survival mode thinking, having our clients better recognize their negative interpretations of their partners, developing more realistic appraisals of threat and other people's intentions, uh, coping with stress, uh, relaxation training. And the last several sessions are focused on communication skills.

So we have a session called roots of Your Communication Style, where we have group members reflect on what did they learn growing up about how to handle anger, how to express anger, and how to express other feelings if they're veterans. What did you learn in the military about how to deal with anger and other feelings? And usually the group will, will say that throughout the course of their lives, they were taught to either keep in all of their feelings and stuff, their feelings. You don't talk about feeling hurt or sad or to express it aggressively, um, to go from one extreme to the other and never really to express their feelings more assertively in more kind of pro-social kind of ways. Uh, and then again, we teach them active listening, how to listen better, how to give an assertive message, how to express feelings.

Um, so the, the focus of the later sessions is all on communication. Now we also, so that is stage one of Strength at Home. That's 12 weeks. We also have additional stages that are used, um, with some, in some areas and some states and some jurisdictions with some clients. Uh, so for example, there's a stage two that's an additional eight sessions that gets more into those core themes I was just talking about. There's a stage three, that's an additional six sessions that gets, we're into preventing relapse. There's also a Strength at Home couples version of the program that's more prevention-focused for couples, um, that we're implementing in the VA. And we've implemented it in a lot of different military deletions. So that's more of a prevention program.

Although some people who do our regular Strength at Home program, after they finish that program, then they might wanna do the couples program. So, this is the breakdown for the sessions. Every week we spend it probably about half the session or maybe even more on reviewing practice assignments. Then we introduce some new skill and we do some kind of in session practice and assign them practice for the next week.

So, at the time I have left, I wanna talk a little bit about the research we've done on Strength at Home. Uh, first I'll talk about studies that have been done in service members and veterans. So this was the first clinical trial we published. This was published in the Journal of Clinical Psychiatry. This was a study funded by the Department of Defense. There were 135 veterans who were enrolled in this program. And they received either Strength at Home or what was called enhanced treatment as usual. So enhanced treatment as usual was basically an enhanced version of care that one would receive at the . And, um, most of these clients in enhanced treatment,

as usual, were getting individual therapy. They were seeing an individual therapist, I think it's 80 something percent of clients in the control condition were receiving individual therapy or substance use treatment.

So, the control condition actually was a really strong intervention in and of itself. Uh, almost 60% were court-ordered. And you see the demographic breakdown here. This is, these are the main findings. So overall what we found, and these are rates of recidivism, physical violence, recidivism, uh, at the follow-up time points. And this is based on reports by both the veteran as well as their partner. We use combined reports based on the revised conflict tactic scale. And we wanted to look at yes, no, was, was the client violent towards their partner at each one of these time points.

So, at baseline, virtually everybody had violence, whether they were in Strength at Home or in his treatment as usual. But then we see as we get out to post-treatment, the rates of recidivism went down significantly in Strength at Home. So, the rate of recidivism was essentially cut in half for those who did Strength at Home relative to enhanced treatment as usual. And then we see the rate of violence continue to go down more in Strength at Home than enhanced treatment as usual.

We also looked at psychological abuse and similarly found greater reductions in psychological abuse, in Strength at Home over time compared to enhanced treatment. As usual, we looked at another subscale called restrictive engulfment. Looking at the, this is reflecting coercive controlling kind of behaviors and str the home seems to work especially well in reducing coercive control behaviors. Um, we've published a number of follow-up studies from this sample that we looked at with, um, military veterans. Um, in one follow-up study we sent, we found that those who received Strength at Home showed a 50 56%, uh, less likelihood to engage in physical violence compared to those who didn't receive Strength at Home. So, a 56% reduction in rec recidivism, which compares favorably to the five or 6% reduction in recidivism that the general literature shows.

And we found that those with and without PTSD seemed to benefit from Strength at Home. We published another study where we looked at something called alexithymia. Alexithymia refers to one's ability to identify and express their feelings. And so what we found in this study was that Strength at Home was very effective in reducing ALEXATHYMIA compared to enhanced treatment as usual. So enhanced treatment as usual, alexithymia was essentially unchanged over time, but in Strength at Home it went down substantially suggesting that clients who did Strength at Home may have improved in part, at least in part because they got much better at dealing with their feelings.

