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Reframing domestic violence through a trauma-informed lens: integrative interventions for healing and empowerment

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Abstract. Domestic violence is a pervasive public health and human rights issue that leaves profound psychological, emotional, and physiological impacts on survivors. Traditional intervention models, often grounded in risk assessment and legal protection, may overlook the complex trauma that underpins victim behavior and response. This paper proposes a trauma-informed approach to domestic violence intervention, emphasizing safety, trustworthiness, empowerment, and relational healing. Drawing on theoretical frameworks such as Herman's theory of trauma and recovery and SAMHSA's principles of trauma-informed care, the paper examines how trauma affects survivors' self-regulation, relational patterns, and help-seeking behavior. Through a narrative review of interdisciplinary literature in social work, psychology, and criminal justice, this study identifies key components of trauma-informed intervention—including collaborative safety planning, survivor-centered counseling, and institutional responsiveness. The findings underscore the importance of culturally responsive, community-based interventions that prioritize emotional safety and avoid re-traumatization. The paper concludes with recommendations for integrating trauma-informed principles into practice, policy, and organizational culture, with particular attention to interprofessional collaboration and systemic reform.

Keywords. domestic violence, trauma-informed care, intervention, complex trauma, safety, empowerment, social work, victim support

1. Introduction

Domestic violence remains one of the most pressing and persistent forms of interpersonal trauma, affecting individuals across gender, age, and socio-economic contexts. Far beyond isolated incidents of physical aggression, domestic violence encompasses a pattern of coercive control, emotional abuse, and psychological harm with deep-rooted consequences for survivors' well-being, autonomy, and dignity. As trauma accumulates in such contexts, survivors frequently experience disruptions in self-regulation, identity, and interpersonal trust—areas that are critical to recovery and reintegration. Responding to these complex needs requires more than protective measures or crisis interventions; it necessitates the integration of trauma-informed care (TIC) across the entire continuum of social and health services (Runcan, Runcan, Rad, & Cădariu, 2025; Koss, Wilgus, & Williamsen, 2014).

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Within the field of social work, trauma-informed intervention is not merely a theoretical orientation but a professional and ethical obligation. Social workers operate at the interface between vulnerable populations and institutional systems, where they must navigate the competing demands of safety, empowerment, and systemic accountability. As Viscu and Rad (2025) emphasize, the social worker's responsibility today extends beyond the provision of immediate assistance; it involves fostering environments of relational safety, trust, and long-term psychosocial resilience. In this context, the supervisory process itself becomes a site of ethical reflection and professional development, especially when supervision is grounded in strategic, integrative, and reflective models (Vîșcu & Rad, 2024).

Recent research underscores the centrality of learning organizations in social work institutions, where trauma-sensitive practices, collaborative reflection, and supervision support professional growth and client-centered care (Viscu, Rad, Cadariu, & Pintea, 2025). However, this ideal is often compromised by abusive or poorly structured supervisory practices, which can exacerbate secondary trauma, emotional burnout, and moral injury among practitioners (Viscu & Rad, 2024). These institutional dynamics are particularly detrimental in the context of domestic violence, where practitioners are regularly exposed to narratives of chronic trauma, loss of agency, and structural oppression. A trauma-informed approach to intervention therefore demands internal organizational coherence—not only in therapeutic models, but also in the institutional climate and supervision systems that support frontline professionals (Vîșcu & Rad, 2024).

The COVID-19 pandemic brought additional complexity to the landscape of domestic violence intervention. Lockdowns and remote service delivery led to an increase in violence severity and isolation among survivors, while simultaneously disrupting supervision, peer support, and organizational learning mechanisms (Rad et al., 2024). These disruptions revealed systemic fragilities and underscored the need for resilience-oriented, trauma-informed infrastructures in both practice and training environments. Furthermore, the shift toward digitalization in social work—while offering new tools such as ecological momentary interventions—has introduced fresh ethical challenges related to client privacy, emotional containment, and practitioner readiness (Cadariu & Rad, 2025).

At the psychological level, trauma from domestic violence is deeply entangled with survivors' self-perceptions, relational scripts, and mental well-being. Research by Demeter et al. (2024) and Chiș et al. (2024) illustrates how traits such as self-efficacy, introversion, and emotional reactivity are not only relevant in shaping victim experiences, but also in determining their access to help-seeking behaviors and relational repair. These findings align with earlier trauma research by Koss (1985), who noted that personality and attitudinal dimensions often mediate how survivors navigate both violence and institutional responses.

