

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Website

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PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

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INTERPERSONAL VIOLENCE

CHAPTER 5

Issues of Loss and Grief

JUDITH L. M. MCCOYD AND LISA LÓPEZ LEVERS

Although the world is full of suffering, it is full also of the overcoming of it.
—Helen Keller (1880–1968)

CHAPTER OVERVIEW

This chapter focuses on understanding issues of loss and grief as well as their intersections with trauma experiences. It examines the classical theories associated with loss and grief, describing the transition to a postmodern perspective of how grief is experienced. The chapter describes interventions that can be used with clients experiencing loss and grief, along with the counseling implications. Practice-based resources are available online.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Describe how loss, grief, and trauma are interwoven constructs;
2. Identify a variety of theories associated with grief;
3. Comprehend the implications of complicated bereavement as a traumatic experience;
4. Understand how to help clients make meaning out of loss and grief; and,
5. Identify clinical interventions that are most likely to be effective in the face of loss and grief.

INTRODUCTION

Not all experiences of loss and grief necessarily involve trauma; however, loss, grief, and destabilization are implicit aspects of all types of trauma. This chapter explicates loss and grief contextually and illuminates their centrality to the experience of trauma. We explain the rejection of stage theories of grief and the embrace of postmodern grief concepts that allow culturally sensitive and tailored treatment for those who are bereaved or traumatized. We hope that this chapter enables clinicians to understand the many ways that individuals experience grief, influenced by biological responses to stress, by psychological responses to loss in the face of previous attachments, by social norms and support networks, by cultural attitudes, and by spiritual frameworks. Grief, like trauma, can only be fully understood through a truly bio-psycho-social-spiritual perspective. We expect that the intertwined nature of trauma and loss is clear: losses of people, ideals, and things often are traumatic in the intensity of the loss; trauma always entails a loss of the assumptive world (Beder, 2004) in ways that destabilize just as loss does. We anticipate that clinicians will learn to help mourners make meaning of their losses and validate their experiences of loss. We envision clinicians who are client centered rather than advocates of a particular grief model, and who therefore help mourners process their losses and traumas in a manner tailored to their needs. Clinicians must help mourners explore their (often-changed) assumptions about how the world works, their new identities in the face of the loss, and subsequently help them learn more about themselves and their “fit” in the world. This chapter aims to introduce concepts of loss and grief, describe the phenomenology of loss and grief, and explicate counseling

of loss and grief, describe the phenomenology of loss and grief, and explore counseling implications. These main sections are followed by a summary of the chapter and an online list of helpful resources for students, clinicians, and instructors.

LOSS, GRIEF, AND TRAUMA

Loss and trauma are intimately interwoven. Loss can occur whenever there is a change in one's world, even with a happy occasion like having a baby (e.g., losses of free time, sleep, intimacy with one's partner). Although losses can span benign through painful events, trauma always carries with it a sense of loss, and usually subsequent grief. When one experiences a traumatic event, such as sexual or physical assault, the losses inevitably include one's sense of safety, self-efficacy, and trust in the world as a good place. Trauma can be interwoven with loss also, as when one loses a loved one in an unexpected or otherwise traumatic manner.

Yet, loss is at the heart of life and growth. This seems a bit paradoxical; however, the reality is that new life, change, and forward movement only come as a result of losing (changing) a prior lifestyle, behavior pattern, or other functioning of the status quo. Trauma and loss both entail a destabilizing set of forces that can leave people in a vulnerable state, questioning their assumptions about the way the world works and their place in it. Reworking one's assumptions about the way the world works and one's identity in that world are a part of negotiating loss. Both trauma and loss open people to the possibility of growth as they process their response to the loss or trauma. Posttraumatic growth (Tedeschi & Calhoun, 2004) is possible after both trauma and traumatic losses. Clinicians who strive to assist clients in their growth must be aware that losses and trauma work involve helping clients to recognize their losses and trauma as valid and grief provoking. Although grief does not follow any set pattern, assisting grievers of loss and trauma involves helping them recognize the value of what they have lost (whether a person, job, or sense of themselves as safe and loved). Once able to recognize the value of what was lost, a critical next step in treatment is telling the story of the trauma or loss until clients develop some sense of meaning and continuity in their life story. Re-building a sense of safety and connection is a third goal that applies to clients who have experienced trauma or loss. In short, there is tremendous overlap in the experience of loss and trauma and the treatment of both.

Three editions of a seminal text on *Grief and Loss Across the Lifespan* (McCoyd et al., 2021) focused on loss as a normative, though destabilizing, experience and process. Loss is customary, though upsetting, and it promotes self-reflection and growth, particularly when the mourner's experience is validated and supported. We view normative losses as those that are relatively common in each age group, although not necessarily experienced by each individual of that age. These types of losses receive little support, precisely for the reason that they are considered "fairly normal." Of course, "normative" becomes an especially interesting concept in the face of trauma.

Whether "normative" in the sociological sense of an event happening (or not) to a large proportion of people, loss and trauma tend to lead individuals to feel that their world is no longer safe, that the person who they have been is changed on some intrinsic level, and that the trust they had in the world to be predictable has disappeared. Work with clients mourning loss and/or trauma is therefore aimed at helping to ameliorate those distressing thoughts and feelings by helping the griever to develop a sense of safety again, assess their identity in light of the loss, and work to help the griever identify what helps them feel the world to be predictable again. Here, we discuss the constructs of loss and grief in light of a normative, growth orientation, while also attending to the implications of complicated bereavement as this may relate to traumatic experiences.

PHENOMENOLOGY OF LOSS AND GRIEF

Loss and trauma are emotionally painful. This is the basic phenomenology of grief. When we lose a person, possession, characteristic, or environment that is important to us, we grieve. When trauma assaults us with feelings of threat, uncertainty, and being overwhelmed, we grieve for our loss of a sense of safety. Nevertheless, losses of various types are a part of human existence and not pathological states. We believe that these loss states can produce

human existence and not pathological states. We believe that these loss states can produce growth and insight, with or without professional help, though we also believe that most people process losses more easily when they talk with someone. It is notable that some early work examining the impact of adverse childhood events (ACEs) asserts that having two to three of the ACEs may actually promote better coping as an adult (Seery et al., 2010). Although complicated grief reactions exist (Shear, 2015), we also are aware that people have experienced losses since the beginning of humankind, but that grief therapy has existed for only a little over a century. We write from the perspective of clinicians who fully believe in the power of most human beings to manage their grief responses, while also believing that grief counseling allows clinicians to be present with people as they make this journey in ways that are beneficial and promote the most growth and insight. In this section, we examine the phenomenology of loss and grief through discussions of grief theory and transition to postmodern grief theory.

Classical Grief Theory

Classical grief theory arises from the work of Sigmund Freud, evolving into a task-based set of theories that includes subsequent work by other theorists and researchers (e.g., Lindemann, 1944; Worden, 2018). Also arising from classical origins is the parallel set of stage-oriented grief theories (e.g., Bowlby, 1980/1998; Kübler-Ross, 1969). In the remaining parts of this section, we review the implications of these task-based and stage-oriented theories of grief.

Classical Grief Theory and the Implications of Task-Based Grief

According to Freud (Freud, 1917/1957), "Mourning is regularly the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, an ideal, and so on" (p. 243). He proposed that griever have one task, to decathect (remove emotional energy) from the lost entity. Freud's theory of behavior states that the psyche "cathects" people and loved entities with libidinal energy that must be withdrawn for a mourner to heal after loss. He believed that people experiencing melancholia had not successfully withdrawn the libidinal energy (cathexis) and needed help to do this. Freud was one of the first to address grief, melancholia, and mourning in a scholarly manner. He also contributed the understanding that mourning can occur for things, values, and statuses and does not only occur in response to a death. He also assured that grief and mourning are "not pathological" but goes on to say:

This demand (to decathect libidinal drive) arouses understandable opposition—it is a matter of general observation that people never willingly abandon a libidinal position, not even, indeed, when a substitution is already beckoning to them. This opposition can be so intense that a turning away from reality takes place. (Freud, 1917/1957, p. 244)

Freud allowed for the possibility of psychotic (turning away from reality) thoughts, feelings, and behaviors as an understandable (and normal) reaction to loss. He asserted (Freud, 1917/1957) that mourning is only completed when the ego becomes free by virtue of decathecting libido from the lost love object and re-cathecting a new love object. He suggested that this generally takes about a year. As a person of Jewish heritage, despite his skepticism of religious belief and practice, he may have internalized the traditional year of mourning that is accepted and ritualized in the Jewish faith.

Freud's was the primary theoretical paradigm for early grief-work efforts. Usually couched in the language of "letting go," counselors have long held to the idea that a mourner must separate from their attachment to the lost entity, and this continues to be a theme running through clinicians' "practice wisdom," despite the development of new theoretical understandings of loss and grief that better explain the process of grief.

Some of the first empirical work to explore the grieving process was done by Lindemann (1944). He studied the responses of people following the Cocoanut Grove nightclub fire in Boston in November 1942 (where many young adults died suddenly), thereby precluding anticipatory grief as a factor that might change mourners' responses. Trauma theory had not

yet developed and was not incorporated into his theory about grieving and loss. He theorized that grief normally includes somatic distress, preoccupation with the deceased, guilt, and sometimes hostile reactions. He asserted that eight to ten sessions with a psychiatrist over the course of a month and a half were sufficient to manage grief work (Lindemann, 1944). As an assertion based on research rather than theoretical speculation, this met with widespread acceptance. He believed that tasks of grief must be accomplished, but moved beyond Freud's two tasks of decathexis and recathexis. He postulated the following tasks:

1. Emancipation from bondage to the deceased;
2. Readjustment to the environment in which the deceased is missing; and,
3. Formulation of new relationships.

Although step 1 mirrored decathexis and step 3 mirrored recathexis, Lindemann (1944) contributed the idea that this was not a totally interior, psychological process. He acknowledged through step 2 that bereft individuals live in a social world and that they must adjust to a world that no longer has their loved one living in it. His unfortunate claim of a 4- to 6-week time frame meant that mourners who wanted to be perceived as healthy would avoid grief expression after 4 to 6 weeks. Another unfortunate consequence of Lindemann's study was that grief-work clinicians began to view grief that lasted much longer as pathological in some way. However, Lindemann contributed to our understanding by asserting that distressing symptoms experienced by bereaved people are quite customary, and he expected that the social world has an impact on grief. Simos (1979), a social worker who recognized the limitations of task- and stage-centered grief theories, said, "Anyone who took longer than the prescribed number of weeks to get over a loss was considered maladjusted and treated as emotionally disturbed. Thus, the helping professionals themselves became deterrents to the proper working through of grief" (p. 41).

Most recently, Worden (2018) refined his task-based grief theory and intervention framework. Worden's model includes the following steps:

1. Accept the reality of the loss;
2. Process the pain of the grief;
3. Adjust to a world without the deceased; and,
4. Find a way to remember the deceased while embarking on the rest of one's journey through life.

Worden (2018) originally required experiencing the pain of the grief as the second task, adding the experience of emotional ventilation, something that recently has become known as the grief-work hypothesis. Many embraced Worden's and others' suggestion that emotional ventilation (e.g., crying, mourning, anger) needed to be expressed before one could begin to heal from a significant loss. The implication is that if this type of ventilation did not occur, and if the person were seemingly healthy, the attachment to the lost one must not have been that strong. This has been found to be inaccurate in multiple studies (e.g., Bonanno, 2009; Carr et al., 2006; Konigsberg, 2011; Stroebe & Stroebe, 1991; Wortman & Silver, 2001), which reveal that a significant group of bereaved people actually become worse if emotional ventilation is pushed on them. Worden revised this task to require processing the pain of grief, and to recognize that people do this in a variety of ways. Worden also revised task 4 to allow for recognition that a relationship with the deceased continues in a modified manner—a major step forward in grief work and grief theory.

Freud depathologized grief, and the other task-based theorists helped to explicate what tasks the bereaved needed to accomplish to heal. Yet these tasks could imply an oversimplified "cookie-cutter" type of intervention. Worden (2018) has greatly refined his text to incorporate recognition of mediators of the grief response, criteria for assessing problematic grief, and a model for intervening.

ary and the Implications of Stage-Oriented Grief Theory

Kübler-Ross (1969) was, like Lindemann (1944), more interested in empirical data than

Kubler-Ross (1969) was, like Lindemann (1944), more interested in empirical data than theorizing. She is known as a leader in the field of death and dying, yet her classic stages have been applied to a population that is different from the population she researched. She lived through the societal transition from when people died at home surrounded by family to when people died in hospitals, often with little information about the true status of their prognosis. As part of a seminar on death and dying at Chicago Theological Seminary, she and her students began interviewing dying people about their beliefs and experiences. Her book, *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy and Their Own Families* (1969), was the source of the now widely reified stages of denial and isolation, anger, bargaining, depression, and acceptance. Her stages of adjustment to a terminal diagnosis are now inaccurately applied to all types of losses, despite their development from an anticipated loss of self after critical illness (M. Stroebe et al., 2017).

The stage of denial is particularly misunderstood. Kübler-Ross (1969) originally conceptualized it as a stage during which the diagnosed would “shop around” to ensure an accurate diagnosis or express hopes that the testing results and terminal diagnosis were incorrect. She viewed this as a “healthy way of dealing with the uncomfortable and painful situation with which these patients have to live for a long time” (p. 39). It is unfortunate that this stage has been misinterpreted widely and misapplied in grief counseling. It often has been viewed as a stage to be “broken through” or confronted, with counselors often applying draconian methods to ensure that denial is not maintained in connection with a death loss. This assertive confrontation of denial has become one of the suspect interventions associated with early grief-work counseling. Yet, in trauma work, denial often is encountered as a tendency to deny the impact of the trauma; individuals are ready to dismiss the impact of trauma without spending much time actually processing the events. One development in trauma work with veterans is to use flooding techniques to have the veteran grapple with the impact of the trauma (Foa & Meadows, 1997). We have come to learn that gently and firmly encouraging re-processing and re-telling of the story is helpful for people experiencing trauma and/or grief.

The fact that denial is viewed as a stage to get through, rather than as the protective adjustment time that Kübler-Ross described, reveals one of the difficulties of stage theories more generally. Individuals, both the bereaved and less reflective clinicians as well, can view these models as a recipe, an intervention plan to be applied with a broad sweep. This assumes a one-size-fits-all quality to mourning. It also implies that knowledge of the stages allows one to move more quickly through them, which is a fallacy with major implications.

Kübler-Ross's (1969) model of moving from this protective denial to a state of anger and irritation (in her study, often directed at caregivers) is usually viewed as a one-way journey. Her original conception involves movement through the stages rather than the back-and-forth or recursive movement seen most commonly among the bereaved. Despite some few who continue to adhere to “stages of grief” that are inaccurate (see M. Stroebe et al., 2017) for the problems of this approach, clinicians must interrogate the model, both because it does not fit empirical data, but also because it implies one-size-fits-all, and anyone with even a bit of cultural humility understands that each person's grief is influenced and made unique by the multiple intersectional identity and contextual factors that affect the griever.

A second classic stage theory grows from the empirical data of Bowlby (1980/1998), who followed children separated from their parents in war-torn countries during World War II. He later studied widows (and a few widowers) and found similar responses. He postulated the following stages:

- **Numbness:** Defined as being shocked and stunned, not as denial; Bowlby identified the protective nature of this stage.
- **Separation Anxiety (yearning/searching):** Defined as an alternating state of despair and denial, with anger folded in, much like that found in children separated from parents. He believed pathological grief is characterized by being stuck in one of these modes—either yearning, or angry and detached, an assertion supported by Shear's work (2015). Bowlby (1980/1998) noted the following:

Thus anger is seen as an intelligible constituent of the urgent though fruitless effort a

Thus anger is seen as an intelligible constituent of the urgent though fruitless effort a bereaved person is making to restore the bond that has been severed. So long as anger continues, it seems, loss is not being accepted as permanent and hope is still lingering on. (p. 91)

- **Despair and Disorganization:** As the loss sinks in, there is an attempt to recognize the loss and develop a "new normal." It is a time of lost objects (e.g., keys or other personal items) as well as lost thoughts and lost time.
- **Acquisition of New Roles/Reorganization:** When the bereaved relinquishes attempts at preparing for the deceased's return (e.g., gets rid of clothes) and moves into new aspects of life and relationships with others, the bereaved is viewed as moving through reorganization.