Uh, Strength at Home is really the only program that the VA healthcare system endorses as an effective intervention. It's the only program that the VA is supporting and we're in basically all the VAs now. Um, these red dots indicate VA medical centers where Strength at Home is being has been implemented. There's probably a few missing dots here. Um, but this is something we've been doing for several years now. We've trained 152 out of the 166 VAs that are out there. We have 52 master trainers in the program who are spread out all across the country who train new providers all the time in the program. There's been over 1200 clinicians trained. I'm sure at this point more than 3000 veterans have been enrolled in the program. Um, so this is a kind of been a, a large undertaking we've been doing for several years now.

Uh, recently we published a paper in the open-access version of JAMA, where we published some of the results from this implementation in the VA. So, this was data looking at over 1700 veterans, um, as part of this implementation. And what we found was basically what you would expect, we found significant reduction in, um, in, in different types of partner aggression over time for the, these are who are doing strike the home. This is something that we've also found in several studies now where we're also seeing reductions in PTSD symptoms. So this seems to be an additional benefit of Strength at Home.

We're not only reducing their violence and abuse, but we're also reducing PTSD symptoms, which we're very happy to see. Their alcohol problems also tend to go down. So basically, their trauma-related problems also seem to improve when they do Strength at Home.

They also report very high levels of satisfaction when they do the program. So, for example, when our, our, our, when veterans are asked if they would recommend the program to a friend, 82% say yes, definitely 17% say yes, I think so. So, add them up and you get 99% are saying yes, they would recommend the program to a friend. Similarly, when we ask how much the program helped them deal more effectively with their problems, 75% say a great deal. 23% say somewhat. So again, 98% are reporting in the positive direction here, considering most of these clients are court ordered. You know, this was actually pretty surprising to me that we have, you know, in the high 90, you know, percentile, you know, folks who are saying the program is helpful for them.

I'm gonna briefly just go through some of the work we've been doing with civilians. Um, we published one pilot study, uh, where we were looking at court-ordered civilians in Providence, Rhode Island. This was a pilot study funded through NIMH. Um, this is the paper we published from that study. This was a sample of 23 court, court-mandated men in Rhode Island, 87% identified as racial or ethnic minority. The whole sample was low-income. Um, so this is an inner-city sample who had engaged in severe physical aggression. 73% reported the history of severe physical aggression.

So, these are behaviors such as punching, kicking, beating up, uh, choking, um, or, or using a weapon on a partner. So, these are very severe forms of physical violence, so very severe, um, severely violent sample. Almost all of them had been incarcerated for a long period of time. Um, and we wanted to see how to Strength at Home with this population. And what we found was essentially the same as what we've been finding with veterans. Really strong reductions in both physical and psychological abuse.

Another measure of psychological abuse, strong reductions, significant and strong reductions in PTSD symptoms, also in alcohol use problems, and very high satisfaction. Now, this was a hundred percent court-mandated sample, uh, inner-city sample, mostly people of color. And they were reporting very high satisfaction with the program. For, for example, when we asked them if the program helped them deal more effectively with their problem, 100% said yes, a great deal to that question. Um, so the data seemed to be very strong that the program works well with civilians. You know, in addition to, um, to veterans.

More recently we've been doing implementation work with Strength at Home in several counties in New York State. So far we've been in three counties. In New York State, we're about to expand to up to 10 other counties in New York State. This is work funded through the Mother Cabrini Health Foundation as well as an OVW grant. That was, um, that was awarded to folks in Albany, uh, Albany County, the New York State Unified Court System. So, um, or a hundred, and this is just looking at some of the initial data. There's the data is growing, you know, all the time. Um, but here was an initial look at the data of 145 men and 30 women, all who are court-mandated.

And the data look virtually the same as what I just reported for our, all of our other work in civilians and veterans. Significant reductions in physical aggression, significant reductions in psychological abuse, improvements in alexithymia. So, for this civilian group, they seem to improve in their ability to identify and express their feelings. Just like we found in our first clinical trial with veterans reductions in PTSD symptoms, alcohol use problems.