In parallel, trauma-informed approaches must be situated within a broader interdisciplinary and ethical framework, one that acknowledges social and structural vulnerabilities such as age, gender, economic marginalization, and institutionalization. The work of Gavrilă-Ardelean and Moldovan (2014) has demonstrated that occupational stress and social exclusion, particularly in institutionalized settings, can exacerbate the cycle of violence and retraumatization. In response, educational strategies that enhance social workers' employability and reflexivity—as advocated by Gavrilă-Ardeleana (2016)—become essential tools in building a responsive and ethically grounded workforce.

This paper responds to the urgent need for trauma-informed responses to domestic violence by offering a narrative synthesis of current models, challenges, and opportunities. It integrates research from social work, psychology, and ethics to critically examine how trauma-

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informed care can be ethically implemented at both the individual and systemic levels. Specifically, the review will address (1) the theoretical underpinnings of trauma-informed care in domestic violence contexts, (2) current evidence-based interventions, (3) institutional barriers and supervisory gaps, and (4) future directions for culturally grounded, ethically responsible, and interprofessionally supported care. Through this lens, we argue for a justice-oriented, survivor-centered, and professionally sustainable model of trauma-informed intervention.

2. Conceptual and theoretical background

The experience of domestic violence (DV) is not only an event of interpersonal harm, but also a form of complex, cumulative trauma that disrupts survivors' psychological integrity, physical safety, and social trust. Understanding domestic violence through a trauma-informed lens necessitates a departure from linear, incident-based models of intervention toward frameworks that recognize the chronic nature of victimization, the neurobiological imprint of trauma, and the systemic barriers survivors face in accessing support (Warshaw, Sullivan, & Rivera, 2013; Wilson, Fauci, & Goodman, 2015).

The trauma produced by DV often fits the definition of complex trauma, characterized by exposure to prolonged, repeated interpersonal violence within a caregiving or intimate context. Such trauma typically involves distorted self-concept, difficulties in emotion regulation, and disruptions in attachment patterns—symptoms that mirror post-traumatic stress but extend into the domain of relational and developmental functioning (Melton et al., 2020; Phillips et al., 2021). Survivors may experience intrusive memories, hypervigilance, dissociation, and a persistent sense of powerlessness that can endure long after the abuse has ceased.

These symptoms are compounded by sociocultural and systemic factors, including stigma, economic dependency, and discrimination, which often prevent survivors from seeking help or being believed when they do (Satyen, Rogic, & Supol, 2019). Cross-cultural studies have shown that help-seeking behaviors are shaped by intersecting identities—such as race, gender, migration status, and addiction—which can either facilitate or obstruct access to trauma-informed care (Trabold et al., 2020; Phillips et al., 2021).

In response to the limitations of conventional service models, the trauma-informed care (TIC) framework has emerged as a promising paradigm. TIC is defined by its commitment to six core principles: safety, trustworthiness, peer support, collaboration, empowerment, and cultural humility (Wilson et al., 2015). These principles seek to reverse the dynamics of power and control inherent in abusive relationships and replace them with relationships rooted in mutual respect and attunement.

Trauma-informed interventions do not focus solely on pathology; rather, they prioritize relational repair, survivor agency, and systemic responsiveness. As Warshaw et al. (2013) note, trauma-informed responses must not only be trauma-aware but also trauma-responsive—actively working to avoid re-traumatization through coercive, dismissive, or overly clinical interventions.

However, trauma-informed care is not a one-size-fits-all model. The effectiveness of TIC depends on its cultural adaptability and institutional embedding. For example, survivors from racialized or marginalized groups may require services that acknowledge both individual trauma and structural violence, including racism, xenophobia, and gendered discrimination (Satyen et al., 2019; Runcan et al., 2025).

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Within social work, trauma-informed care intersects with professional ethics, reflective practice, and interdisciplinary collaboration. As Vîșcu and Rad (2024) assert, social workers must navigate a spectrum of responsibilities that extend beyond service delivery to include supervision, organizational learning, and systemic advocacy. Trauma-informed care is therefore not only a clinical imperative but also an ethical one, grounded in respect for the client's autonomy, voice, and lived experience.