Bowlby's (1980/1998) stages mirror what he recognized in children—they yearn and pine for their parent(s) when separated. He theorized that the attachment style that the child exhibited (secure, anxious, avoidant) would influence the impact of the loss, and that children who were less secure in their attachments would be more likely to exhibit anxious or detached feelings when experiencing a loss. He and others have speculated that these influences carry on into adulthood, with adults playing out their reactions to loss via one of the attachment styles. This is an important conceptualization, with current research actively exploring its basis ([Fraley & Shaver, 1999](#); [Kominsky & Jordan, 2016](#); [Zech & Arnold, 2011](#)). Yet, it does not incorporate the reality that bereaved individuals experience a sense of uncertainty about what the future holds, a legitimate uncertainty that is intensified by trauma, as many of the plans for the future change abruptly as a result of loss and separation. This uncertainty itself may provoke anxious behavior ([Hirsh et al., 2012](#)) and is an attempt to defend against attachments that may leave the individual open for more emotional distress if circumstances change once again.

Despite the general critique of most stage theory due to its lock-step, one-size-fits-all approach, [Maciejewski et al. \(2007\)](#) found some support for Bowlby's stages, though [Roy-Byrne and Shear \(2007\)](#), "Comment," para. 1) asserted that the authors had "overstated their findings" and that they "drew oversimplified conclusions that reinforce formulaic, unhelpful ways of thinking about bereavement." Concerns remain about stage theories and their susceptibility for being approached as a recipe for grief work. Again, our position is that no model can fit all people's grief experience and their need for tailored support. Newer postmodern theories provide conceptual tools allowing clinicians to better tailor treatments to the unique experiences of individuals experiencing trauma and/or grief.

A recent classic comes from the work of [Rando \(1993\)](#). Rando asserts that individuals move through similar general phases that are fairly universal and chronological. Each phase incorporates "processes" or tasks that she asserts are the outcome of a healthy grieving process. Her model (1993, p. 45) is prescriptive in that it describes a process bereaved people must participate in to proceed toward healing. Using [Rando's \(1993\)](#) terminology for the phases and processes, we offer brief descriptions of each in the following:

■ **Avoidance Phase:**

1. Recognize the loss. The bereaved must acknowledge and understand the reality of the death.

■ **Confrontation Phase:**

2. React to the separation. The bereaved must experience the pain of the loss, give it expression, and mourn secondary losses.
3. Recollect and re-experience the deceased and the relationship. The bereaved is to review and remember the relationship realistically and also review and re-experience the feelings they had as a result of that relationship.
4. Relinquish the old attachments to the deceased and to the old assumptive world. The bereaved is to let go of previous bonds and beliefs and develop a "new normal" with new relationships and attachments.

■ **Accommodation Phase:**

5. Readjust to move adaptively into the new world without forgetting the old. The bereaved

5. Readjust to move adaptively into the new world without forgetting the old. The bereaved is to revise their assumptive world, develop a new relationship with the deceased, adopt new ways of being in the world, and form a new identity.
6. Reinvest. This is a time to invest in new relationships and roles and indicates a resolution to active grieving.

Rando (1993) provides a model with a bit more room for individualized tailoring of the treatment process. It has an inherent assumption that complicated grief is common and requires treatment when grief is deemed to be too extended, too brief (or absent), or when it does not follow the typical trajectory. Despite Rando's obvious compassion and concern for bereaved people, her model is subject to some of the same criticisms as the other models: These models are viewed as normative in a way that means that any deviation from the models is viewed as pathological. In a postmodern world of intersectional identities and multiple cultural contexts, grief theory had to evolve to better capture the multitudinous experiences of human life. Nevertheless, recent work has identified complicated grief as a specific disorder of grief found in about 7% to 10% of griever, often connected with intense, long-term relationships or with traumatic loss and benefiting from a specialized approach to grief therapy (Iglewicz et al., 2020). Complicated grief is characterized by continuing intense feelings of longing/yearning, rumination on the deceased (or lost entity), sometimes avoidance of discussing the loss, and ongoing inability to begin re-engaging with customary life. We discuss treatment of complicated grief in the Intervention section.

Transition to Postmodern Grief Theory

Some theorists in the Foucauldian tradition critique stage and task theorists for their "disciplining of grief" (Foote & Frank, 1999). They view pathologizing grief as a means to allow therapeutic intervention as a form of diffuse power, which produces conformity to societal norms. This is not overt coercion, but a form of self-care and self-improvement (something Foucault, 1988 calls "technologies of the self") that functions to contain grief within a therapeutic context. Foote and Frank comment:

Grief, like death itself, is undisciplined, risky, wild. That society seeks to discipline grief, as part of its policing of the border between life and death, is predictable, and it is equally predictable that modern society would medicalize grief as the means of policing. (Foote & Frank, 1999, p. 170)

Tony Walter (2000), too, has recognized how policing grief can be destructive. He traces the evolution of policing grief from an enforcement of contained, formalized, and time-limited grieving during the Victorian era to a current expectation of more expressive grief with a tendency toward medicalization of the grief process. He asserts that mutual help/self-help support groups have evolved as a form of resistance to policing and medicalization, although they, themselves, are evolving norms that contain an expectation of grieving similar to other group members (T. Walter, 2000). He notes:

In postmodern times, both old and new maps are challenged by those who claim no maps can be made of a land that is entirely subjective and individual (Stroebe et al., 1992) ... Yet the evidence presented in this article also suggests that the desire (of both mourners and their comforters) for security, for a map, for fellow travelers, for rules that must be policed, is sufficiently strong that most mourners will never be allowed to be entirely free spirits. (T. Walter, 2000, pp. 111-112)

Postmodern theories of grief grow from a social constructionist understanding of the world (Berger & Luckmann, 1967), which asserts that humans construct their understanding of the world in ways that they then see as self-evident and believe to be true. This "trueness" is part of the construction, because others construct their own truths in different ways. This leads to the postmodern understanding that there are many truths, each created within the context of a person's social and historical milieu, their individual and family experiences, and the person's capacity for reflection and insight. The narrative tradition of therapy (White & Epston, 1990) grew from these social constructionist and postmodern understandings and is

Epston, 1990) grew from these social constructionist and postmodern understandings and is predicated on each individual developing their own story with the help of the therapist as someone to help construct, edit, and frame the story. Making meaning of the deceased's life, death, and relationships becomes critical to the bereaved processing their grief (Neimeyer, 2001; Neimeyer & Sands, 2011).

Along with the evolution of this meaning-making approach to grief work, grief theorists and clinicians began to question classic models and templates for grief. The implications of social constructionism and postmodernism include the idea that no individual's grief must follow a certain preset path; deconstruction, resolution, "closure," and acceptance are no longer envisioned as unitary end states for all. This allowed Klass et al. (1996) to theorize about what many mourners had been saying all along, that the end of active grieving does not have to entail a separation from the deceased. Indeed, most often, it actually entails continuing bonds that change in quality. Foote and Frank (1999) assert that postmodern meaning-making narrative approaches provide more promise for resistance to disciplining of grief.

Meaning-Making and Grief

Although Frankl (1946/1984) is most associated with *Man's Search for Meaning* and White and Epston (1990) are most associated with the application of meaning-making and storytelling via narrative therapies, Robert Neimeyer is perhaps the best known for applying these concepts to grief theory and intervention. He traces this back to:

... Kant (1787/1965) who emphasized that the mind actively structures experience according to its own principles and procedures. ... Significant loss—whether of cherished persons, places, projects, or possessions—presents a challenge to one's sense of narrative coherence as well as to the sense of identity for which they were an important source of validation. ... Bereaved people often seek safe contexts in which they can tell (and retell) their stories of loss, hoping that therapists can bear to hear what others cannot, validating their pain as real without resorting to simple reassurance. Ultimately, they search for ways of assimilating the multiple meanings of loss into the overarching story of their lives, an effort that professionals can support through careful listening, guided reflection, and a variety of narrative means for fostering fresh perspectives on their losses for themselves and others (Neimeyer, 1998). (as quoted in Neimeyer, 2001, pp. 263–264)

This is quoted at length, because Neimeyer's (2001) explanation fits with our own perspectives—that understanding grief and working with people in grief therapy is a mutual project, not one of diagnosis and therapeutic intervention. Grief counseling is a respectful project and process of hearing and witnessing the stories people tell of their lives and their losses, questioning them in ways that allow them to open other perspectives while also leaving room for them to reject those interpretations. At its best, grief work encourages mourners as they construct and reconstruct stories of meaning that enable them to move into their new lives and their new assumptive worlds in the physical absence of the entity who or which was lost (Box 5.1).

BOX 5.1

Clinical Vignette: Anna's Loss

Anna lost her teenage son in an accident approximately a year before contacting Carol, a professional counselor whose expertise included working with grief. Anna was anxious and tearful when she arrived for her intake session with Carol. Anna opened with a little information about her profound sense of grief after the loss of her child, but much of her initial dialogue focused on her family and friends. It seemed that many of the people in Anna's life believed that she was "stuck" in early "stages" of grief. They pushed her to "get it together" and to "move on" with her life. Anna described receiving both implicit and explicit messages that "it's been a year now" and that "that's long enough." Anna's husband was particularly angry with her for "clinging to the past"—after all, he was "dealing with it," and the boy was his son too. In desperation, Anna decided to seek counseling, particularly as significant people in her life convinced her that she had a

"mental problem."

Carol immediately sensed that Anna really had never had an opportunity to tell her story, in her own voice. Carol also came to realize that, even before their son's death, Anna's husband was an emotionally distant person who appeared to ruminate and not express his emotions. Carol helped Anna realize that it was okay to sit with her own feelings and not be influenced by the dictates of others in her life. Throughout a number of sessions, Carol facilitated Anna's growing ability to construct her own narrative about her loss and the significance that this had in her life. Anna finally was able to discuss her true feelings, with a sense of safety, in the counselor's office. She began to make meaning of her son's life and about everything that had happened that led to his death. Carol observed that Anna was becoming less anxious than when she first arrived for counseling, and that she was beginning to self-regulate, allowing for increased relaxation. Eventually, Carol and Anna identified an activity that allowed Anna to engage in prevention efforts related to the type of accident that had taken her son's life. As Anna told Carol, "This doesn't make the pain go away, but it makes it more bearable, and I can feel like I'm doing something proactive and in his memory—I might even be helping to prevent other mothers from going through this agony." They continued to process Anna's feelings about her loss. Anna was beginning to experience a sense of control over her life, decreased anxiety, and her relationships with her family members improved once again.

It is important that clinicians working with people who are grieving recognize that the stories may take multiple forms, and that the task of the therapist is *not* to force an adherence to a "true" or "real" one. Instead, we are there to help the client create their own coherent story while

assisting in shining new light on the possibilities of blind spots that may enable a story that fits the client's evolving and dynamic worldview in evermore useful and function-promoting ways. This is a relational project involving a willingness on the part of the clinician to truly engage with the client in an authentic and caring manner, exhibiting genuine curiosity about the way the client is unfolding their story. Successful grief counselors convey realistic hope that this process can enable the client to return to full engagement with their life and loved ones. Clinical work with survivors of trauma benefits from a similar stance.

Dual Process Theory

Dual process theory is another evolution of grief theory built on the ideas of [Bowlby \(1980/1998\)](#) and the stages of disorganization and reorganization. Although Bowlby conceptualized these as discrete stages that one passes through as one heals from a loss, [M. Stroebe and Schut \(1999, 2010\)](#) envisioned an ongoing cyclical process of loss orientation and restoration orientation. This differs from the linear organization stages in that the bereaved person cycles between times of experiencing grief actively and focusing on the loss, and then moving into times of restoration orientation. During the restoration orientation, the bereaved focuses on rebuilding a new life and engaging in new relationships, activities, and other distractions that move the person away from active grieving. It is imperative to understand that these are not viewed in any hierarchy of value for the bereaved; indeed, it is clear that both have value, and that the oscillation between these two orientations provides distraction and restoration time that allows the mourner to move into new roles and activities. Alternately, moving into a loss orientation permits time for processing the loss. Both are necessary. Notably, children and adults seem to oscillate somewhat differently, with children spending more time in restoration orientation (particularly using distraction), whereas adults may linger in loss orientation more frequently. Current research suggests that people with dismissive attachment styles may need more help engaging with the loss orientation, whereas those with an insecure/anxious style may need strong encouragement to engage in the restoration orientation ([M. S. Stroebe et al., 2005](#); [Zech & Arnold, 2011](#)), recommendations that have implications for trauma work as well.

Another concept that is implicit within the dual process theory is the revision of the assumptive world. [Parkes \(1988\)](#) was one of the first to write about the assumptive world as a set of assumptions (e.g., my husband will always be there to kiss me good night, buildings will never fall to the ground, pandemics will never affect the United States) that coalesces into a cognitive schema, defining how one views one's world. Parkes defines grief as a psychosocial transition necessitating a readjustment of the assumptive world:

For a long time it is necessary to take care in everything we think, say, or do; nothing can be taken for granted any more. The familiar world suddenly seems to have become unfamiliar, habits of thought and behavior let us down, and we lose confidence in our own internal world. ([Parkes, 1988](#), p. 57)

[Parkes \(1988\)](#) captures the phenomenology of grief, an issue of "our own internal world," yet the assumptive world entails levels of assumptions from personal to societal, and we argue that these must be understood using an ecological perspective. For instance, on the micro levels, assumptions exist along the lines of "I'll predecease my child"; on the mezzo level, one may hold assumptions like "schools will always be available for education and supervision of children"; but macro level assumptions can be violated too, as when Hurricane Katrina devastated Mississippi and Louisiana, and assumptions that "communities and the country will always take care of people when tragedy hits" were shown to be false. Similarly, when COVID-19 hit the United States, beliefs that the U.S. medical system would be supported by the government to avoid tremendous loss of life was also shown to be false. Whenever assumptions require revision, an individual's world feels uncertain; yet, when these assumptions are dashed at multiple levels, it may be assumed that the challenges to adapting and revising the assumptive world will be greater.

Continuing Bonds and Grief

A pivotal understanding in contemporary grief theory came when [Klass et al. \(1996\)](#) each examined the data from their disparate research populations and realized that all found evidence of the same phenomena—that bereaved people tended to hold on to some type of relationship with the deceased. They challenged the notion that disengaging from the deceased or lost one is the goal of grief and they coined the term “continuing bonds.” They observed that bereaved people seem to intuitively maintain connections to the deceased and that they re-worked those connections to allow a sense that the deceased remained a part of their life in varied ways such as through memories, a protective presence that watches over, an entity to pray to, or even just qualities of that person to emulate. They assured bereaved people that they do not need to sever their relationships with the deceased in order to grieve in a healthy manner.

The idea of continuing bonds, therefore, implies that, like meaning making, each individual may have a fairly unique outcome to their grief; yet there is a potential hazard here. Just as bereaved people were “policed” into non-expression of their grief (or more recently into full expression, even when this did not fit their needs), we must remain cognizant that some subgroup of griever may not feel the need to have continuing bonds, whereas many others can find this comforting. Regardless, the concept of continuing bonds ([Klass et al., 1996](#)) was revolutionary and gave the bereaved permission to maintain their sense of relationship with their deceased loved ones.

This not only challenges the concept of “letting go” and “acceptance,” but it also challenges notions of closure. “Closure” came into the lexicon during the 1990s and reflects the hope of griever to be relieved of pain and suffering. [Berns’ \(2011\)](#) exposé of closure reveals multiple meanings used for the term, but, more insidious, closure came to justify capitalistic efforts from “burials” in space to “diamonds” made of cremains ([Berns, 2011](#)). Berns found that the word “closure” is used for closing a chapter, remembering, forgetting, getting even, knowing, confessing, and forgiving. Closure is therefore a slippery word, not likely symbolizing an ending of grief so much as “justifying” services and products to be sold.