So again, the findings seem to be identical, uh, across these different populations. Also, again, very high program satisfaction ratings, very similar to what we've been finding with other populations with this a hundred percent core ordered sample.

Uh, this is our website, strengthathome.org. If any of you wanna reach me or learn more about the program, one great way to do that is just through the contact link on our website. In the resources tab on our website, there's PDFs of pretty much all of our main clinical trials and the papers that I just reviewed, as well as some other ones. So, if you're interested in learning more about Strength at Home, you can download articles from the resources tab.

Um, so I'm gonna end there. I think we have some time for questions now.

***[Scott Tirocchi]***

Alright, Dr. Taft, thank you. That was absolutely fantastic. Wow. I am gonna go off camera 'cause I have to concentrate on these questions, so are you ready?

***[Dr. Casey Taft]***

I'm ready. Sure.

***[Scott Tirocchi]***
Okay, here we go. What research has been done on individuals who are abusive to their partners, but not because of, or solely because of their PTSD trauma, or TBI, for example, an individual who is abusive in a myriad of ways that are nonviolent, financially, sexually, and after a period of years, they finally take it to the point of violence. In other words, people who would likely have been abusers even if they never had trauma or PTSD, that individual's very hard to find, right?

***[Dr. Casey Taft]***

So in our studies, um, I don't, I have not, I have not encountered any client who does not have, um, of course, who does, who does not have any kind of trauma or past events that affect their ability to trust their power and control issues, their self-esteem, their guilt and shame. I've yet to see a client where, um, none of this is relevant.

Um, but I will say that in our own research, we've looked at folks who have PTSD and don't have PTSD and the program works equally well, whether one has PTSD or not.

So, I just wanna make it clear this isn't a program only for those with PTSD. This is a program for everybody, and it seems to work equally well, regardless of, of who we're talking about.

***[Scott Tirocchi]***

Fantastic. Thank you, sir. Um, was there any difference between the number of partner aggression when looking at non-combat veterans versus combat veterans?

***[Dr. Casey Taft]***

That's a great question, and I don't know that we've looked, we've broken it down in that way. I, I don't think we've had a large enough sample to be able to look at specific subgroups. Um, so I'm not really sure about that. We'd have to go back to the data to look at it. Although, like what I had just said, we did find really no difference between those who had PTSD and those who didn't have PTSD in terms of how they benefited. So that might suggest that regardless of one's level of trauma or PTSD, they may benefit similarly. Um, but, but we haven't specifically looked at that.

***[Scott Tirocchi]***
Okay, thank you. Um, should this program be used in conjunction with batteries intervention program?

***[Dr. Casey Taft]***

So, um, well across the country it's being used, you know, as a quote unquote BATERS intervention program. Um, in most jurisdictions, at least with veterans, um, the courts recognize Strength at Home as an effective intervention, um, and an and a referral that can be made instead of ERs intervention. Um, you know, again, as I mentioned earlier, um, the state of affairs is such that, um, your mainstream programs generally have not been shown to be particularly effective through clinical trials and through, you know, evidence, you know, research evidence. Whereas Strength at Home has, you know, so I would argue, um, it's probably, um, we should be considering, you know, what's been shown to be effective, you know, and, um, try to use evidence-based practice.

So, um, so from my perspective, I would feel more comfortable, you know, with a client who's going into something that's been shown to be effective than something that hasn't been shown to be effective.

***[Scott Tirocchi]***

Here, here, um, next three questions are all, um, actually very similar. And I think you, you did, you definitely addressed this in the, the picture you had the pictograph there, but, um, question was, how can I refer to Strength at Home program for individuals living in Idaho? Is there a Strength at Home program, uh, for folks in living in Nebraska? Uh, and um, so I guess probably the answer to that doc would probably be the website.

***[Dr. Casey Taft]***
Um, I would say, well, first of off, if we're talking about, we're talking about civilians, it's, it's a little bit more difficult, right? If we're talking about, if we're talking about veterans, then, uh, your local VA will have Strength at Home. Every VA has an intimate partner violence coordinator who's in charge of programming. And if they don't have Strength at Home there, then they could, they would still get you access to Strength at Home in another place.