Supervision in trauma-sensitive contexts must also be trauma-informed. The emotional toll of working with survivors of chronic interpersonal violence can lead to vicarious trauma, burnout, and moral distress if not supported by reflective and ethically coherent supervisory practices (Viscu & Rad, 2024). Learning organizations, as discussed by Viscu, Rad, Cadariu, and Pintea (2025), can facilitate this support by embedding supervision, continuing education, and peer dialogue into institutional cultures.

Additionally, trauma-informed interventions in DV contexts must embrace psychosocial complexity, particularly when survivors experience overlapping vulnerabilities such as mental health disorders, substance use, or histories of institutionalization (Phillips et al., 2021; Gavrilă-Ardelean & Moldovan, 2014). A trauma-informed social worker must be equipped to recognize and respond to these intersections without resorting to pathologization or disengagement.

Bridging theory and practice requires trauma-informed care to be fully integrated at multiple levels of intervention—individual, relational, organizational, and policy. Cadariu and Rad (2025) propose innovative techniques such as ecological momentary interventions (EMIs), which tailor psychological support in real time, grounded in survivors' lived environments and digital contexts. These methods demonstrate how trauma-informed theory can be extended into responsive, scalable, and individualized interventions that align with the dynamic needs of survivors.

Moreover, as Runcan, Marici, and Rad (2024) argue, trauma-informed systems must be responsive not only to individual distress but also to broader socioeconomic conditions, such as exclusion from education and employment—factors especially relevant for NEET populations and institutionalized youth (Gavrilă-Ardeleana, 2016; Demeter et al., 2024). Trauma, in this view, is not merely an internal disruption but a relational and structural rupture requiring community-based, culturally competent, and ethically accountable repair.

3. Methodology for narrative review

This paper employs a narrative review methodology to synthesize interdisciplinary knowledge on trauma-informed interventions in domestic violence contexts. The narrative approach was selected for its flexibility in integrating diverse theoretical, empirical, and practice-based perspectives from social work, psychology, and trauma studies. Given the complexity and contextual specificity of trauma-informed care, a narrative review allows for critical reflection and the inclusion of both peer-reviewed empirical studies and conceptual contributions relevant to professional ethics, supervision, and institutional dynamics (Warshaw et al., 2013; Vîșcu & Rad, 2024).

The literature was selected based on relevance to trauma-informed responses to domestic violence and included sources published between 2013 and 2025 in English or Romanian. Studies focusing exclusively on criminal justice outcomes without a trauma lens, or addressing trauma unrelated to interpersonal violence, were excluded. Databases searched included Scopus, PubMed, Web of Science, EBSCOhost, and Google Scholar, using Boolean terms such as "domestic violence," "trauma-informed," "intervention," and "social work." The

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final dataset consisted of 47 full-text sources, reviewed and coded through an iterative thematic analysis approach. Themes were guided by trauma-informed principles such as safety, empowerment, and collaboration, while also considering organizational practices, cultural responsiveness, and supervision dynamics (Wilson et al., 2015; Cadariu & Rad, 2025).

This methodology has limitations. It does not include a formal quality appraisal or meta-analysis, and the findings are interpretive rather than generalizable. Language restrictions and selective inclusion of grey literature may limit scope. However, the approach offers a meaningful synthesis of current knowledge and identifies conceptual gaps for future inquiry.

4. Trauma-informed interventions: models and practices

Trauma-informed interventions represent a paradigmatic shift in how professionals respond to the complex and cumulative harm caused by domestic violence. Moving beyond reactive, incident-based service models, trauma-informed care reorients intervention practices toward principles of safety, trustworthiness, empowerment, and collaboration. These principles are not merely ethical imperatives but therapeutic necessities—particularly when survivors of domestic violence have endured prolonged exposure to coercive control, emotional neglect, and relational betrayal. As Wilson, Fauci, and Goodman (2015) emphasize, trauma-informed practice entails not just modifying techniques but transforming the relational and institutional environments in which care is delivered.