Cultural contexts are important, too. Mexican “Day of the Dead” celebrations and Buddhist worship at shrines of deceased loved ones reflect the practices of only two of many cultures that have allowed maintenance of continued bonds, despite the fact that many Western cultures have not recognized these ties/bonds historically. Individualized assessment of the client, discussion of cultural inputs into the grief process and customs, an intuitive and respectful stance by the therapist, and awareness of the wide range of ways in which people move through and process their grief are all imperative for sensitive, competent grief work with bereaved people. Another imperative is to recognize that although grief is partially a psychological state, it also is defined socially, in both cultural context and normative inputs, and it has physical effects as well. When social expectations are violated, grief and grieving are affected. The concepts of disenfranchised grief and ambiguous grief are fundamentally social, as well, and have been part of the evolving theorizing of grief.

Disenfranchised Grief

[Doka \(1989, 2002\)](#) coined the term “disenfranchised grief” to conceptualize grief that is not recognized, validated, or supported by the social world of the mourner. Essentially, the concept of disenfranchised grief involves grief that does not meet the norms of grief in the griever’s culture. [Hochschild \(1979, 1983\)](#) has referred to norms such as these, which guide the individual in what is an “appropriate” feeling in a given situation, as *feeling rules*. Disenfranchised grief comes as a result of breaking the feeling rules, or of living in a time when feeling rules are not established or are discrepant ([McCoyd, 2009](#)). This then leaves the griever uncertain as to whether they are “allowed” to feel sad about a loss experience that is not recognized by social peers. Further, it may leave the griever wondering if they are even “allowed” to call the experience a loss (or a trauma). [Doka \(2002\)](#) defines five categories of disenfranchised grief: (a) grief in which the relationship is not recognized, such as gay and lesbian relationships, extramarital relationships, and other relationships that lack social sanction; (b) grief in which the loss is not acknowledged by societal norms as a “legitimate” loss, as when abortion, adoption, pet loss, amputation, and other losses are not viewed as

loss, as when abortion, adoption, pet loss, amputation, and other losses are not viewed as worthy of sympathy; (c) grief in which the griever is excluded, as is often the case for individuals who are children, aged, or developmentally disabled and are (inaccurately) not believed to really experience grief; (d) grief in which the circumstances of death cause stigma or embarrassment, such as when a person dies of AIDS, alcoholism, crime, or in other ways that are viewed as moral failures on the part of the deceased; and (e) grief that is expressed in non-socially sanctioned ways, as when a griever is deemed to be either too expressive, or not expressive enough (Doka, 2002).

The nature of disenfranchised grief means that grieving individuals do not receive the social support and sympathy from others that have been shown to be crucial to being able to process grief and move on from it in healthy ways. The very core of this experience (for most) is to engage the pain of grieving actively. Yet, for many, this pain is exacerbated by social isolation or rejection. Many types of losses fall into some of these categories, particularly losses that are not recognized as worthy of support by others. In these cases, the mere validation that it is accurate to perceive the event as a loss, along with normalizing the grief response, can allow the griever to move through the loss response without the complications that may occur when the griever is bereft not only of the lost entity, but of validation, recognition, and normalization of their grief. Certainly, trauma such as childhood abuse of all forms often entails disenfranchised losses. Indeed, trauma's pain is often disenfranchised by those who suppress their trauma, and validating the grief due to losing one's integrity and sense of safety is often vital to helping the traumatized person to begin to grapple with their trauma and its subsequent grief.

Ambiguous Loss

Ambiguous loss (Boss, 1999) is a form of "frozen grief" which is difficult to process, because the definition of who is lost is so uncertain. In ambiguous loss, the lost entity is

- physically present but psychologically absent—for instance, a loved one with Alzheimer's disease or head trauma/brain injury; or
- physically absent but psychologically present—such as when someone is kidnapped, homeless, or missing in action during a war.

These types of losses are confusing because it is unclear how one is to adjust to them. Without an overt death in the first case, it seems premature and even cruel to grieve in socially sanctioned ways; in the second, to begin to grieve would remove the hope of the return of the lost one to the social milieu. Boss points to the following factors as creating difficulty for those experiencing ambiguous loss:

- Uncertainty means that adjustment cannot occur because it is unclear what one is supposed to adjust to.
- Rituals are not available, and there are few social supports.
- The irrationality of life is on display. It is hard to feel that there is a rational world when nothing seems clear or rational.
- The grief is unending. The uncertainty drags out, and there is little ability for resolution.

These types of losses also confuse formal and informal support people who are just as perplexed about whether to express sympathy or to maintain a stolid sense of normalcy and hope. Disenfranchised and ambiguous losses are heightened in intensity by the lack of social support. This may be why peer support and mutual help groups seem so efficacious with grievers such as these. Theoretically, it is appropriate to create groups for those for whom social nonrecognition of the loss occurs, because the group members are all in similar situations and are aware of a sense of loss. Groups have similar benefits for people who experienced similar traumas. Although having similar types of losses or trauma does not ensure having similar responses, the social contexts can be discussed, and strategies for coping can be addressed.

BIOPSYCHOSOCIAL EFFECTS OF GRIEF

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The biopsychosocial approach requires an understanding of the ways that mind and body interact within a social context. The biological impact of psychosocial factors seldom is addressed, explicitly, in much of the therapeutic literature. This said, the link between higher mortality and bereavement has been strong, long-lasting, and significant (Bowling, 1989; Parkes et al., 1969; M. S. Stroebe et al., 1982), including findings that the rates are higher for widowers than widows (Helsing et al., 1982; M. S. Stroebe & Stroebe, 1993). Recent research illustrates that individuals can and do “die of a broken heart” at double the rate of nonbereaved people matched for age and other demographics (Carey et al., 2014; Dande & Pandit, 2013). Understanding the possible mechanisms for the increased mortality and morbidity risk is important.

A full understanding of the interaction of emotions and physical health is beyond the scope of this chapter, but having a basic understanding of how immune systems, neurological systems, and cardiovascular systems may be affected by stress, grief, depression, anxiety, and traumatic events can help clinicians to think about ways of promoting health, despite bereavement, and of recognizing the impact of psychosocial factors on physical health. Koch (2013) provides a useful overview of the ways that mind-body interactions can elicit disease.

The immune system is one of the most potent mediators of the interaction between mental and physical health (Brod et al., 2014; Salovey et al., 2000). A significant body of work (well summarized in Salovey et al., 2000) shows that negative emotions decrease secretory immunoglobulin A (S-IgA), which then causes individuals to be much more susceptible to infection from viruses such as the common cold. Likewise, grief’s negative emotions reduce immune system efficiency and inflammation ensues along with decreased activity of T-lymphocytes and natural killer cells (Buckley et al., 2012), reducing ability to fight everything from short-term viral diseases to cancer.

Neurotransmitters and other neurochemical interactions also play a major role in the interaction of mental and physical health. The major mediator of brain chemistry under stress is the hypothalamic-pituitary-adrenal axis (HPA), which, when activated, causes a release of cortisol, the stress hormone. Norepinephrine and adrenocorticotrophic hormone (ACTH) are also released when the HPA is activated, with rises in ACTH typically providing a feedback loop with cortisol, which then rises, ideally leading to lowered ACTH production. This feedback loop seems to break down in depressed individuals, with cortisol staying elevated (Buckley et al., 2012). Parentally bereaved children and youth are reported to have disturbed cortisol functioning; their cortisol awakening response becomes blunted, and cortisol levels remain high (Dietz et al., 2013; Kaplow et al., 2013). Cortisol influences sleep-wake cycles and sleep disturbance is highly associated with grief reactions in most age groups. Theoretically, sleep disturbances may contribute to poor health during bereavement (Buckley et al., 2012).

Genes are often viewed as static, but we now understand that genes are “turned on and off,” as a result of environmental stresses (Rothstein, 2013). Indeed, the genome can be changed in ways that can be passed down to offspring (epigenetics) (Bienertová-Vášková et al., 2014; Zucchi et al., 2013). These environmental stresses can include the stress of prolonged grief. Associations between complicated grief and genomic findings suggest genes play a part in influencing who experiences complicated (prolonged) grief (O’Connor et al., 2014; Schultze-Florey et al., 2012). Mindfulness work has been shown to reduce the inflammatory responses believed to negatively affect both immune system function and genetic expression (the inflammatory response is regulated by genes) (Creswell et al., 2012). We must continue to learn more about the interactive relationship between genomics and grief.

Gundel et al. (2003) and O’Connor et al. (2007) suggest an intriguing link between the biological effects of grief and the reasons narrative meaning-making is a useful intervention. The researchers used functional magnetic resonance imaging (fMRI) to scan acutely bereaved individuals’ brains after interviewing them about their loss. They then said words from the interview to the bereaved and watched the response on the fMRI. They discovered that the posterior cingulate cortex, the cerebellum, and the inferior temporal gyrus are all affected, and each has a role in autobiographical memory and creation of the “storyline” of individual’s lives. Van der Kolk et al.’s (1996) understandings about trauma suggest that grief

individual's lives. [Van der Kolk et al.'s \(1996\)](#) understandings about trauma suggest that grief is affected differently when the loss is experienced as traumatic. At this point, the emotional memory of the loss is "stamped in" by the flood of neurotransmitters that occurs at the time of a trauma; further, the amygdala is activated, though often in a less than conscious manner, so that similar events and thoughts may provoke the amygdala to continue to send signals of arousal even when the loss has already occurred ([van der Kolk, 1998](#)).

In light of the physiological aspects of bereavement just described, it becomes important for the grief counselor to be aware of how to promote physical health and wellness. Regular exercise, a balanced diet with an increase of B vitamins and antioxidants, increased omega-3 intake, and exposure to light ([Zisook & Shuchter, 2001](#)) all need to be encouraged. During the bereavement period, a checkup by a physician is indicated; counselors should encourage conscious provision of self-care and monitoring of risks to one's health.

INTERVENTIONS

As noted in the many task- and stage-related grief theories initially detailed, there is a tendency among grief theorists to identify phases (and associated tasks) through which the mourner must move to heal. Newer theories avoid the prescriptive nature of many of the earlier theories; yet, the onus remains on the bereaved to move through the process. Interestingly, when working with students and others who want to be of use in assisting those who are grieving, their question tends to be "What can I do?" not "What should the bereaved do?" This is actually a much more important question. [Lloyd \(2002\)](#) suggests that the clinician do the following: (a) explore attitudes toward death and dying from psychological, sociological, and philosophical/religious perspectives; (b) explore and analyze the bereaved's constructions of life; and (c) explore the processes of adjustment to the world without the lost entity. Within each area for exploration, attention is paid to how the bereaved redefines roles, rebuilds identities, negotiates transitions, survives trauma, and maintains a hopeful spirit.

Another framework for intervention was developed by [McCoyd \(1987, October\)](#) for use with perinatal loss but has been applied to disenfranchised losses more generally. Called the "Five Vs," this model specifies domains for exploration and intervention; these guide the clinician without resorting to structured, predetermined tasks. The Five Vs are validating, valuing, verifying, ventilation, and being visionary. Validating helps the bereaved to identify any areas where they may not feel that they have social support for grieving and helps them to recognize and validate their right to be a mourner. Valuing and verifying relate to validating by recognizing that the lost entity had value to the mourner and supporting the bereaved in discussing all aspects of the way the lost entity/person had value to them. Verifying is any intervention done to assist the bereaved in gathering concrete mementos or developing rituals that "make real" the loss. These concrete reminders may be used to help enlist the support of social networks. Ventilation has become almost stereotyped in that people are urged to "vent," to "let it all out," or in other ways to be emotionally expressive. Ventilation can be done in various ways and does not always need to incorporate tears. Indeed, if the counselor falls prey to the grief work hypothesis ([M. Stroebe & Stroebe, 1991](#)), and insists on tears as a form of ventilation, they risk harming the mourner.

The ventilation domain entails an expectation that the bereaved can talk about the loss with authenticity and consistent affect and content, not necessarily overt tears. Ventilation is often the domain within which meaning making begins to occur as the bereaved is helped to explore the many ways in which the loss has affected the bereaved person's life. This is the time for the grief counselor to remain quietly supportive, avoiding platitudes that could interrupt the mourner's ability to ventilate their thoughts, feelings, and reflections freely. The final domain, being visionary, is often a part of the ending process but is found in small amounts throughout the work. This entails assisting the bereaved person to think through events that are likely to occur in the future and to recognize their potential for intensifying grief feelings. [Rando \(1993\)](#) calls these STUG reactions—sudden temporary upsurges of grief. Often, they come without warning, but in being visionary, the grief counselor can share lessons learned from others about when grief is likely to be heightened. For instance, with perinatal loss, the arrival of the due date for a pregnancy that has been lost is often a time of

permanental loss, the arrival of the due date for a pregnancy that has been lost is often a time of intensified feelings of grief; the bereaved needs to allow time for reflection and mourning. The Five Vs can provide a model for grief counselors who desire some structure for the work, yet who recognize the importance of allowing the bereaved to follow their own needs and inclinations for grief work.

Rubin's two-track model of bereavement (Rubin et al., 2017) provides yet another approach for assessment and intervention. The focus is two-fold: Track One focuses on the biopsychosocial functioning of the griever and Track Two focuses on the relationship between the griever and the lost entity/person. The premise is that bereavement creates a disruption in the griever's homeostasis and that intervention is geared toward the two tracks using CBT-REBT (cognitive behavioral therapy—rational emotive behavior therapy) techniques to help the griever assess cognitions related to their adaptation to their own functioning post-loss, as well as to the development of the continuing bond to who/what was lost. Focusing on evaluating beliefs and their consequences is different from the more narrative approach embraced in meaning making interventions, but may be preferred by some who want a more structured approach to their grief counseling, particularly in the face of a traumatic component to the loss.

Perhaps the most useful intervention in considering traumatic bereavement is the empirically validated treatment for complicated grief developed by M. K. Shear. Developed to be used in a compassionate, collaborative, and tailored manner, it was previously more structured and now uses lessons learned in the previous iterations to allow broader dissemination of the approach. The seven steps (again, interventions to be used by the therapist rather than stages or tasks of the bereaved) are: (1) understanding and accepting grief, using psychoeducation to help the bereaved understand typical expectations of grief responses and helping them think about what makes their grief complicated; (2) managing painful emotions, which also involves teaching the bereaved to track their grief on a 10-point scale and observe when it is low and when it is high; (3) planning for a meaningful future, which capitalizes on the Dual Process model, by gently urging movement into restoration orientation and goal-setting for the future; (4) strengthening ongoing relationships by helping the bereaved identify at least one confidant in their social group to whom they can talk, (5) telling the story of the death, which is the primary focus of sessions that help reinforce emotional regulation, challenge avoidance, and build meaning making capacity; (6) learning to live with reminders by helping the bereaved identify and emotionally regulate when triggers are present; and (7) establishing an enduring connection with memories of the person who died, by promoting continuing bonds. See the online Resources section for more information to attain detailed training and worksheets.

COUNSELING IMPLICATIONS

The counseling literature suggests that the counselor's own history of grief and loss and their self-reflexive capacity must be understood if they are to assist grievers (e.g., McCoyd et al., 2021; Worden, 2018). Clinicians can experience a parallel process of feeling overwhelmed by client losses and moving into a passive role of hopelessness, thereby making the clinicians less helpful. Clinical supervision is a necessary instrument for dealing with the compassion fatigue that may be associated with counseling complex bereavement. Unidentified countertransference can lead clinicians to do grief work *at* rather than *with* their clients. Attunement to the griever is vital to the work, so self-knowledge must precede work with grievers. Use of the Professional Quality of Life Scale (ProQoL—found in the online Resources section) can help clinicians self-monitor for compassion fatigue and secondary traumatization (issues related to secondary and vicarious trauma are detailed in Chapter 30 of this textbook, and Chapter 31 details counselor self-care).