If we're talking about civilians, yeah, I would say contact us through the website, through the contact LinkedIn, the website. And I have, I, we have a roster of providers, civilian providers across the country who've been trained in Strength at Home. So, I would try to link up that individual with a local provider. Um, and if there isn't a local provider, there are folks who deliver Strength at Home virtually, um, who you might be able to join their, their program. Um, most of them are probably in New York State 'cause we're doing this large implementation there, but I would say just reach out to, basically you would be reaching out to me through our website.

***[Scott Tirocchi]***

Very well. Thank you, sir. Um, there, there's several questions actually around, um, how can one become trained in Strength at Home as a facilitator?

***[Dr. Casey Taft]***

Yeah, so, um, I regularly conduct trainings for civilians. So, in the VA we have other trainers who do all the training. So, I, I, we've trained trainers to do that, but in the civilian world, we don't really have all these trainers, so there's really just me. So, um, if anybody's interested in becoming a civilian, uh, provider of Strength at Home, again, you could reach out to me through the website, through the contact link in the website. I usually do trainings every three months or so or so for civilian providers.

Um, there is a small, you know, cost for that and everything. Um, but I offer CEUs and ongoing consultation after the training, so just reach out to me and we can, uh, talk about it.

***[Scott Tirocchi]***

Wonderful, thank you. Speaking of CEUS folks, um, if you, you'll receive a link after this training and, um, it'll provide you with an, uh, an evaluation to do once you do the evaluation. You'll receive, um, uh, CEUs for attending this session today.

Uh, kind of related, uh, another question, uh, I believe you also answered was, um, can this program be delivered in a virtual group format for people living in rural communities, lack of transportation? Can the vet do the program on Zoom?

***[Dr. Casey Taft]***

Yes. Um, so this is something that obviously during covid, right? We all went virtual, and in the VA, we moved everything to virtual. Um, so, and still today, almost all of the, um, Strength at Home programs intervention across the VA has been done virtually. The implementation work we're doing in other places is all being done virtually. So, yeah, that, that is the most common way that we're, um, delivering this.

We have a paper that we're about to submit where we've looked at data, um, from our VA implementation and have found that the virtual delivery of the program works as well and maybe even slightly better than what we have found with in-person delivery of the program. Um, so we finally have, you know, some good data that it, that it still works, doing this, doing this virtually.

So, we're, yeah, we're happy to, um, see that we're also working on developing an app for the program, um, that'll probably be done within a year or so, uh, where that, that'll make it a little easier because one of the, the biggest challenges to virtual delivery of these kinds of programs is having clients do their homework and us knowing whether they're doing it or not, and sharing it back and forth. It's a lot harder to do when things are virtual. Um, but I think the app will help us deal with that a little bit better.

***[Scott Tirocchi]***

Excellent. Um, and then there's the question, and I, I know you addressed this, uh, regarding, is there a Strength at Home follow-up? Uh, I understand it's 12 weeks long, um, but is there beyond that, and I believe you had a slide dedicated to that.

***[Dr. Casey Taft]***

We do, yeah. So, in recent years we've developed a stage two, which is an additional eight weeks and a stage three, which is an additional six weeks. One of the reasons we developed these, you know, additions to Strength at Home was to meet state standards, right? If, if folks, um, you know, needed the program to be a certain length. And also because many of our clients who were doing Strength at Home wanted to continue and they needed, they needed, they felt like they needed more, you know, they didn't wanna end there.

Um, so, um, so yeah, we regularly do stages two and three in the VA; um, and, uh, and the feedback we've gotten has been very positive. It gets more into those core issues, more in depth, into issues of power and control and trust and self-esteem and guilt and shame.

***[Scott Tirocchi]***
Excellent. Is there a cost to participate in the civilian program? I believe they're for referencing.

***[Dr. Casey Taft]***

So, um, well, I guess that depends. That depends on where somebody is. So, so for example, in, in New York State where we're implementing the program, if we're grant funded, there isn't no cost. Um, but otherwise it really depends on where you're receiving it and who's delivering it and what the, what the, what the setup is.