At the core of effective trauma-informed intervention is the recognition that healing from domestic violence requires a sense of agency and connection to be gradually restored. This is evident in survivor-centered therapeutic modalities such as Eye Movement Desensitization and Reprocessing (EMDR), trauma-focused cognitive-behavioral therapy (TF-CBT), and compassion-focused interventions, which support the reprocessing of traumatic memories while fostering self-worth and emotional regulation (Gonçalves, Martinho, & Ghafoori, 2024; Steindl, Kirby, & Tellegan, 2018). The use of motivational interviewing within compassion-based therapy has proven particularly valuable in domestic violence contexts, where survivors may vacillate between ambivalence, shame, and the desire for change (Lala & Odedokun, 2025).

Beyond clinical settings, community-based advocacy and shelter models play a crucial role in trauma recovery, offering survivors immediate physical safety, informational support, and a space to rebuild their autonomy. These models often incorporate peer support and empowerment frameworks that counteract the isolation and dependency imposed by abusive relationships. However, as Matsas et al. (2025) note in their development of simulated trauma-informed training for emergency care, the effectiveness of such community-based responses is contingent on how well emergency and frontline personnel are trained to recognize trauma indicators and respond without retraumatizing survivors.

Equally critical are innovations in trauma-informed primary healthcare, particularly for women experiencing the dual burden of domestic violence and chronic health consequences such as traumatic brain injury (TBI). Ivany and Schminkey (2016) argue that the intersection of IPV and TBI remains under-recognized in clinical practice, often leading to misdiagnosis, inadequate referrals, and unintentional retraumatization. The coMforT study led by Pitt et al. (2020) further illustrates the promise of integrated mindfulness-based interventions for survivors, particularly when such interventions are tailored through feasibility trials and refined based on survivor feedback.

Emerging practices in restorative and transformative justice also offer valuable contributions to trauma-informed intervention frameworks. These models emphasize accountability, dialogue, and reparation, rather than punishment alone. When practiced

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ethically and with survivor consent, such approaches may allow for healing of relational rupture and offer an alternative justice process that centers the survivor's voice. However, this requires rigorous facilitation, clear boundaries, and trauma-informed oversight to avoid emotional harm or coercion. The inclusion of compassion-based strategies in work with offenders—particularly those exhibiting tendencies toward violence—has shown promise in interrupting cycles of abuse while supporting internal desistance processes (Emery et al., 2023; Lala & Odedokun, 2025).

Despite these advancements, the implementation of trauma-informed care in domestic violence intervention is fraught with systemic, relational, and ideological challenges. Organizational fragmentation, lack of cross-sector coordination, and insufficient training often hinder the consistent application of trauma-informed principles. Many institutions continue to operate on deficit-based or compliance-driven models, which can retraumatize survivors through impersonal procedures, limited engagement, or judgmental attitudes (Wilson et al., 2015). Moreover, ideological resistance—such as minimization of trauma impacts or prioritization of procedural neutrality—can obstruct the cultural transformation required within justice, health, and social service systems.

The role of practitioners across sectors—social workers, counselors, medical staff, and law enforcement—is pivotal in sustaining trauma-sensitive responses. As Matsas et al. (2025) highlight, effective trauma-informed intervention depends not only on the individual's technical competence but on their relational posture, capacity for empathy, and institutional support. Trauma-informed social work, in particular, requires reflective supervision, organizational learning structures, and continuous training that integrates survivor perspectives and interdisciplinary knowledge.

Recent developments in predictive modeling, such as the use of decision tree approaches to assess recidivism risk in domestic violence offenders, offer promising tools to enhance responsiveness and resource allocation (Wijenayake, Graham, & Christen, 2018). Yet such technologies must be deployed within an ethical framework that ensures transparency, minimizes bias, and prioritizes survivor safety. Data-driven tools must support, rather than replace, the nuanced relational work that defines trauma-informed practice.

In conclusion, trauma-informed interventions in domestic violence are most effective when they are layered, responsive, and grounded in both empirical evidence and survivor-defined values. They must operate across clinical, community, and systemic levels while recognizing that healing is not linear and safety is not merely the absence of violence, but the presence of dignity, agency, and relational trust.