The efficacy of grief work has been questioned, and the potential for iatrogenic effects raised (e.g., Bonanno & Lilienfeld, 2008; Neimeyer, 2000; W. Stroebe et al., 2005). Nevertheless, Larson and Hoyt (2007) argue that grief therapy is as effective as other forms of psychotherapy. The prudent therapist certainly wants to be aware of theoretical nuances, which may contribute to best practices for particular clients. As the theoretical overview illustrates, there is no one way of doing grief, and therefore, no one way of doing grief

illustrates, there is no one way of doing grief, and, therefore, no one way of doing grief therapy or counseling. We believe counselors must listen deeply and reflectively to the griever discuss their relationship to who/what was lost, their experience of the loss itself, their concerns about how their life has changed as a result of the loss, and how they anticipate their life evolving as a result of the loss. Helping them consider how to maintain a connection to the entity who/which was lost over time and helping them recognize the reality that this will be a lifelong process of re-evaluating each of those aspects as they age/mature are also critical aspects of the work with grievers.

In 1991, Stroebe and Stroebe asked the question, "Does 'grief work' work?" Their answer at that time was a tepid "maybe." Findings that widowers who avoided emotional expression seemed to have worse outcomes than those who were not actively avoiding their grief showed tepid support for grief work; however, widows did not exhibit this same association. This led the authors to suggest that "the view 'everyone needs to do grief work' is an oversimplification" (M. Stroebe & Stroebe, 1991, p. 481). Indeed, Bonanno et al. (2004), in a prospective study with 276 older couples, found that 46% of the older widows and widowers they interviewed were classified as "resilient," with little depression or active search for meaning-making after their spouse's death, but neither were they considered avoidant. Another 10% were called "depressed improved" and actually improved in mood and coping after the death of the spouse (often those who were caretakers or who had been abused). The people they classified with "common grief" typically experienced depressive symptoms intensifying to about 6 months post loss and then resolving over the course of the following year. This implies that more than half of typically bereaved mourners are capable of adapting to loss, given time and a modicum of supportive social outlets. This reinforces the notion that grief is a normal part of life and something that can promote growth, even in the absence of professional assistance. Yet another 25% or so struggle to manage adaptation after loss, and these individuals, along with those who experience traumatic components to their loss, may benefit from someone with whom to reflect on their loss and its meaning in their lives.

The reflective clinician must weigh skepticism about grief work for all mourners against the paralysis that can result from giving so much weight to these concerns that we neglect to provide support for those who are asking for our assistance. Particularly after traumatic losses, supportive counseling is generally appreciated, and if complicated grief symptoms arise, grief therapy is beneficial. Remaining open and reflective about new understandings in grief theory and trauma theory, while also using the empirical data derived from one's actual interaction with individual clients and how they perceive the work to be useful (or not), are requirements of ethical and sensitive practice in the world of grief support.

CONCLUSION

In this chapter, we have introduced the phenomenology of loss and grief, especially as these constructs apply to losing a loved one, and we have considered the implications for traumatic loss. We have provided an overview of classical grief theory and examined the transition from the classical to more contemporary theories that acknowledge the intersectional nature of grievers' unique experiences. We have emphasized the importance of understanding the biopsychosocial effects of grief, along with explicating recent advances in counseling interventions, especially in situations where bereavement is connected with trauma. We have addressed the implications for counselors working with clients who have experienced the grief and suffering that may result from loss. Grievers deserve our deepest compassion, paired with our most current understanding of how to help them continue to move through their grief and re-engage with their lives.

ADDITIONAL RESOURCES

instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Websites

American Academy of Grief Counseling www.aihcp.org/aagc.htm

American Death Education and Counseling www.adec.org

Mental Health Association Bereavement www.mhanational.org/bereavement-and-grief

National Institutes of Health Grief Resource <https://newsinhealth.nih.gov/2017/10/coping-grief>

Professional Quality of Life Scale <https://proqol.org/use-the-proqol>

The Center for Complicated Grief-Columbia University
<https://complicatedgrief.columbia.edu/professionals/complicated-grief-professionals/overview>

Films and Videos

Carved from the Heart-Kanopy.

We don't "move on" from grief. We move forward with it, Nora McInerney: www.youtube.com/watch?v=kxkjkR-1pfw&t=10s

Grief: What Everyone Should Know, Tanya Villanueva Tepper: www.youtube.com/watch?v=BwPoqQPynEc&t=49s

Media Kits

Sesame Street. (2010). *When families grieve* [includes manuals and DVD]. Materials are free and downloadable from <https://sesamestreetincommunities.org/topics/grief/>

Substance Abuse and Mental Health Services Administration. (2007, October). *The courage to remember: Childhood traumatic grief curriculum guide with CD-ROM [DVD]*. Available from <https://archive.org/details/the-courage-to-remember-childhood-traumatic-grief-curriculum-guide-with-cd-rom-he-20.408t-692014>

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PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Websites

American Academy of Grief Counseling www.aihcp.org/aagc.htm

American Death Education and Counseling www.adec.org

Mental Health Association Bereavement www.mhanational.org/bereavement-and-grief

National Institutes of Health Grief Resource <https://newsinhealth.nih.gov/2017/10/coping-grief>

Professional Quality of Life Scale <https://proqol.org/use-the-proqol>

The Center for Complicated Grief-Columbia University
<https://complicatedgrief.columbia.edu/professionals/complicated-grief-professionals/overview>

Films and Videos

Carved from the Heart-Kanopy.

We don't "move on" from grief. We move forward with it, Nora McInerney: www.youtube.com/watch?v=khkjkR-ipfw&t=10s

Grief: What Everyone Should Know, Tanya Villanueva Tepper: www.youtube.com/watch?v=BwPoqQPynEc&t=49s

Media Kits

Sesame Street. (2010). *When families grieve* [includes manuals and DVD]. Materials are free and downloadable from <https://sesamestreetincommunities.org/topics/grief/>

Substance Abuse and Mental Health Services Administration. (2007, October). *The courage to remember: Childhood traumatic grief curriculum guide with CD-ROM [DVD]*. Available from <https://archive.org/details/the-courage-to-remember-childhood-traumatic-grief-curriculum-guide-with-cd-rom-he-20.408t-692014>

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Sexual Trauma: An Ecological Approach to Conceptualization and Treatment

LAURA HENSLEY CHOATE

CHAPTER OVERVIEW

Sexual violence is a significant social problem worldwide, occurring at alarmingly high rates and is associated with a host of negative outcomes including posttraumatic stress disorder (PTSD). The purpose of this chapter is to present an ecological model that enhances an understanding of survivor responses to sexual violence and informs treatment for sexual trauma. The chapter will examine the many systems that affect survivors' recovery and will provide an overview of clinical guidelines for treating sexual trauma, including prolonged exposure (PE), trauma-informed CBT (TF-CBT), cognitive processing therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR).

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Understand posttrauma symptoms that commonly follow an experience of sexual violence, with particular attention to PTSD;
2. Conceptualize a survivor's responses to sexual trauma in terms of an ecological model that includes the multiple systems involved in response to and recovery from sexual violence;
3. Describe evidence-based clinical guidelines for treating sexual trauma, including prolonged exposure (PE), cognitive behavioral therapy (CBT) and cognitive processing therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR).

INTRODUCTION

Sexual violence is a significant social problem worldwide, and because of the intimate nature of sexual violence, it is considered one of the most distressing types of trauma an individual can experience (Dworkin et al., 2017). Sexual violence is defined by the Centers for Disease Control and Prevention, the National Center for Injury Prevention and Control, and the Division of Violence Prevention as any sexual act committed against someone without that person's freely given consent, including sexual acts obtained by force, coercion, or perpetrated against an individual unable to give consent due to age, disability, or impairment following voluntary or involuntary substance use. It includes a broad spectrum of nonconsensual sexual activities that are perpetrated upon a victim by partners, spouses, friends, acquaintances, family members, or strangers (Basile et al., 2014; D'Inverno et al., 2019).

It is disconcerting that sexual violence and its resulting trauma occurs at high prevalence rates, particularly for women. According to the National Intimate Partner and Sexual Violence Survey, 44% of all women in the United States will experience some type of contact sexual violence in their lifetimes, with one-third of all women (37%) experiencing unwanted sexual contact, and one in five women (21%) experiencing attempted or completed rape (D'Inverno et al., 2019). Although women are disproportionately affected by all forms of sexual violence, men are also victims of these crimes. Approximately one in 17 men (compared to one in five women) have experienced an attempted or completed rape in their lifetime (Smith et al., 2017), and almost 25% of men report some form of contact sexual violence in their lifetime (D'Inverno et al., 2019).

In addition, women and men of all cultural backgrounds experience sexual violence. When comparing most racial/ethnic groups, there are no statistically significant differences between groups, with the exception of Native American/Alaska Native women, who experience significantly higher rates of sexual assault and violence (34%) than do individuals

experience significantly higher rates of sexual assault and violence (34%) than do individuals from all other cultural backgrounds (Tjaden & Thoennes, 2006). To demonstrate the comparison between racial groups, 45% of Native American women experienced contact sexual violence in their lifetime, compared to 38.5% of non-Hispanic White, 35.5% of non-Hispanic Black, 26.9% of Hispanic, and 22.9% of Asian American women (Smith et al., 2017). Further, members of several marginalized groups also experience increased vulnerability to sexual victimization, including individuals with disabilities, sexual and gender minorities, homeless individuals, and individuals engaging in sex work (International Society for Traumatic Stress Studies [ISTSS], 2018). Because of these high prevalence rates that cut across all age groups and populations, counselors need to be knowledgeable about sexual violence and resulting trauma, how it operates in survivors' lives, and how to provide effective treatment.

The purpose of this chapter is to present an ecological model that enhances understanding of survivor responses to sexual violence and informs treatment for sexual trauma. This is accomplished by the discussions offered in the following sections: (a) a brief examination of the symptoms that commonly follow an experience of sexual violence; (b) a conceptualization of an ecological model for use in understanding sexual violence, including descriptions of the systems that affect survivors' recovery; and (c) an overview of clinical guidelines for treating sexual trauma, including prolonged exposure (PE), cognitive behavioral therapy (CBT) and cognitive processing therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR). This chapter concludes with counseling implications and an online list of resources for counselors and survivors.

SEXUAL TRAUMA

It is not surprising that trauma resulting from sexual violence is associated with a host of negative mental health problems, including PTSD, anxiety disorders, depression, substance abuse, disordered eating, dissociation, suicidal ideation, and suicide attempts. In fact, in a recent meta-analysis, the experience of sexual assault was associated with an increased risk for and severity of all psychiatric disorders, including a strong increased risk for suicidal ideation and behaviors (Dworkin et al., 2017).

Most individuals develop PTSD-like reactions within days after a sexual assault, and these typically resolve within a month following the event as the individual processes the event; in fact, posttraumatic reactions such as intrusive memories, emotional numbing or withdrawal, or hyper-alertness are considered normal and expected reactions to this type of trauma (American Psychological Association, 2017). However, if these reactions do not remit but become recurring symptoms, which last over a month, then the symptoms may meet criteria for PTSD. Overall, lifetime prevalence rates indicate that PTSD develops in a significant number of survivors (Scott et al., 2018). Because PTSD is likely to occur in individuals who experience sexual trauma, it is important for counselors to be knowledgeable of PTSD symptoms and how they might manifest in a particular client. The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013), groups PTSD symptoms into four clusters: (a) intrusion (e.g., at least one of the following: re-experiencing of the trauma through nightmares, flashbacks, or intense distress at exposure to cues that symbolize or resemble an aspect of the traumatic event); (b) avoidance (e.g., efforts to avoid one or more: thoughts, feelings, physical sensations, people, conversations, activities, places, or physical reminders that arouse recollection of the event); (c) negative alterations in cognitions and mood (e.g., as evidenced by three or more of the following: inability to remember certain aspects of the event, persistent self-blame, negative expectations of one's self, others, or the world; strong and persistent negative emotional reactions, diminished interest or participation in significant activities, feelings of detachment, or inability to experience positive emotions); and (d) alterations in arousal and reactivity at activities associated with the event (e.g., at least three of the following: irritability, aggressiveness, reckless or self-destructive behavior, hypervigilance, exaggerated startle response, problems with concentration and sleep). To meet *DSM-5* criteria for PTSD, this constellation of symptoms must occur for at least 1 month and cause clinically significant

constellation of symptoms must occur for at least 1 month and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, 2013). The frequency, severity, and duration of a client's PTSD symptoms may be influenced by many factors, and the primary influences are addressed in the sections that follow.

ECOLOGICAL MODEL FOR CONCEPTUALIZING SEXUAL TRAUMA

Research indicates the importance of understanding a survivor's responses to trauma as a complex interaction between the individual and their environment. An individual's adjustment to trauma can be influenced by multiple systems—including the immediate environment, the broader community, and the larger cultural context in which sexual violence is understood (Campbell et al., 2009). For the purposes of this chapter, I draw on the ecological model of Campbell et al. (2009) for conceptualizing the impact of sexual violence on a survivor's posttrauma functioning. This systems model is based on Bronfenbrenner's (1995) ecological theory of human development and consists of six levels, all of which are described in the paragraphs that follow.

Individual Level

This level refers to the individual survivor's particular sociodemographical characteristics. Although any individual can be a victim of sexual trauma, it is a gendered experience, with women far more likely to be victims, and men far more likely to be perpetrators (e.g., between 91% and 100% of female victims report that the perpetrator was male; Smith et al., 2017). As summarized by ISTSS (2018), some additional individual risk factors include the following:

- Younger individuals are at higher risk for all forms of sexual violence, in general, and for rape in particular. More than 80% of women say they first experienced sexual victimization before the age of 25, 43% before the age of 18, 30% between the ages of 11 and 17, and about 13% when they were 10 or younger. Men report being even younger than women at the time of their first sexual victimization: 51% experienced victimization prior to age 18, 25% between the ages of 11 and 17, and almost 26% were age 10 or under when they were first victimized (D'Inverno et al., 2019).
- Native American/Alaska Native Women are at increased risk of all forms of sexual violence. They are more likely than any other ethnic or racial group to have experienced a violent sexual assault, such as one involving a weapon or physical injury. In addition, they are more likely than other women to report that the perpetrator was using alcohol at the time of the assault.
- Individuals with disabilities are raped and sexually assaulted at high rates. One study found that women with disabilities face a five times increased risk of experiencing some form of sexual assault, in the past year when compared with women who do not have a disability. Men with disabilities are seven times more likely than men without a disability to have experienced completed rape, and five times more likely to have experienced some form of sexual assault during the past year (ISTSS, 2018).
- Sexual orientation also places one at an increased risk for sexual violence. Bisexual women are at particularly high risk, with 46% of bisexual women experiencing rape in their lifetime (compared to 17% of women who identify as heterosexual and 13% who identify as lesbian; Walters et al., 2013). Gay and bisexual men are also at elevated risk; 47% of bisexual men and 40% of gay men report a history of some form of unwanted or nonconsensual sexual activity.
- Gender minorities, including transgender and gender nonbinary individuals, experience disproportionately high rates of sexual assault. Around 50% of transgender-identified individuals in the United States say they have experienced unwanted, nonconsensual sexual activity. Male transitioning to female transgender individuals are at higher risk compared to female to male transgender individuals (ISTSS, 2018).

Assault Characteristics Level

This level provides an understanding of the relationship of the survivor to the perpetrator and also refers to the use of alcohol or other drugs during the assault. Sexual trauma is generally classified according to the perpetrator: stranger, date/acquaintance, and marital partner. There is a pervasive stereotype that sexual assault is most likely to be perpetrated by a stranger, although data indicate that sexual assault is most likely to be perpetrated by someone whom the survivor knows, as 80% of rapes are committed by someone known to the victim (U.S. Department of Justice, 2017). Survivors of acquaintance, date, partner, or spousal rapes tend to engage in more self-blame and receive more victim-blame than do those who experience stranger rapes. Sexual violence committed by an intimate partner is particularly traumatic, in that although rape by a stranger may be experienced as a singular event, survivors of intimate partner rape typically endure multiple sexual assaults and must live with the continuous threat of repeated incidents of trauma, including other types of partner violence such as physical and psychological abuse (Temple et al., 2007). In fact, one in four women and one in ten men have experienced contact sexual violence, physical violence, or stalking by an intimate partner and say that they experienced significant short-term or long-term impact (e.g., PTSD, injury) that resulted from these events (Smith et al., 2017).