***[Scott Tirocchi]***

Okay. Is any part of the program directed at assisting direct victims of intimate partner violence, or, or are they, or are they as it appears mostly directed to the, at the perpetrators?

***[Dr. Casey Taft]***

So, we do, what we do with, with the survivors is we do outreach and, and link them with, with services. So, we're not doing direct therapy with the partners. That's a little bit outside of our scope, um, but we try to link them up with others who can help them. We, we do, um, safety planning with them. We try to find referrals for them. Uh, even though, um, many states don't actually require that, excuse me, don't, um, require the, um, the partner outreach, we think it's really important, um, to do that regardless of whether, um, whether it's required, you know, in that jurisdiction or not.

***[Scott Tirocchi]***

Excellent. Um, boy, you, you have so many questions here. I'm just trying to make sure that I'm covering all of them and combining a few as we go along.

Um, and, uh, let's see. Does the program focus at all on accepting, respecting their partner's choice if they choose to end the relationship?

***[Dr. Casey Taft]***

Oh, sure. Yeah. I mean, that's often, that's a big, um, discussion point, um, that, that we can't control the other person, that we can only control ourselves, right? And our focus in the program is helping the client focus on themselves and not trying to change their partner or control what their partner does. Um, and same thing for our clients. You know, oftentimes for them the best outcome is getting out of the situation, getting out of the toxic relationship. So that's a discussion that comes, comes up often.

***[Scott Tirocchi]***
Can regular couples therapy be conducted in place of Strength at Home couples track, or is the Strength at Home track more beneficial?

Well, Strength at Home, the Strength at Home couples program is found to be especially helpful for preventing and ending IPV specifically. So, we, I wouldn't recommend couples therapy for couples who are having conflict or any kind of a, a abuse or risk for abuse. Um, so it's certain, um, is not just couples therapy, but it's more how to prevent conflict and how to, you know, understand and prevent abuse in particular.

***[Scott Tirocchi]***

Okay. Thank you. Um, can you mix populations while, while in, when, while in a group setting, for example, can you have, uh, women and men in the same group together?

***[Dr. Casey Taft]***

We don't do that historically. That's not really what's been done, um, for these kinds of programs. There's too much potential for conflict, you know, in, in that kind of environment. So we're, we're, you know, somewhat traditional in that we keep, keep the groups separate.

Um, there's been a handful of cases in the VA where we have had maybe a woman who said, I feel more comfortable in a group of men, and we've made exceptions, you know, in some cases where somebody really wants to do a group with, with, you know, others. Um, so we can be a little flexible, but as a rule, generally not.

***[Scott Tirocchi]***

And is participation at Strength at Home truly voluntary?

***[Dr. Casey Taft]***

Well, it depends. So we get a lot of court-order folks. It depends on, um, yeah, it depends on where we're, you know, how they're being referred. In the VA, we get about 40% who are self-referred, 60% court referred in. The other work we do with, with civilians is almost 100% percent court-ordered, so it's usually not voluntary.

Even if they are coming on their own, usually there's somebody else telling them to come in too.

So even the, the self for people are, aren't coming in completely voluntarily.

***[Scott Tirocchi]***
There's a lot of truth in that one. Um, first of all, I just wanna also say Doc really quickly is that, um, you have so many tremendous comments saying how wonderful the presentation was.

***[Dr. Casey Taft]***
Oh, thank you.

***[Scott Tirocchi]***Um, um, can anyone be an instructor or facilitator, meaning law enforcement, probation officers, or must they be trained of master's level clinicians?

***[Dr. Casey Taft]***

We don't have a specific education requirement. So essentially anybody who is kind of able to do these kinds of programs in the community, um, can be trained in Strength at Home.

***[Scott Tirocchi]***

Wow, that's fantastic.

***[Dr. Casey Taft]***

There, there's obviously issues, right? Like there, there's, there's challenges if you have, uh, probation officers who are delivering the program. And there are also, you know, there, there's that dual relationship issue. So, there are, you know, some are, you know, maybe a little bit, it's a little bit less complicated than, than others, but, um, we don't have specific rules about that.