5. Organizational and systemic integration

While individual-level trauma-informed interventions are critical, their effectiveness is significantly shaped by the organizational and systemic environments in which they are delivered. Institutions that serve survivors of domestic violence—such as shelters, hospitals, courts, and social service agencies—can either facilitate healing or perpetuate harm, depending on the extent to which trauma-informed principles are embedded into their culture, training, and operational practices. As Wilson, Fauci, and Goodman (2015) emphasize, it is not sufficient for individuals within an organization to adopt a trauma-informed stance; the entire institutional framework must align with principles of safety, empowerment, trustworthiness, and collaboration.

Frontline professionals, particularly in social work, healthcare, and emergency services, often operate under high-stress conditions while encountering complex trauma cases.

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Without adequate training, support, and supervision, these professionals are at risk of burnout, secondary trauma, and ethical erosion. Vîșcu and Rad (2024) highlight the essential role of reflective supervision in preparing social workers to navigate the emotional labor and ethical tensions inherent in trauma work. Supervision, when rooted in an integrative and strategic model, enables practitioners to maintain professional integrity while sustaining empathy and responsiveness in high-stakes contexts. Conversely, as shown in Viscu and Rad's (2024) work on abusive supervision, toxic or dismissive supervisory practices can replicate the dynamics of control and invalidation experienced by trauma survivors, thereby compromising the quality of care.

In building trauma-informed organizational cultures, institutions must become learning organizations—spaces that prioritize continuous professional development, dialogic learning, and adaptive practice. According to Viscu, Rad, Cadariu, and Pintea (2025), learning organizations in social work are better equipped to respond to the evolving needs of both clients and practitioners, particularly in rapidly changing or uncertain contexts. During the COVID-19 pandemic, for instance, many service providers experienced a breakdown in supervision, communication, and relational coherence. The study by Rad et al. (2024) on workplace learning disruptions in educational counseling highlights how such ruptures can undermine professional resilience and weaken trauma-sensitive practice unless institutions proactively invest in recovery-oriented strategies.

A particularly urgent concern in trauma-informed systems is the risk of re-traumatization, which can occur when survivors encounter cold, bureaucratic, or coercive responses from the very institutions tasked with their protection. Courts that disregard survivors' voices, hospitals that fail to screen for IPV-related injuries, or shelters with rigid and depersonalized rules can all re-enact elements of the original trauma. Ivany and Schminkey (2016) point out that survivors with traumatic brain injury, for example, are often misunderstood or overlooked in healthcare settings, reinforcing their sense of invisibility and helplessness. Likewise, survivors navigating institutional procedures may encounter barriers such as stigma, disbelief, or intrusive assessments that further disempower them.

To mitigate these risks, intersectoral collaboration and integrated care models are essential. Effective trauma-informed systems require coordination between health services, legal systems, advocacy groups, and social work institutions. This collaboration must go beyond referrals and case management; it must involve shared principles, cross-training, and unified trauma-aware protocols. The coMforT study (Pitt et al., 2020) exemplifies such integration by refining mindfulness-based trauma interventions through coordinated research, healthcare delivery, and survivor feedback. Similarly, Emery et al. (2023) underscore the role of protective informal social control and community engagement in sustaining desistance from violence and reinforcing trauma recovery.

Emerging technologies also offer new possibilities for trauma-informed innovation. Cadariu and Rad (2025) introduce ecological momentary interventions (EMIs) as a promising avenue for delivering psychological support in real time, tailored to survivors' immediate environments and emotional states. These digital tools, if ethically designed and supported by human oversight, can enhance accessibility and responsiveness, especially for individuals who face mobility, privacy, or geographical barriers. However, as Runcan et al. (2025) caution in their discussion of AI in social sciences, the implementation of digital solutions must prioritize transparency, ethical safeguards, and user autonomy to avoid depersonalization or unintended harm.

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Digital transformation must also be accompanied by organizational reflection. As shown by Runcan, Marici, and Rad (2024), structurally excluded populations—such as NEET individuals or institutionalized youth—require trauma-informed systems that are culturally competent, socially inclusive, and psychologically attuned. Institutions must be ready to challenge their own biases and redesign processes that inadvertently reproduce harm, especially in the context of complex trauma and intersectional vulnerability (Gavrilă-Ardeleana, 2016; Demeter et al., 2024).

Ultimately, building trauma-informed systems is not a one-time training or policy shift. It is an ongoing organizational transformation that requires ethical leadership, interdisciplinary partnerships, survivor input, and reflective infrastructures. Social workers, emergency personnel, and institutional leaders must be supported through supervision, peer networks, and resource allocation that align with trauma-informed values. Only through such systemic commitment can institutions move beyond crisis management and become true agents of relational healing and social restoration.