In addition to the survivor's relationship with the perpetrator, sexual trauma also may be classified as to whether or not alcohol or other drugs were used in the assault. Sexual assault is highly associated with alcohol use, both by the perpetrator and the victim, particularly for college students and in acquaintance rape cases. Frequently, a person is raped while they are unable to give consent for sexual activity because of intoxication; yet, they are hesitant to label the incident as rape, question their role in the assault, and tend to engage in self-blame. In current culture, there remains a prominent myth that if a person is drinking in a social setting and is victimized, then that person is at fault for drinking excessively or by being in that setting in the first place. As a result, women may believe it is their fault if they are sexually assaulted after drinking in social situations (Zaleski et al., 2016). For these reasons, individuals are less likely to report alcohol-related sexual assaults than they are to report stranger rapes, and when they do, they are more likely to be viewed with skepticism and victim-blaming by others.

Chronosystem Level

This level refers to the cumulative effects of multiple developmental transitions in a survivor's life. In the case of sexual trauma, it refers to a survivor's particular history of victimization. There is a considerable line of research indicating that episodes of sexual abuse or assault that occur across two or more developmental periods (e.g., childhood, adolescence, and adulthood) are related to particularly negative outcomes (Charak et al., 2017). Unfortunately, developmental revictimization occurs to a significant number of childhood female sexual abuse survivors; recent studies indicate that 35% of women raped before the age of 18 also experience rape as an adult, compared with 14% of adults with no history of rape (D'Inverno et al., 2019). Survivors of childhood abuse are two to three times more likely to be sexually assaulted in adolescence and adulthood than are individuals from the general population (Tjaden & Thoennes, 2006), and there is some indication that there are even higher revictimization rates among LGBT individuals who experienced childhood sexual abuse (ISTSS, 2018).

Counselors therefore need to assess for and understand a survivor's victimization history, as people who have been victimized previously are more likely to have differing treatment needs than other survivors. Revictimization is associated with increased levels of PTSD symptoms compared to a single incident of trauma (Scott et al., 2018), and those who experience revictimization report greater levels of depression, PTSD, dissociation, anxiety, and substance abuse than do other survivors of sexual trauma (Fortier et al., 2009). Grauerholz (2000) conceptualized the revictimization process as operating within a system composed of the following four levels: (a) a survivor's initial abuse experience and family history; (b) a demographic, severity, duration, relationship to the perpetrator, and negative

history (e.g., demographics, severity, duration, relationship to the perpetrator, and negative social reactions to initial disclosure); (b) the exosystem (e.g., lack of resources or safe housing concerns that increase a survivor's vulnerability to future sexual violence); (c) macrosystem factors (e.g., cultural norms and institutions that tend to blame the victim, particularly for causing the revictimization); and (d) microsystem factors (e.g., interpersonal and intrapersonal factors, and the interaction between the perpetrator's behavior and the psychological vulnerability of the survivor).

While recognizing revictimization as a multisystemic problem, recent research in this area has centered on microsystem factors. One reason for developmental revictimization is that childhood sexual abuse significantly interferes with a person's subsequent ability to cope with emotions in an effective manner. Instead, people who were abused are more likely to turn to ways to help avoid or escape painful, persistent emotions. People who are abused as children are more likely to use avoidant coping strategies as an adult, such as engagement in high-risk activities (e.g., binge drinking, risky sexual behavior), which then places a person at higher risk for future victimization (Fortier et al., 2009). A recent study indicates that early experiences of abuse disrupt the development of a child's emotion regulation capacity. With the disruption of emotion-regulatory abilities, as the person enters adolescence and adulthood, they will have trouble with emotional clarity (the ability to be aware of, understand, and accept one's emotions); have poor ability to control impulsive behaviors when distressed; and will have decreased ability to use appropriate strategies to help regulate or modulate emotions effectively (Charak et al., 2017). In addition to emotion regulation deficits, childhood trauma also results in reduced ability to respond effectively to threatening situations. When a person experiences sexual trauma in childhood, these early experiences interfere with the development of their ability to cope with and respond to potentially dangerous situations. These experiences also interfere with their ability to process threatening information, perceive and assess risks accurately, react appropriately to threats, and use effective self-protective responses (Fortier et al., 2009).

Exosystem Level

This level refers to survivors' interactions with formal support services such as medical, legal, law enforcement, or mental health systems. A significant barrier for many survivors is a fear of negative consequences if they reach out for formal support services. These fears are often well-founded; it is common for survivors to report that their contacts with formal systems were quite negative and dehumanizing, and caused them to experience guilt, shame, mistrust, and reluctance to seek further help (ISTSS, 2018). These types of negative interactions can result in what often is termed a "*secondary victimization*," which is the result of insensitivity, victim blaming, minimization, and negative reactions from medical, legal, law enforcement, and mental health professionals, and which is often experienced as a secondary trauma that does not help but rather exacerbates trauma (Gravelin et al., 2019).

Survivors also report being hesitant to seek access to formal services because of fears that they will be required to make a formal report to legal authorities or to law enforcement. They fear that reporting might bring about reprisal from the perpetrator (or his family and peers), might cause financial and psychological hardship due to court costs and legal involvement, and they might fear negative effects of reporting on the perpetrator's family, friends, and community (the latter point is discussed in greater detail later in this chapter as it relates to cultural values). They also report reluctance to seek services because they have concerns about confidentiality, believe that sexual experiences are private matters, and members of refugee or immigrant groups may have fears of deportation (ISTSS, 2018). Others from marginalized groups may have experienced a long history of not being believed by law enforcement officials, or they may have developed a strong mistrust of agencies, based on both personal experiences and historical knowledge of violations perpetrated by these agencies.

Individuals report that, even when services are available, they have limited awareness of the supports that are available, and they have lack of access to these resources. Formal services tend to be less available and accessible for survivors who are disabled, non-English

services tend to be less available and accessible for survivors who are disabled, non-English speaking, or who have low levels of education; such individuals often are unaware of available resources or have limited access to hospitals or rape crisis centers (Bryant-Davis et al., 2009). In addition, many social services are not designed to meet the needs of male survivors or of LGBT individuals. Many survivors from marginalized groups say that a lack of clinicians from their own cultural group is a barrier to help seeking. They believe that clinicians from nonmarginalized groups may lack awareness, knowledge, and skill to understand their native language and to respect their cultural values and practices fully.

Further, individuals might avoid seeking help in order to protect themselves from psychological harm (Patterson et al., 2009; Ullman, 2007). After a sexual trauma, survivors may try to suppress their memories and emotions, deny the impact of the trauma on their current functioning, and fear that if they experience the memories and feelings, they may become overwhelmed. They may delay seeking help from professionals until they can no longer suppress their emotions or when their symptoms become intolerable. As a result, many survivors may delay seeking mental health treatment for years, and even when they do seek treatment, they often present for counseling with a different presenting problem. In addition, survivors may delay seeking mental health treatment because of past negative experiences with the mental health system or with particular mental health professionals, or they might possess beliefs that treatment will cause them to feel worse, that they are unworthy of services, or that mental health treatment will not or cannot help them with their particular experiences (Patterson et al., 2009). Because of these findings, it is therefore important for counselors to be aware that (a) survivors may delay treatment and not seek help until their symptoms are chronic, (b) they may be highly mistrustful of the treatment process, and (c) they may present with a different problem, initially, until they feel comfortable in openly disclosing the sexual violence.

Microsystem Level

This level refers to an individual's social support system. It is a difficult choice for survivors to disclose sexual violence to others, and others' reactions to their disclosure may play an important role in future help-seeking and recovery. When survivors receive negative reactions from informal supports, they report higher levels of PTSD symptoms, poor self-esteem, greater self-blame, and are more likely to engage in maladaptive coping strategies (Ullman & Relyea, 2016). Negative reactions following disclosure can range from overt rejection, blaming the survivor, stigmatizing the survivor (i.e., viewing them as "damaged goods"), or outright disbelief that the incident occurred. Some reactions that seemingly appear to provide support are not effective but actually harmful. For example, it is damaging if a survivor discloses an act of sexual violence to a loved one, and the person acknowledges what happened, but minimizes its impact, tells the survivor to "just stop thinking about it," or even resorts to controlling behaviors to try to protect the survivor (Ullman & Relyea, 2016).

Negative reactions from others, however, can be buffered by the availability of positive social support. Research indicates that social support and positive reactions to disclosure can strongly affect a survivor's reactions to trauma as well as the ability to recover from sexual violence (Ullman & Relyea, 2016). The availability of social support increases the likelihood of early disclosure, which is related to a more positive recovery. In fact, survivors with strong support systems, and those who disclose to family and friends, have more positive physical and mental health following sexual trauma (Ullman, 2007).

Macrosystem Level

This level refers to broader societal factors such as cultural differences in responding to rape and the acceptance of rape myths that exist in a particular culture. It is important to understand a survivor's reactions to sexual violence within a sociocultural context, examining the meaning of sexual assault not only to the individual, but also in terms of how it is perceived within the individual's cultural community. For example, when examining rape within a feminist, gendered context, it is viewed not as a crime about sex but about power that serves to devalue women, limit their freedom, and maintain their inequality.

that serves to devalue women, limit their freedom, and maintain their inequality (Brownmiller, 1975). Popular culture contributes to and perpetuates this power differential. In current culture, women are hypersexualized and sexually objectified in popular media representations; women are frequently portrayed as sexual objects that exist for the gratification of men's desires. Sexual aggression and violence against women also are normalized in such media as music, music videos, videogames, and pornography (Gravelin et al., 2019).

With sexual objectification occurring so pervasively at the macrolevel, authors recently have used the term "rape culture" to describe certain hypermasculinized settings in which the glorification of coercive sexual behavior becomes part of the group identity. Sexual aggression is an expected and normative behavior within these groups. Such cultural attitudes may be maintained as victims are silenced through stigmatizing, shaming, or not believing women who speak up. When coercive behaviors are normalized, women may begin to question whether they are to blame or whether or not the experience was even a sexual assault (Gravelin et al., 2019). Endorsement of what authors have termed "rape myths" also contribute to the perpetuation of rape culture (see Box 6.1).

BOX 6.1

Rape Myths

Myths about rape may exist within a particular society that influence both survivors' and others' reactions to acts of sexual violence. Women, in particular, are harmed when the following types of commonly accepted rape myths are endorsed:

- Only stranger rape is "real" rape;
- Sexual violence is the norm; it is natural and normal for sexual activity to involve aggressive behavior;
- She must have deserved it (rape) because of the way she dressed and where she was when it happened;
- Women are just "asking for it" (rape) if they are out alone, late at night;
- If she is drinking alcohol and is raped, then she should have acted more responsibly with her alcohol consumption;
- She must have wanted it (rape), because she didn't say no or didn't put up a struggle;
- If a woman sexually teases a man, she deserves to be raped;
- Men can't control themselves sexually, once they are aroused; they can't control their urges;
- When she says 'no,' she really means 'yes' and is just playing hard to get (termed "token resistance"; implies the belief that many women say 'no' to sex even though they want to say 'yes' because it is considered 'unladylike' for women to desire sex—so she says 'no' when she really means 'yes');
- A woman who accuses a man of rape is doing it to get back at him for not going out with her" (or she is lying and made the story up for attention or for money);
- It is not really rape if a woman has had many sexual partners; and,
- Men can't be raped.

(Burt, 1980; Gravelin et al., 2019)

It is clear that accepting rape-related myths perpetuated by society can lead to greater levels of negative reactions from others to minimization by the survivor, and to the likelihood of increased victim blaming. All of these can have an impact on an individual's ability to recover from sexual trauma (Campbell et al., 2009).

Recent social justice activism such as the #MeToo movement has brought the pervasiveness of rape culture into greater focus, with more survivors speaking out about abuses in the film/television industry, by politicians, on college campuses (and fraternity houses in particular), among professional and elite-level athletes, and the high levels of sexual trauma within the military (Gravelin et al., 2019). It remains to be seen whether this movement will have an impact on decreasing or even eradicating rape culture in the future.

movement will have an impact on decreasing or even eradicating rape culture in the future.

Cultural norms around sexual identity also affect the perpetration of and disclosures about sexual violence against LGBT individuals. For male survivors, cultural beliefs about masculinity (that men cannot be raped) and sexuality ("if a man is raped by another man, he must be gay") may cause blame, stigma, and reluctance to report. As stated previously, men who do not conform to cultural norms of masculinity often are targeted as victims of violence; bisexual men are at especially high risk for sexual violence, as well as transgender individuals who are transitioning from male to female. Further, in cultures where there exists strong homophobia, or even laws against homosexuality, sexual minorities are at particularly high risk for sexual assault. In certain African countries, for example, there still is evidence of what is called "corrective rape" for lesbian women, to "cure" them of their sexuality, as well as experiences of rape/murder for both men and women as a form of "punishment" for their sexual identity (Mwambene & Wheal, 2015).

Finally, a person's experience of sexual violence can be influenced by their racial/ethnic background and cultural values within a particular community. According to Bryant-Davis et al. (2009), the sexual assault of ethnic/racial minority men and women should be understood within the broader context of *societal trauma*, considering that an individual's previous experiences with racism, sexism, classism, heterosexism, cultural violence, or historical violence are cumulative and contribute to the way in which a survivor experiences sexual violence when it occurs. For example, Native American women may have a distrust of government agencies and law enforcement, not only related to their current life experiences but also due to the accumulation of historical abuses and cultural trauma resulting from colonization (ISTSS, 2018). Asian American families may place pressure on survivors to remain silent about their experiences so as not to bring the family shame or dishonor. Finally, Slatton and Richard (2020) write about the societal marginalization of African American women that serves to delegitimize their experience of sexual violence and to increase their reluctance to report when it occurs. Black American women may believe they will be blamed for their own victimization, will not be taken seriously by law enforcement, and that they must uphold the stereotyped role of the Strong Black Woman who should bear her pain without complaint. African American women may also receive pressure from their own communities to refrain from any reporting of intraracial assaults; they are told their primary allegiance should be to protect members of their own race and that a report would be viewed as an attack against the Black community. When receiving this type of pressure, it is understandable that women may be conflicted as to whether to protect African American male perpetrators from incarceration, or to promote their own needs for justice and safety (Slatton & Richard, 2020). The clinical vignette that follows illustrates the importance of viewing sexual assault through a multisystemic lens (Box 6.2).

BOX 6.2

Clinical Vignette: Michelle's Story

Michelle, a 25-year-old African American woman with two children ages 3 and 5, lives with her mother and children. She seeks assistance from Marybeth, a Caucasian counselor (age 45) at the community college she is attending part-time. Michelle has many reservations about being in Marybeth's office and speaks hesitantly, wondering if this White counselor, who is 20 years older than she, actually can be of help to her. While she initially talks about concerns with her young children and time management issues, eventually she reveals that she needs to talk about an incident in which she was raped 1 year ago by a friend of her mother's. At the time of the assault, she was home alone and allowed this friend to come in and wait until her mother returned from work. She never told her mother or anyone in her family of this incident, nor did she discuss it with anyone else until today. She thought she could put the rape out of her mind and told herself to be strong. She questioned whether anyone would even believe her if she told anyone. She is seeking help now, due to recent difficulty going to class, because her professor reminds her of the man who attacked her. She also is experiencing flashbacks, nightmares, and persistent symptoms of anxiety. She keeps asking Marybeth if she is doing the right thing in discussing this private incident.

keeps asking Marybeth if she is doing the right thing in discussing this private incident.

Marybeth reassures Michelle that she is taking an important step toward recovery by talking about the rape with her. When assessing Michelle's attitudes toward help seeking, she learns about her fears of counseling (i.e., that she will be forced to report the incident to police, that she will have to withdraw from school, that she will be interrogated in court, or that Marybeth will tell her family). She is adamant that she does not want to go to the police, because she has observed male police officers act in a nonresponsive manner with women in her neighborhood who have called them for help with domestic violence. She thinks the police will not believe her, and even if they did, she does not want her mother's friend (who is also African American) to go to jail. She asserts, "There are too many African American men in this city who are already in jail, and I don't want to be responsible for putting another man behind bars." After Marybeth assures Michelle that she will respect her decision not to report and that she will keep her information confidential, she tries to begin to understand

Michelle's cultural values and life history that might be contributing to her reactions to the rape. As an African American woman, Michelle says that she learned that it is very important to be strong and independent, to bear any painful burdens in silence. She fears her mother will support her friend and will be angry that she is trying to cause trouble for him, because she believes he is a "good man." When asked about social support, Michelle states that she is close to her sister and a few women at her church, but she does not want to tell anyone about this, because she fears it is pointless; they either will blame her or just tell her to "be strong and this will pass."