***[Scott Tirocchi]***

Okay. Is there any research done specifically to address participants with mental health-related issues, schizophrenia, schizoaffective disorder? Um, if so, is there a modification to the program when working with those individuals?

***[Dr. Casey Taft]***

That's a, that's a really good question. There hasn't been any research because we don't get enough of those folks to study. I can, I can tell you anecdotally though, I I have had clients who, um, who may be diagnosed with schizophrenia and because they're doing our program, they, for example, at the end of one of the groups that we did, one of my clients came up to me and he was telling me, I'm hearing my, those voices again, and they're telling me to, to hurt my partner. I don't know what to do.

I've had a number of instances like that where folks who may have had psychotic disorders or more serious mental health problems, um, I was able to help because we didn't exclude them from the group. So, we're very inclusive. We include folks in the group unless there's like a very good reason why we, why we think they just can't benefit from it.

Um, the program is also really built to be as simplified as it possibly can be. So, there's a handful of really important basic concepts and just a lot of repetition. So even if somebody has, you know, severe attentional problems or head injury history or other mental health problems, it might just be one or two concepts that if they can really get, that can make all the difference for them. So, you know, I, I believe the program can be helpful for folks, even if they do have some of these other problems.

***[Scott Tirocchi]***
Excellent. Um, question, personal professional question. Do you work with veterans in federal or state prison?

***[Dr. Casey Taft]***
I do not. Um, I have not worked with folks in prison. Uh, I've, I work with folks, you know, who, who have been incarcerated obviously, but the, and that, that is something that we've been looking into and that there's a lot of interest in trying to deliver the program in an actual prison setting.

So, if anybody has any interest in doing that and you wanna deliver it, you know, in, in that setting, um, or if you wanted, you know, evaluate it or anything like that, definitely reach out to me. Uh, I'd love to get something like that going.

***[Scott Tirocchi]***

That's fantastic. Um, and also within, within the Strength at Home program, is there a separate module, um, that addresses children?

***[Dr. Casey Taft]***

The effects of this on children, We don't have specific modules focused on children. There is a whole separate Strength at Home program that focuses on parenting who, um, my colleague Susanna Creech developed and she just got a large, um, grant from the Department of Defense to do a, a big clinical trial. Um, so I think that would be more appropriate, you know, if we were focused on children or parenting.

Now, of course, the issue of children comes up all the time in our groups, in, in our discussions, you know, many of our topics relate to communication around parenting and, um, visitation and disciplining children. So it's a topic that comes up, but there isn't a specific module on it.

***[Scott Tirocchi]***

Okay. Um, and just two more questions. It looks like, um, those that engage in partner, uh, family strangulation have been shown to have a higher risk of committing a fatality. Um, have you looked at whether the treatment programming has helped reduce risk of lethality? How about Duluth’s model Batter's intervention? Has that been shown to be effective?

***[Dr. Casey Taft]***

So, we haven't done research on lethality just because we're not able to do a large enough study to be able to look at that. As far as I'm aware, none of the clients in any of our studies or implementation has, um, committed, you know, homicide towards their partners. So, it's low base rate events like that are very hard to study, you know, in relatively small clinical trials.

Um, I don't know about Duluth in terms of lethality. I do know in terms of clinical trials, the Duluth program has not been shown to be especially effective.

***[Scott Tirocchi]***

Very well. Um, Dr. Taft, I think that's all we have. Um, folks, I'm gonna apologize if I missed any questions. I really tried to roll them all up and wrap them all up. But, um, Dr. Taft, I, here's where we are right now.

Um, I want to thank you so much for participating, for providing your knowledge to everyone in the field. Um, we hope that everyone listening, I sure sounds, it got a lot out of this. And, um, I want to thank you Dr. Taft, that you do, um, for everyone you are working with. Um, and I also, um, want to thank everyone for being here today and, uh, attending a Justice for Vet's uh, webinar.

So that's it, folks. That's a wrap. Thank you very much again.

And, uh, feel free to email myself or Dr. Taft in the future for any follow-up.