6. Discussion

This narrative review has examined the contemporary landscape of trauma-informed interventions in domestic violence, drawing on interdisciplinary research and professional practice frameworks from social work, psychology, healthcare, and justice. A key finding across the literature is that trauma-informed care (TIC) offers a fundamentally different paradigm for addressing domestic violence—one that centers the lived experiences, safety needs, and agency of survivors. Unlike traditional models that focus narrowly on immediate risk management or legal remedies, TIC frames healing as a long-term, relational process requiring institutional accountability, professional reflexivity, and survivor empowerment (Wilson, Fauci, & Goodman, 2015; Warshaw, Sullivan, & Rivera, 2013).

Synthesizing insights from empirical studies and conceptual contributions, this review highlights several critical components of effective trauma-informed intervention. These include the principles of safety, trust, empowerment, and collaboration (Matsas et al., 2025), the integration of survivor-centered therapeutic models such as EMDR and mindfulness (Pitt et al., 2020; Gonçalves et al., 2024), and the importance of organizational learning, supervision, and intersectoral coordination (Vîșcu & Rad, 2024; Viscu et al., 2025). It also emphasizes the value of culturally responsive and community-based responses, particularly in addressing the complex realities faced by survivors with intersecting vulnerabilities such as poverty, disability, or substance use (Phillips et al., 2021; Gavrilă-Ardeleana, 2016; Emery et al., 2023).

Yet, despite its growing prominence in policy and academic discourse, the practical implementation of trauma-informed approaches often lags behind theoretical developments. Many institutions lack the structural readiness or cultural alignment to fully embrace trauma-informed practice. As shown in research on organizational supervision (Viscu & Rad, 2024), trauma-insensitive systems may inadvertently reproduce control, neglect, or invalidation—echoing the very dynamics survivors are seeking to escape. Similarly, poorly supervised practitioners may internalize systemic pressure or emotional fatigue, leading to compromised care and secondary trauma. The COVID-19 pandemic further exposed these systemic vulnerabilities, disrupting workplace learning, reducing peer support, and deepening ethical tensions in professional decision-making (Rad et al., 2024).

This gap between theory and practice is particularly evident in settings such as emergency departments, family courts, and shelters, where institutional procedures often prioritize efficiency, neutrality, or legal compliance over relational safety. As Ivany and

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Schminkey (2016) have shown, survivors with traumatic brain injury may be dismissed or misdiagnosed in clinical settings due to a lack of trauma-informed protocols. Similarly, court procedures that rely heavily on standardized assessments or adversarial language may disempower survivors, especially those navigating long-term trauma, housing instability, or co-occurring disorders (Lala & Odedokun, 2025). These systemic shortcomings underscore the need for comprehensive, context-sensitive training and policy reform.

For survivors, the implications of trauma-informed practice are significant. When delivered with fidelity and sensitivity, trauma-informed care can facilitate not only symptom reduction but also the restoration of agency, dignity, and relational trust. Survivor-centered models provide an alternative to pathologizing or deficit-based narratives, instead validating the strength and adaptability of individuals navigating complex trauma (Gonçalves et al., 2024; Koss, Wilgus, & Williamsen, 2014). Additionally, community engagement and informal protective networks—such as those identified by Emery et al. (2023) in Nepal—can reinforce the protective factors that support both trauma recovery and desistance from violence.

For practitioners, trauma-informed care demands both technical competence and emotional literacy. Social workers, counselors, nurses, and law enforcement officers must be equipped not only with trauma theory but with skills in emotional regulation, active listening, and reflective decision-making. This is where the supervisory environment becomes critical. As shown by Vîșcu and Rad (2024), reflective supervision can serve as a buffer against moral distress and as a catalyst for ethical growth, while abusive or absent supervision risks entrenching practitioner disengagement and survivor retraumatization.

For policymakers, the findings of this review call for a multi-level investment in trauma-informed systems. This includes the development of trauma-informed organizational standards, funding for cross-sector training initiatives, survivor participation in program design, and the scaling of innovations such as ecological momentary interventions (Cadariu & Rad, 2025). Technology must be used with caution and integrity. Predictive models such as those proposed by Wijenayake et al. (2018) for assessing recidivism must be embedded in ethical frameworks that ensure transparency, equity, and survivor safety.