TRAUMA-INFORMED TREATMENTS FOR SEXUAL VIOLENCE

Counselors generally provide assistance to survivors coping with sexual assault in two ways: either through referring to or providing crisis intervention in the immediate aftermath of the event, or through providing treatment, at a later time, when the survivor can no longer tolerate the symptoms that have emerged following the sexual trauma. As highlighted in the previous sections, it is important for counselors to be prepared with the knowledge and skill to provide contextually-sensitive trauma-focused treatment.

The treatment approaches outlined in the following text are based on clinical practice guidelines for PTSD and are recommended as efficacious by major mental health organizations ([American Psychiatric Association PTSD Guideline Watch, 2009](#); [American Psychological Association Clinical Practice Guideline for the Treatment of PTSD, 2017](#); [ISTSS Practice Guideline for PTSD, 2019](#); [Veterans Affairs/Department of Defense Practice Guideline for the Management of PTSD and Acute Stress Disorder, 2017](#)). The evidence-based, recommended treatment approaches are designed to reduce PTSD symptoms that occur following sexual trauma, and they include the following: (a) psychoeducation about trauma and commonly experienced PTSD symptoms, (b) PE to facilitate the client's ability to process memories related to the event, (c) cognitive therapy and CBT with a trauma focus (i.e., trauma-focused CBT for children and adolescents, CPT, and [EMDR]), both to process memories associated with the event as well as to help restructure the client's maladaptive beliefs about the impact of the event.

Psychoeducation

When counselors work with sexual trauma survivors, they first should work to develop a trusting therapeutic alliance, as survivors may have great reluctance to discuss their memories of the trauma and may have had negative experiences with other service clinicians. Counselors should demonstrate empathy and positive regard for clients as they carefully assess client concerns through the multisystemic lens described in this chapter. This type of assessment is imperative in developing a treatment approach that is tailored to the client's specific needs. As part of building rapport, survivors of sexual trauma benefit from receiving information regarding commonly experienced reactions to sexual assault (e.g., guilt, anger, shame, powerlessness, helplessness, fear) and the symptoms of PTSD, as described previously. Many survivors express that they feel relief when they realize that they are not "crazy," but rather are experiencing a normal and expected reaction to a highly traumatic event, and that PTSD symptoms persist, because the natural process of recovery has been interrupted. They feel a sense of hope that effective treatments exist that can help to resolve their distress. The counselor also should be prepared to provide information and resources about medical and legal decisions and assist the survivor in gaining access to local sexual trauma services, as appropriate ([American Psychiatric Association, 2009](#); [American Psychological Association, 2017](#)).

Exposure-Based Therapy

PE is another research-based approach that is strongly recommended in clinical practice guidelines. The goal of PE is to assist a survivor in working through painful memories,

guidelines. The goal of PE is to assist a survivor in working through painful memories, situations, thoughts, and emotions associated with the traumatic event and which currently evoke anxiety and fear (Foa et al., 2007). The client is asked to create a verbal and written narrative that provides a detailed recounting of the traumatic event. This PE to the memory is done with the goal of habituation (and resulting decrease in anxiety and fear). As noted previously, many survivors of sexual trauma engage in avoidant coping strategies in order to avoid this intense anxiety and fear (Fortier et al., 2009), and it is understandable that they will be resistant to this strategy when it is presented to them in counseling. To encourage clients to undertake this difficult work, counselors should express empathy and acknowledge a survivor's fear, spend time educating the client about the rationale for this treatment strategy, and convey positive expectations for recovery. Counselors can explain the rationale for PE to clients in the following way:

1. Memories, people, places, and activities associated with the trauma are now stored as a fear network in your brain. Any time you encounter anything associated with the trauma, your fear network is activated, causing symptoms like nightmares, flashbacks, and intrusive thoughts. These are uncomfortable and make you highly anxious, so you do what you can to avoid the memories or anything else that might remind you of the trauma.
2. Each time you avoid them, however, you do not finish the process of digesting painful experiences, and so they keep returning in the form of intrusive symptoms.
3. You can begin to process the experience by gradually allowing yourself to access the memories, thoughts, and feelings in your imagination, holding them there without pushing them away.
4. You also will practice facing those activities, places, and situations that currently evoke fear.
5. Eventually, you will be able to think about the trauma and resume your normal activities without experiencing intense fear.

After providing a rationale, the counselor can then teach a breathing technique to help the client manage her anxiety as she begins formal processing of the trauma. When the client is ready to begin the process, the counselor can use *imaginal exposure* to assist the client in repeatedly recounting memories associated with the trauma, until the memories no longer cause intense anxiety and fear (Foa et al., 2007). Clients are asked to close their eyes, to imagine the traumatic event in vivid detail, and to describe it as if it were happening in the present. This narrative is recited repeatedly, in sessions, and is recorded for listening, outside of sessions. Writing about the event in a journal also may be helpful for continued practice. This is an extremely difficult phase of treatment for clients as they face the thoughts, feelings, and images associated with the event, which they have been attempting to avoid, out of fear. Counselors should acknowledge this difficulty and encourage clients in their willingness to process the event, gradually, in order to cope with their fears.

PE also involves *in vivo exposure*, a process through which clients are asked to focus on activities and situations associated with the event that they currently avoid because it evokes intense fear and disrupts daily functioning. The client hierarchically lists all avoided situations and activities, ranking them from least to most distressing. It should be noted that the counselor should review this list to ensure that these situations or activities are actually safe and that it includes only those things that are interfering with the client's ability to engage in their daily routines. Starting with the activity or situation that is least distressing, the client remains in this particular environment for a minimum of 30 minutes. This time is recommended because it is long enough for the client to experience fear, to evaluate the actual level of danger present in the situation, and to allow the fear and anxiety to decrease. Anxiety management techniques can be used during this time. Over the course of counseling, the client can progress through the hierarchy until they are able to resume daily routines and functioning (Foa et al., 2007).

Trauma-Focused Cognitive and Cognitive-Behavioral Approaches

According to practice guidelines, cognitive and CBT-based approaches are effective in reducing symptoms associated with sexual trauma. In these approaches, clients learn to identify the automatic thoughts or beliefs that they experience during negative emotional

identify the automatic thoughts or beliefs that they experience during negative emotional states related to the sexual trauma. The counselor's ability to understand the client's broader context can assist the client in fully identifying and exploring thoughts as well as the meaning that the client places on the impact of the traumatic event. As clients identify these thoughts and beliefs, they also learn about typical cognitive distortions related to sexual trauma, learn to evaluate distortions, challenge them, and eventually replace them with more rational or beneficial thoughts.

Trauma-Focused Cognitive Behavioral Therapy

TF-CBT is a structured model of trauma-based treatment for children, adolescents, and their caregivers. The goal of this approach is to help the client process traumatic memories, to overcome problematic thoughts and behaviors, and to develop effective coping and interpersonal skills. The approach also includes a parenting component that focuses on stress management, positive parenting, behavior management, and effective communication (Cohen et al., 2016). The key components of TF-CBT can be summarized according to the acronym PRACTICE:

- P: Psychoeducation (about trauma, PTSD); parenting skills (positive parenting, communication)
- R: Relaxation techniques (e.g., practicing focused breathing, progressive muscle relaxation)
- A: Affective expression and regulation (identifying and expressing emotions appropriately)
- C: Cognitive coping and processing (identifying and correcting unhelpful thoughts, understanding how thoughts, feelings, and behaviors are connected)
- T: Trauma narrative and processing (creating a verbal, written, and other creative recounting of traumatic events)
- I: In vivo exposure (gradual exposure to trauma reminders in a child's environment so that the child can learn to control emotional reactions, as fear is reduced)
- C: Conjoint parent/child sessions (working with a family to teach effective communication, and to provide the child with an opportunity to share the trauma narrative with caregivers)
- E: Enhancing personal safety and future growth (education and training on personal safety, healthy relationships and sexuality, and encouraging the use of new skills in future situations) (Child Welfare Information Gateway, 2018; Cohen et al., 2016).

Cognitive Processing Therapy

One form of CBT that originally was designed specifically for rape-related trauma in adults is CPT (Resick et al., 2017). CPT recently has been expanded and shows strong success in treating PTSD in multiple populations, including military veterans and for military sexual trauma (VAA/DOD, 2017). In CPT, PTSD is conceptualized as a disorder of halted or interrupted recovery. While painful memories are typically processed and resolve naturally, over time, for some individuals, recovery becomes stuck due to repeated avoidance of the feared memories, thoughts, feelings, and places associated with the event. Recovery also can become stuck when the impact of the trauma results in the development of unhelpful beliefs about the self, others, and the world. Therefore, the goal of CPT is to help the client break the pattern of avoidance, through repeated exposure to the traumatic memory, so that the memory can be processed adequately. A second goal is to challenge and restructure unhelpful beliefs that have developed related to the trauma.

In therapy, the client is asked to write an impact statement—a statement regarding why she thinks the event happened, and the impact that it has had on her beliefs about self, others, and the world. The client and counselor then explore the client's interpretation of the event, along with the implications of the trauma, as these relate to the client's belief system. Through the counselor's line of questioning, the client can start to consider alternative viewpoints and multiple ways in which to view the trauma. The therapist can use questions such as:

What is the evidence for and against this idea?

Is your belief a habit or based on facts? Is the source of information reliable?

- Is your belief a habit or based on facts? Is the source of information reliable?
- Are you using words or phrases that are extreme or exaggerated (i.e., always, forever, never, need, should, must, can't, and every time)?
- Are you taking the situation out of context and only focusing on one aspect of the event?
- Are your judgments about yourself or the event based on feelings rather than facts?

In identifying and examining the client belief system, the counselor first helps the client analyze her beliefs regarding self-blame. Resick et al. (2017) encourage counselors to help their clients to distinguish between responsibility and blame in a situation. On the one hand, *responsibility* is related to the actions an individual took in a situation that contributed to a certain outcome. In contrast, *blame* involves a combination of both responsibility and intentionality. The following questions might be posed to the client: What did you do in the situation, and did you intend to cause or contribute to the resulting outcome? Did you intend for harm to come to you or to others?

As described throughout this chapter, self-blame is perpetuated by cultural beliefs and by negative reactions from others in the survivor's life who engage in victim blame. Individuals who incorporate self-blame into their overall view of themselves tend to be the most stuck in recovery. It therefore is important for counselors to help their clients distinguish between avoiding attributions of self-blame assigned to their *character* (e.g., "I am a bad person and deserved to be raped") versus accepting responsibility for some aspect of their *behavior* (e.g., "I made a decision that day that I might not make now"). Guilt often is related to self-blame, in that the survivor may perceive that they are to blame for putting themselves in the situation or for not doing enough to fight back or to prevent the crime. The counselor can assist the client in examining self-blaming and guilt-related beliefs and can help the client begin to replace these thoughts with more logical and growth-enhancing self-statements (e.g., "I did not do everything right in this situation, but the perpetrator is fully responsible for this crime. I will now do everything I can to reclaim the power taken away from me by this crime").

In addition to attributions about self-blame, survivors learn skills to identify and challenge "stuck points" in five specific areas: safety, trust, power/control, esteem, and intimacy. The CPT stuck points are described briefly in the following text.

Safety: The first stuck point to explore relates to prior and current beliefs about safety. The client is asked to examine her prior beliefs about safety (e.g., Did you believe others were basically safe and that you had what it takes to protect yourself in the world? Or did you grow up believing that others are dangerous and that you were unable to protect yourself?). The nature of these prior beliefs will be altered because of the trauma. Through a gentle questioning process, the counselor can help the client develop a more balanced view that incorporates the traumatic event but that does not lead to avoidance or undue fear. An example of a new and balanced view might be: "I can't control my safety at all times, but I can take steps to protect myself from harm. There may be some people I encounter, who intend to harm others, but it is unrealistic to expect that everyone I meet is going to harm me."

Trust: Disruptions in trust of self and others is a common stuck point for survivors. For some individuals who had a prior trusting outlook (e.g., "I have good judgment," and "Others are trustworthy"), this belief will become disrupted, while for those who held previous negative beliefs about trust in self or others ("I can't trust myself to make good decisions," and "Others can't ever be trusted"), their worldview might be reinforced to an extreme degree that contributes to fear and isolation. The client will need to develop a more balanced belief that accepts and incorporates the traumatic event. For example, a new belief might be: "I can learn from my experiences and I can trust myself to make the best decisions I can in the future. There may be some people I cannot trust to talk to about what happened to me, but they can be trusted to support me in other areas."

Power and Control: During an act of sexual violence, an individual is stripped of their power, and often survivors continue to feel powerless and out of control long after the trauma has ended. In examining her prior beliefs, the counselor can help determine if she viewed herself as always in control of her life (e.g., I can control what happens to me and I can

always protect myself") or if she viewed herself as powerless to effect change (e.g., "I am powerless in most situations"). The goal in therapy is to help the client create a more balanced view of power and control, one in which she recognizes that she will not have total control over every situation, but in which she recognizes that she is not helpless. For example, "I do not have total control over my reactions, other people, or everything that might happen in my life, but I definitely have some control over my reactions to events and the power to influence the outcome of many situations." Counselors also can assist the client in focusing on restoring their sense of personal power, particularly regarding decisions made in the present. As a part of regaining power and control, counselors should encourage clients to take an active role in the counseling process, providing them with as many choices as possible and allowing for flexibility in the timing and pacing of sessions.

Self-Esteem: In their CPT treatment manual, Resick et al. (2017) recommend helping clients to focus on the effect that the sexual trauma has had on their self-image and self-esteem. Clients can uncover negative beliefs, such as "I am unlovable" or "I am damaged goods," which have surfaced or have been reinforced by the trauma. Through CPT, clients can learn to separate the events and their reactions from their views of themselves as individuals (e.g., "Being a survivor of sexual trauma is a part of who I am, but it does not define me. I have strengths and a sense of self that this trauma did not disrupt"). As a part of this process, the survivor gradually can learn to view the sexual violence as a traumatic yet growth-enhancing event. It is helpful for clients to know that growth often occurs after a traumatic event, including greater self-awareness, strength, maturity, a more flexible worldview, increased empathy, greater sensitivity to the suffering of others, and changes in relationships, spirituality, life philosophy, or overall values.

Intimacy: Because sexual violence often is committed by someone the survivor knows and trusts, a client's capacity for intimacy may be disrupted. If a survivor questions their judgment in selecting safe relationships, engages in self-blame, and receives victim-blaming reactions, they can develop particular problems in intimacy with both existing and new relationships. To change these stuck points, clients can explore beliefs that they have developed, related to relationships and about the world in general (e.g., "People can't be trusted and I should not allow them to be too close"). They can then modify any beliefs that are impediments to their recovery, evaluate current relationships and their interactions with others who can provide support, and fully explore the need for positive connections with others as part of the recovery process. For example, one area that is common for survivors is the need to process any disappointment they feel in others who reacted in an unsupportive manner following disclosure of the trauma. They can then decide if they want to communicate their feelings openly to the people involved (Box 6.3). They can be encouraged that, by communicating directly about their feelings, the overall level of safety and trust in the relationship might be clarified, and overall communication actually might be enhanced. A helpful and more balanced view of intimacy, then, may be: "I can still be close to people, and I have the right to choose whether or not I want to be intimate with others. I don't have to be close to everyone, but I don't have to push everyone away either."

BOX 6.3

Clinical Vignette: Michelle's Treatment and Recovery

Recall the case of Michelle from earlier in the chapter. Once in treatment, the counselor, Marybeth, first reassures Michelle that her symptoms are normal reactions to a traumatic event such as rape. She educates her about symptoms of PTSD and describes the elements of recommended treatment approaches. With Michelle's permission, they gradually create a trauma narrative and impact statement. Marybeth asks Michelle to describe the rape in detail and to re-experience her emotions around the event. Over time, Michelle learns to use relaxation techniques, while sitting at her desk before class, and then once the professor enters the room. She uncovers self-blaming thoughts that are keeping her stuck: "I deserved this," "I can trust no one," "I am disgusting because this happened to me." She then learns to let go of some of her blame, guilt, and mistrust of others. While she decides not to tell anyone in her family about the rape at this time, she discusses the benefits and

not to tell anyone in her family about the rape at this time, she discusses the benefits and consequences of doing so in the future. With Marybeth's encouragement, Michelle is able to disclose the rape to one friend and is relieved when she fully supports her. Gradually, she experiences some symptom relief and is able to function better at home and school.

Eye Movement Desensitization and Reprocessing

Although initially developed 30 years ago ([Shapiro, 2001](#)), EMDR has emerged as an effective and widely accepted treatment for PTSD. It is a treatment that integrates elements of the exposure-based and cognitive therapies described previously and focuses on changing the way that traumatic memories are stored in the brain. When under extreme stress, our natural fight, flight, or freeze instincts are activated. When PTSD symptoms develop, it is assumed that the memory (including images, cognitions, affects, and bodily sensations) has been stored in the brain exactly as it was at the time of the event. When the memory or anything associated with the memory is triggered, the original fight/flight or freeze response is reactivated and is experienced by the individual as if the event is happening again in the present moment. Because this is so unpleasant, the individual does what is possible to keep this from happening and tries to avoid memories and associations with the trauma.

EMDR uses bilateral brain stimulation through eye movements, taps, or tones to help the individual to process these distressing memories directly. While undergoing bilateral brain stimulation, the person is asked to recall the image, associated cognitions, affects, and physical sensations. The treatment assumes that as both the left and right hemispheres are activated in processing the memory, the brain becomes better able to integrate the memory with less emotion and more logical reasoning. With integration, the individual finally can experience the memory as not actually happening in the present, but rather, experience it as an occurrence in the past that is now over. The memory remains, but the fight/flight or freeze response (along with distressing symptoms) is no longer reactivated ([EMDR International Association, 2020](#)). The sessions are structured according to the following phases (summarized from [American Psychological Association, 2017](#)):

- **History:** The counselor conducts a history of the trauma, develops a treatment plan, and ensures the client has adequate resources for affect management and containment both within and outside of sessions.
- **Assessment:** The client is asked to view a list of common negative core beliefs about self, others, and the world. The client is asked to rate the validity of their belief on a scale from one to seven ("How true does this feel to you with one being completely false and seven being completely true?") and is also asked to rate the memory on a scale that measures the level of distress she experiences related to that memory.
- **Desensitization:** The client focuses on a segment of the memory while exposed to eye movements (or tones or tapping) that bilaterally stimulate both hemispheres of the brain. The client's memory exposure is interrupted after a few moments, and she is then asked about what new thoughts or feelings emerged for her. Ideally there is a new understanding about the experience and its impact. The process continues until the particular memory is experienced as no longer distressing.
- **Installation:** The client is asked to compare the prior negative cognition with a new, more positive and integrated belief about self, others, and the world.
- **Body Scan:** The client is asked to scan the body and to note if any remaining somatic distress is present.
- **Closure:** The counselor ends the session and assesses for safety and containment until the next session.
- **Re-evaluation:** At the start of the next session, the counselor assesses for any new memories or thoughts that have emerged since the last session, and these are used as targets for the current session.

EMDR continues to gain popularity among clinicians around the world, but it is clear that it is a complex and highly structured treatment that involves considerable training and skill to

is a complex and highly structured treatment that involves considerable training and skill to be utilized ethically and effectively. Counselors should not practice EMDR without appropriate training and supervised experience (see Eye Movement Desensitization and Reprocessing International Association for training and certification requirements).

COUNSELING IMPLICATIONS

Counselors who work with survivors of sexual trauma can provide more sensitive and effective treatment when they conceptualize client concerns through the ecological model presented in this chapter. It should be clear that counseling treatment that is focused solely on an individual's posttraumatic symptoms is inadequate, as the counselor ultimately fails to address the client's unique responses as affected by the multiple systems that operate in their life. The more the counselor can understand the client's background, cultural values, previous victimization history, relationship to the perpetrator, current level of support, and experiences with victim blame from other service clinicians, the more effective the counselor will be in tailoring treatment to the client's specific needs. While providing this multisystemic understanding of a client's responses to sexual trauma, counselors also should be knowledgeable of clinical practice guidelines for sexual trauma. Because these treatments require clients to address the memories and situations that produce intense fear and anxiety, so they can be fully processed, counselors should balance treatment techniques with adequate support and validation, so that the client remains in control of the direction of their treatment. As the counselor demonstrates empathy and an understanding of the client in context, the client can remain empowered as they undertake the difficult but growth-enhancing process toward recovery.

CONCLUSION

In summary, because of the pervasiveness of sexual violence and resulting trauma, it is important for counselors to be able to provide treatment for sexual trauma in a contextually sensitive manner, while also remaining knowledgeable of evidence-based approaches to treatment. Future research should prioritize a multisystemic approach to the conceptualization of sexual violence. Research also is needed to refine current treatment components and how these may be best tailored for individual clients, based on their sociocultural context.

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Trauma Experienced in Early Childhood

ANDREA DOYLE AND LISA LOPEZ LEVERS

CHAPTER OVERVIEW

The purpose of this chapter is to outline some of the consequences of trauma that occur during early childhood. The chapter discusses particular trauma-relevant issues in early childhood, identifies therapeutic responses, and examines the counseling implications. These major sections are followed by a summary of the chapter and an online list of relevant resources.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Become cognizant of the developmental issues in early childhood that interface with and complicate diagnosis;
2. Become aware of the main treatment approaches to trauma in early childhood, how they differ, and how they intersect; and,
3. Develop insight regarding the counseling implications of treating the effects of trauma experienced in early childhood.

INTRODUCTION

Advances in developmental science have marked an increased recognition of the formative nature of early childhood for growth and development across the life-span. Early childhood encompasses the first 8 years of life—including infancy, toddlerhood, preschool, and the early elementary school years. During these years, children develop critical cognitive, social-emotional, and physical competencies that will enable them to negotiate early developmental challenges successfully and to support their future well-being (Durwin & Reese-Weber, 2021; National Research Council, 2000). These early years also are marked by increased vulnerability to traumatic events, such as child abuse and neglect or witnessing intimate partner violence (IPV) or domestic violence (DV). According to Harvard University's Center on the Developing Child (2021), "Toxic Stress," p. 1), "healthy development can be derailed by excessive or prolonged activation of stress response systems in the body and brain [and] such toxic stress can have damaging effects on learning, behavior, and health across the lifespan."

After a significant decline in number and rate of abused children from 2006 to 2007, as cited in the first publication of this chapter in 2012, the rate and number of abused and neglected children continued to decrease until 2012, when both began to rise again. In 2017, there were approximately 674,000 abused and neglected children in the United States, at a rate of nine per thousand (U.S. Department of Health and Human Services, Children's Bureau, National Child Abuse and Neglect Data System [NCANDS], 2019). As in previous years, rates of abuse and neglect have been greatest among infants and young children (Administration for Children and Families, 2020). Similarly, nearly 60% of children who have witnessed DV are younger than the age of 6 (Fantuzzo & Fusco, 2007; Fusco & Fantuzzo, 2009). Given the critical nature of early childhood for children's development, experiences of trauma in these early years can have a particularly adverse influence on development. From birth to age 5, children are exposed disproportionately to traumatic events relative to older children, but until the last decade, they have been underrepresented in the trauma research literature. Children of color and those living in poverty particularly are affected by the social and behavioral determinants of toxic stress and trauma (Lieberman et al., 2011; Morsy & Rothstein, 2019).

Early childhood can be a toxic or even dangerous time for young children (Center on the Developing Child, 2021), and risk factors associated with poverty and ethnicity may increase the threat of toxic stress and trauma (Kim & Drake, 2018). Some children have experienced

the threat of toxic stress and trauma (Kim & Drake, 2018). Some children have experienced untold suffering due to the long-term consequences of child abuse and neglect (Child Welfare Information Gateway, 2019). The purpose of this chapter is to provide an overview of the influence of trauma on early childhood development and to illuminate ways to begin mitigating the effects. This is accomplished through discussions in the following sections: development in early childhood, the influence of trauma on early development, and practice implications for working with young children who have experienced trauma. These sections are followed by concluding remarks and an online list of practice-based resources.

EARLY CHILDHOOD DEVELOPMENT

Early childhood is a critical time for brain development (Centers for Disease Control and Prevention [CDC], 2021; Shonkoff & Phillips, 2000). Between birth and age 2, the brain more than triples in size, reaching 75% of its adult size by age 2 (Davies, 2004; National Research Council, 2000). Neural development begins soon after conception and continues at a rapid rate through early childhood (Durwin & Reese-Weber, 2021; Nelson & Bosquet, 2000). The early stages of neural development consist largely of primitive cells migrating to and forming specific parts of the brain. Once this migration of cells has been completed, the processes of synaptogenesis and myelination begin (Durwin & Reese-Weber, 2021; Nelson & Bosquet, 2000). Synaptogenesis is the process by which connections are made between brain cells, and myelination functions to increase the speed with which cells communicate with one another. The rate of development for synaptic connections is highest in the first few years of life. It is largely contingent on the quantity and quality of stimulation to which children are exposed—or neural plasticity. Positive early experiences have been associated with increased synaptic connections, whereas negative, adverse, or traumatic early experiences have been associated with decreased synaptic connections—or pruning (Durwin & Reese-Weber, 2021; Perry et al., 1995; Siegel, 1999). A primary source of information about the world, and thus a primary source of neural development, comes from infants' and young children's interactions with their caregivers (Siegel, 1999). For this reason, the development of the relationship between infants and their caregivers is a primary early developmental task.

Attachment as a Developmental Competency in Early Childhood

A fundamental task of early childhood is the development of a secure attachment relationship(s) with a parent or guardian. Bowlby (1982), who originated attachment theory, defined "*attachment*" as "any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world" (p. 26). Attachment relationships are transactional, in that they result from the mutual interactions between the infant and their caregiver, and they serve to provide the infant with a "sense of security," "affective" regulation, "expression of feelings and communication," and a secure base from which to explore the world (Cicchetti & Valentino, 2006; Davies, 2004; Sroufe et al., 1999; Tronick, 2017).

Starting at birth, infants begin a process of moving through phases of attachment. The first phase of attachment, "orientation and signals with only limited discrimination of figure," occurs in the first 8 weeks of life (Ainsworth, 1964; Bowlby, 1982, p. 266). During this phase, the infant is relatively indiscriminant in terms of the target of their attachment behaviors. The second phase occurs between the eighth and 12th week of life and involves "orientation and signals towards one (or more) discriminated figure(s)" (Bowlby, 1982, p. 266). In other words, the infant is beginning to show preference for one or more specific caregivers. The third phase of attachment is characterized by "maintenance of proximity to a discriminated figure by means of locomotion as well as signals" (p. 267). This phase lasts from about 12 weeks to 18 months. During the third phase, typically, developing infants gain mobility skills through crawling or walking. In doing so, they gain the capacity to retain close physical proximity to their caregiver. The fourth phase of attachment begins at about 18 months and lasts indefinitely. This phase is characterized by "formation of goal-corrected partnership" (p. 267).

2077.

As the infant progresses through each of these attachment phases, they engage in attachment behaviors. These behaviors are elicited with the purpose of drawing a caregiver into closer proximity, and as the child moves through the phases of attachment, the behaviors become increasingly discriminating in favor of the primary caregiver (Ainsworth, 1964). Even very young infants show evidence of these behaviors. For instance, as noted by Lieberman and Knorr (2007), a baby may cry, smile, track, cling, or follow a caregiver in an attempt to bring the caregiver closer.

The nature of the caregiver's response to the infant's attachment behaviors has a direct relationship with the resulting pattern of attachment. Consistent and sensitive caregiver responses to infant attachment behaviors are positively associated with the creation of a secure attachment (Rothbaum et al., 2000; True et al., 2001). In accordance with attachment theory, the development of a secure attachment relationship is critical to children's early development. It is from the safety and security of the secure attachment relationship that an infant gains the confidence to explore the world around them. Research has indicated that the lack of secure attachment may result in a child exhibiting social competency deficits (Durwin & Reese-Weber, 2021).

When parents/caregivers respond inconsistently, unpredictably, or adversely, infants are at risk for developing one of three forms of insecure attachment relationships: avoidant, ambivalent/resistant, and disorganized/disoriented (Schuder & Lyons-Ruth, 2007). Infants whose primary caregivers either reject or discourage their children's attachment behaviors typically exhibit "avoidant" attachment styles. Infants demonstrating an avoidant attachment style often seem indifferent to the presence or absence of their caregiver (Ringel, 2011). Although these children are capable of exploring the world around them, research demonstrates that these children are thought to camouflage their emotional need for their caregivers through a seeming indifference to whether or not the caregiver is present. In fact, research examining the cortisol (stress hormone) levels of children with avoidant attachment styles has found that children with this attachment style have higher cortisol levels than children with secure attachment styles (Mueller & Tronick, 2019).

Children evidencing an anxious-avoidant attachment style are less likely to feel confident exploring the world around them, and they are more likely to evidence stronger attachment behaviors toward their caregivers. Unlike children with ambivalent attachments, these children are hypersensitive to maintaining proximity to their caregiver. Caregivers of children with anxious-avoidant attachment behaviors have been found to be inconsistent in their responses to their children. At times, they are highly attentive; at other times, they are largely emotionally absent.

The final attachment style is referred to as "disorganized" attachment. This attachment style is characterized by unstable, unpredictable patterns of attachment behaviors (Wenar & Kerig, 2000). This style of attachment frequently is observed in children who have experienced abuse or neglect and is the result of children seeking protection from a caregiver in times of stress, even if/when the caregiver is abusive.

Other Developmental Competencies in Early Childhood

In addition to the formation of a secure attachment relationship, the infancy, toddlerhood, preschool, and early elementary school years are marked by the acquisition of several other stage-salient developmental competencies (Durwin & Reese-Weber, 2021). These are outlined below.

Infancy:

- **Beginning gross motor regulation:** Gross motor development follows cephalocaudal (head to toe) and proximodistal (inside to out) trends. This means that infants will learn to lift their heads before they learn to sit up or crawl.

Self-regulation: At birth, infants are completely dependent on their parents or caregivers to meet their needs. Parents/caregivers regulate the infant's sleep and eating cycles. Through interactions with parents/caregivers, infants eventually begin to regulate these cycles for themselves. According to Binet (1952), the infant learns that they can have

cycles for themselves. According to [Piaget \(1952\)](#), the infant learns that they can have control over and interact with their environment.

- **Secure attachment formation:** The formation of a secure attachment is tied into the infant's development of trust versus mistrust, that is, the degree to which the infant experiences the world as a good and positive place ([Erikson, 1968](#)).

Toddlerhood:

- **Language:** During the toddler years, young children learn to speak, and they experience a rapid growth in vocabulary.
- **Gross motor development:** By the end of the first year/beginning of the second year of life, children start to walk. Their increasing mobility offers children the opportunity to explore the world around them. Children with a secure attachment relationship can use their parent/guardian as a secure base. That is, the child feels safe to explore the uncertainty of the world around them and becomes secure in the knowledge that their parent/caregiver is there, if needed. Children without a secure attachment relationship may be more reticent or fearful of exploring their environments.
- **Autonomy:** According to [Erikson \(1968\)](#), the "conflict" of the toddler years is autonomy versus shame/doubt. The language and gross motor development of the toddler years lends itself to an increasing sense of independence. During this developmental stage, young children are eager, almost adamant, about trying to perform tasks on their own. When supported by their parents/caregivers, toddlers begin to develop a positive sense of self. Children whose parents/caregivers either overregulate or underregulate these opportunities may experience feelings of shame or doubt regarding their ability to accomplish new tasks.
- **Continued self-regulation:** The newly acquired autonomy of the toddler years also offers increased possibilities of frustration (for instance, being unable to reach something or do something that they want to do). Toddlers in this stage do not yet have the cognitive or language capacities to manage these frustrations, which can result in "temper tantrums," particularly early in the toddler years. Toddlers evidence gains in self-regulation toward the end of the toddler years as they simultaneously gain increased language and cognitive capacities.
- **Egocentrism:** According to [Piaget \(1952\)](#), toddlers and preschoolers have an egocentric view of the world. This means that the child believes that others around them experience the world the same way they do.