Ethically, trauma-informed care challenges institutions to rethink power, voice, and participation. It requires a move from paternalism to partnership, from crisis response to structural prevention. The ethical foundations of trauma-informed work lie in affirming survivors' humanity, restoring relational justice, and creating systems that do no further harm. As Runcan et al. (2025) note, this also includes a critical interrogation of how research, digital tools, and institutional norms shape the possibilities of care. Trauma-informed interventions must not only be effective but equitable—recognizing that trauma is both an individual and a collective experience, shaped by social determinants and historical injustices.

Bridging the gap between trauma-informed theory and systemic practice is an urgent task for the fields of social work, health, and justice. It requires the co-creation of knowledge and care, where survivors are not merely recipients but agents of change; where practitioners are supported, not burdened; and where institutions are transformed, not merely trained. This vision, though complex, is the ethical horizon of trauma-informed intervention.

7. Conclusion and future directions

Trauma-informed care (TIC) has emerged as a transformative framework in the response to domestic violence (DV), offering both theoretical richness and practical tools for addressing the complex, enduring impacts of trauma. This narrative review underscores the critical necessity of TIC across systems of care, criminal justice, and community support. By

centering safety, trust, empowerment, and collaboration, trauma-informed approaches provide a counter-narrative to institutional practices that have historically retraumatized survivors or rendered their experiences invisible (Wilson, Fauci, & Goodman, 2015; Warshaw, Sullivan, & Rivera, 2013).

The review contributes to theoretical development by bridging trauma theory, desistance research, and systems thinking within a coherent model that recognizes both individual healing and structural change. It also advances professional practice by mapping out effective models of intervention—from survivor-centered therapies such as EMDR and compassion-focused care (Gonçalves et al., 2024; Lala & Odedokun, 2025), to interdisciplinary collaborations and digitally mediated care (Cadariu & Rad, 2025). The role of reflective supervision, organizational culture, and ethical accountability has been especially emphasized, providing a multidimensional view of what sustainable, survivor-oriented care entails (Vîșcu & Rad, 2024; Runcan et al., 2025).

Looking forward, several directions for research, policy, and practice are imperative. First, longitudinal and intersectional studies are needed to better understand the long-term trajectories of healing and re-victimization across diverse populations. Current knowledge is limited by cross-sectional data and a lack of culturally nuanced frameworks. Research that includes Indigenous, migrant, LGBTQ+, and neurodivergent survivors will deepen the inclusivity and relevance of trauma-informed models (Satyen et al., 2019; Phillips et al., 2021).

Second, there is a pressing need for survivor-informed policy design. Survivors should not merely be consulted but positioned as co-creators in the development of services, evaluation tools, and safety protocols. This participatory ethos can shift the moral center of DV interventions from institutional protectionism to relational justice and lived expertise (Koss, Wilgus, & Williamsen, 2014; Goodman et al., 2015).

Third, the field must invest in globally relevant and culturally grounded TIC models. As shown by studies from Nepal and other non-Western contexts (Emery et al., 2023), informal social networks, spiritual practices, and community-based interventions may hold significant protective power. Western-centric models must be critically examined and adapted to reflect diverse epistemologies, care traditions, and social conditions.

Finally, there is a clear call for structured, trauma-informed training and evaluation frameworks for professionals across health, social services, and justice. These frameworks should move beyond knowledge transmission toward embodied, reflective practice that prioritizes emotional intelligence, ethical clarity, and institutional coherence. As proposed in recent works on digital integration (Rad et al., 2024; Runcan et al., 2023), emerging tools like ecological momentary interventions and network-based support systems offer promising avenues—but they must be assessed rigorously and deployed ethically.

In conclusion, trauma-informed care is more than a clinical trend or policy directive; it is a paradigm of social and relational ethics. It affirms that how we respond to violence matters—not just in the moment of crisis, but in the long arc of recovery and social reintegration. Building trauma-informed systems requires more than good intentions—it demands sustained commitment, structural change, and shared accountability. Only by centering survivor voice, practitioner well-being, and institutional reform can the promise of trauma-informed intervention be fully realized.

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