Preschool Years:

- **Cause-effect thinking:** Preschool children's increasing cognitive capacities provide them with the ability to begin thinking about events in cause-effect terms ([Piaget, 1952](#)). Early in the development of this competency, children may confuse the sequencing of events or not account for the influence of other events ([Davies, 2004](#)). This confusion, coupled with a tendency toward egocentric thinking, may leave preschool age children prone to believing that they "caused" traumatic events.
- **Initiative:** The developmental crisis of the preschool years is initiative versus guilt ([Erikson, 1968](#)). During this stage, children are eager to try to do new things.

TRAUMA AND EARLY CHILDHOOD

Given the importance of the formation of a secure attachment relationship in early childhood, disturbances to the parent/caregiver-child relationship in these early years are particularly traumatic for young children. Young children depend on their parents/caregivers for protection from external stressors and for helping them to understand how to respond to stressful/traumatic events ([Lieberman & Van Horn, 2008](#); [Sparrow, 2007](#); [Winston & Chicot, 2016](#)). When parents cannot provide this protection, or the parents themselves are the source of the stress, young children's development and well-being becomes increasingly vulnerable to poor outcomes ([Child Welfare Information Gateway, 2019](#); [Dorsey et al., 2017](#)).

Child Maltreatment

In 2017, as in prior years, younger children were mistreated at higher rates than older children; the rate for children ages 0 to 3 was three times that of the rate for those aged 16 to 17 (U.S. Department of Health and Human Services, Children's Bureau, National Child Abuse and Neglect Data System [NCANDS], 2019). Child maltreatment includes experiences of physical abuse, neglect, sexual abuse, and emotional abuse. These experiences represent a proximal disruption to the caregiver-child relationship and thus have the potential to exert a strong influence on children's development (Cicchetti, 2004). In cases of child maltreatment, the child's caregiver often is both the threat/source of traumatic experiences as well as a source of comfort. As a result, the child is likely to experience an approach-avoidance relationship with the parent or a disorganized attachment (Milot et al., 2010; Schuder & Lyons-Ruth, 2007). Very young children who experience child maltreatment are at increased risk for evidencing poor developmental outcomes, including increased behavioral problems as well as poor educational well-being (Cook et al., 2005; De Bellis, 2001; Fantuzzo et al., 2011; Hildyard & Wolfe, 2002; Milot et al., 2010; Perlman & Fantuzzo, 2010).

Domestic Violence and Intimate Partner Violence

An estimated 10% of U.S. children are exposed annually to DV, with approximately 25% experiencing at least one event during childhood (Carlson, 2000; Huecker et al., 2021). Young children are more likely than older children to be exposed to DV (Crusto et al., 2010; Fantuzzo & Fusco, 2007). In a Canadian study, up to 34% of legitimate investigations of child maltreatment were characterized as child exposure to IPV (Trocmé, 2010). Research has demonstrated that young children who have witnessed DV show elevated trauma symptoms (Bogat et al., 2006; Graham-Bermann et al., 2008; Levendosky et al., 2002; Scheeringa & Zeanah, 1995; Tsavoussis et al., 2014). Studies by Scheeringa and Zeanah (1995) and Bogat et al. (2006) examined trauma symptomology in infants and young children who had witnessed DV. Scheeringa and Zeanah (1995) found that children show increased arousal and new fears after witnessing DV. The researchers suggested that this may be due, in part, to concerns that (subsequent to witnessing DV) the child perceives that their caregiver is less capable of acting as a "protective shield" (Scheeringa & Zeanah, 1995). Additionally, Bogat et al. found that just less than half of all infants who witnessed DV exhibited at least one trauma symptom (numbing, increased arousal, or fear/aggression), and that the number of symptoms that infants experienced after DV was directly related to the number of symptoms exhibited by their mother. Levendosky et al. (2002) examined trauma symptoms among preschoolers who had witnessed DV. Preschool children who witnessed DV showed high levels of re-experiencing and hyperarousal. Notably, children who lived in households in which DV was occurring, but who did *not* witness the DV event, still demonstrated increased levels of trauma symptoms.

Environmental Trauma

Following the September 11, 2001 terrorist attacks, recent natural disasters (e.g., Hurricane Katrina), school shootings like the Sandy Hook Elementary School massacre, and the COVID-19 pandemic, increased attention has been paid to how these events affect very young children. Chemtob et al. (2010) conducted a study assessing the impact of September 11 on preschool children. This study examined maternal PTSD following September 11 and related it to child behaviors. Findings indicated that children of mothers with co-occurring depression and PTSD were more likely than their peers to evidence increased behavioral problems. Similarly, Celebi Oncu et al. (2010) conducted a study examining trauma symptoms following the 1999 Turkish earthquake. Children who had experienced the natural disaster engaged in more negative storytelling than children who did not experience the natural disaster, even 2 years after the disaster event.

In the aftermath of the Sandy Hook Elementary School shootings, more and more schools have established trauma-informed care at the organizational level (Berger, 2019; Overstreet

have established trauma-informed care at the organizational level (Berger, 2019; Overstreet & Chafouleas, 2016). However, significant challenges remain, including the generation of funding quickly enough to conduct research on how best to intervene as well as the implementation of evidence-based practices that individually focused health insurances will support (Grolnick et al., 2018; Sandy Hook Advisory Commission, 2015; Thomas et al., 2019), when research findings point to multi-tiered approaches to intervention (Berger, 2019). Because of the worldwide devastation of the COVID-19 pandemic, the lives of most individuals have been affected, and children have been particularly vulnerable. Studies already have indicated the need to focus on C-19-related losses and the well-being of children (e.g., Gassman-Pines et al., 2020; Patrick et al., 2020), and this concern, unfortunately, is likely to continue well into the future.

Young children may experience another type of environmental trauma, in the form of bullying. While not necessarily traumatizing, a pattern of bullying may become traumatic for a young child. Cyberbullying, a variation of bullying more typically associated with preteens and teens, has become more prevalent among younger children. The Anti-Defamation League (ADL, 2021) has identified the warning signs that a child or teen may be experiencing cyberbullying, including but not limited to moodiness after online or phone activity, withdrawing or not engaging, refusing to go to school, atypical academic failures, and depression.

EFFECTS OF TRAUMA IN EARLY CHILDHOOD

The effects of traumatic experiences in early childhood vary and are based on several factors, including the individual child's stage of development and the nature of the traumatic event. Given that very young infants cannot yet express their emotions verbally, the effects of trauma experienced in infancy usually are manifested through changes in the infant's behaviors. Infants experiencing trauma may evidence higher levels of agitation, fussiness, and dysregulation of normal routines, including sleeping and eating (Lieberman & Knorr, 2007). Toddlers and preschoolers experiencing trauma may have the capacity to convey their experiences verbally, as well as to use their increased mobility to engage in flight-or-fight responses to traumatic events. However, because egocentric thinking also marks these years, children experiencing trauma in these developmental stages are more likely than older children to attribute the cause of the traumatic event to themselves. For instance, a preschooler, who is physically abused by their parent, is likely to believe that they did something to cause the physical abuse. Traumatic events in early childhood might constitute a pattern of adverse childhood experiences that, as noted in the discussion about the ACE Study in Chapter 2, "Theoretical Contexts of Trauma Counseling," may have deleterious implications across the life-span. Additionally, there may be transgenerational significance, as recent research has indicated that the adverse childhood experiences of parents may result in developmental delays among young children (Folger et al., 2018), which, in turn, may have further developmental consequences.

Posttraumatic Stress Disorder in Early Childhood

Posttraumatic stress disorder (PTSD) in children above the age of 6 is diagnosed using the same *DSM-5* criteria that are used to diagnose PTSD in adults (National Center for PTSD, U.S. Department of Veterans Affairs, 2021). However, PTSD symptoms manifest differently in very young children than they do in older children or adults, and symptoms may persist for longer times (Coates & Gaensbauer, 2009; Scheeringa & Zeanah, 1995; Scheeringa et al., 2005; Vasileva et al., 2018). In fact, different from previous versions of the *Diagnostic and Statistical Manuals*, the *DSM-5* (American Psychiatric Association, 2013) introduced a new developmental subtype of PTSD for children ages 6 years and younger: *Posttraumatic Stress Disorder in Preschool Children* (Scheeringa, 2019).

For very young children, intrusive symptoms of trauma often are manifest as repetitive play (Coates & Gaensbauer, 2009). According to Coates and Gaensbauer (2009), young children who have experienced trauma may engage in play that is devoid of "fun or creative

spontaneity" (p. 613). These play experiences may resemble the traumatic event in either content or expression of the emotions/affect from the traumatic experience (Coates & Gaensbauer, 2009; Markese, 2007). Avoidance symptoms manifest in terms of the child's developmental capacity (Scheeringa, 2019). If the child is mobile, they physically may avoid reminders of the traumatic event. On the other hand, if the child is not yet mobile, they actively may seek to avoid eye contact or, in the case of abuse or neglect, noticeably may be distraught by the presence of the abusive caregiver (Coates & Gaensbauer, 2009; Markese, 2007). Markese (2007) also points out that young children may avoid "symbolic play," that is, substituting one object for another or pretending as a means of avoiding the traumatic experience. Finally, symptoms of increased arousal can manifest in very young children as increased irritability, aggression, and temper tantrums, and in some cases also may resemble symptoms of attention deficit hyperactivity disorder (ADHD; Markese, 2007). Thus, care should be taken in the diagnosis of young children evidencing signs of ADHD.

One other significant difference in the diagnosis of PTSD in very young children, compared to older children or adults, is that very young children need to evidence only *one* symptom in select diagnostic criteria to PTSD (Scheeringa, 2019). In general, the *DSM-5* changes include diagnostic thresholds for PTSD that have been lowered for children (and adolescents). Additionally, for children aged 6 or less, separate, more developmentally sensitive criteria have been added. These new criteria include caregiver-child-related losses such as foster care placement (Scheeringa et al., 2011) as an important precipitant of trauma and behavioral PTSD symptoms. According to the *DSM-5*, PTSD symptoms can develop any time after age 1 (Substance Abuse and Mental Health Services Administration, 2016).

Increased attention has been focused on preverbal experiences of traumatic events. Initially, it was believed that because infants and toddlers could not verbally express their experiences of trauma, these experiences did not have a long-term impact on their development. We now understand this differently. Infants begin storing memories as young as 2 months of age (Durwin & Reese-Weber, 2021; Markese, 2007). These memories are stored as "somatosensory experiences" in the brain (van der Kolk, 1994, 2014). In other words, traumatic experiences in infancy and toddlerhood are stored in the brain as sensory experiences, even if the child cannot yet verbalize these experiences (Green et al., 2010; Markese, 2007). The influence of these experiences on infant and toddler development is seen by the presence of the PTSD symptoms noted previously, as well as an increased likelihood of evidencing disorganized attachment relationships with caregivers (Markese, 2007). The short clinical vignette, presented in Box 7.1, illustrates the early childhood experience of one child.

BOX 7.1

Clinical Vignette: Mark

Mark is a 4-year-old foster child who experienced early childhood maltreatment. He has been in three different placements. He recently was removed from a family that he loved, but the family members could not handle the intensity of Mark's emotional and behavioral outbursts. At the preschool that he attended, it was routine for teachers to place him in "time-out," because they considered Mark's behaviors to be too challenging for their classrooms. Mark's temper tantrums continued to escalate.

Reflection Questions

- How do you begin to conceptualize Mark's situation?
- What theories of childhood development might be useful to consider in this case?
- Was the school-based method of discipline helpful or harmful to Mark?

THERAPEUTIC INTERVENTIONS

Given the primacy of the parent-child relationship in early childhood, therapeutic interventions for young children who have experienced trauma should focus on the parent-child relationship (Lieberman & Van Horn, 2009; Osofsky & Lieberman, 2011). Recent

research has supported evidence-based, neuroscience-informed approaches to a variety of counseling interventions, including behavior modification, play therapy, cognitive behavioral therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR)(Beckley-Forest, 2021; Dorsey et al., 2017; Field & Ghoston, 2020). Several strategies, which can be used by mental health professionals working with young children, are identified and discussed in the text that follows.

Child-Parent Psychotherapy

One evidence-based intervention approach is child-parent psychotherapy (CPP; Lieberman & Van Horn, 2009; Lieberman et al., 2019). Lieberman and Van Horn suggest that "CPP has the goal of making the trauma *knowable* and *sayable* as a shared child-parent experience in which the parent becomes capable of acknowledging the reality of the events and the legitimacy of the child's resulting terror, anger, and broken trust" (p. 714). According to this approach, CPP has four primary goals:

- (1) Create a common language to describe what happened; (2) regulate the overwhelming affects associated with the experience; (3) enhance the parents' capacity to respond ... to the child's basic needs ... and (4) restore [the child's] trust in the parent's ability to protect [him or her] from external and internal danger. (Lieberman & Van Horn, 2009, p. 710)

Initial CPP therapy sessions are attended by the parent/caregiver and are focused on developing an understanding of the nature and magnitude of the traumatic experience. Following these initial sessions, both the child and the parent attend therapy sessions. In the case of preverbal infants or toddlers, much of the therapeutic effort is focused on helping the parent or caregiver to identify how their own childhood experiences are influencing their parenting. The use of CPP with older, verbal children focuses more on helping the child create a narrative about the traumatic experience. This is accomplished through the use of play, by assisting the parent/caregiver in reclaiming their protective role with the child, and by rebuilding a trusting, positive relationship between the child and caregiver. To date, CPP has been found to be an effective intervention for young children who have experienced one or more traumatic events (Ippen et al., 2011; Lieberman et al., 2005, 2006) and has shown effectiveness across various ethnicities and socioeconomic backgrounds (Lieberman et al., 2006).

Parent-Child Interaction Therapy

Another evidence-based approach for working with young children who have experienced trauma is parent-child interaction therapy (PCIT; Eyberg, 1988; Vanderzee et al., 2019). Similar to CPP, PCIT focuses on the parent-child interaction. PCIT was developed for use with young children (ages 4 to 7) who have been identified as having behavioral problems, and it consists of a two-phase intervention (child-directed interaction [CDI] followed by parent-directed interaction [PDI]) that is implemented across 14 to 20 weeks (Timmer et al., 2010). During the CDI phase, the therapist focuses on enhancing the parent-child relationship by encouraging and supporting parents in recognizing their children's positive behaviors. During the PDI phase, the parent is taught specific parenting techniques for behavioral management to reduce the rates of child behavior problems. PCIT has been found to be effective for working with children who have been victims of or are at risk of experiencing child maltreatment, as well as children who have witnessed DV (Herschell & McNeil, 2005; Timmer et al., 2010).

Trauma-Focused Cognitive Behavioral Therapy

Trauma-focused cognitive behavioral therapy (TF-CBT) is another evidence-based approach for working with parents and children who have experienced traumatic events (Cohen & Mannarino, 1993; Vanderzee et al., 2019). This intervention initially was developed to treat young children who had experienced sexual abuse but has since been adapted for use with

young children who have experienced sexual abuse and have been adapted for use with children who have experienced other forms of trauma (Cohen et al., 2006). TF-CBT combines CBT with trauma-informed practice throughout a series of individual and combined sessions with the parent and child. TF-CBT uses a nine-component model (PRACTICE): (P)sychoeducation, (P)arenting skills, (R)elaxation skills, (A)ffective modulation skills, (C)ognitive coping skills, (T)rauma narrative and processing, (I)n vivo mastery of trauma reminders, (C)onjoint child-parent sessions, and (E)nhancing safety and future development (Cohen et al., 2010). The intervention lasts for approximately 12 weeks (Scheeringa et al., 2007). This intervention has been effective for use with preschool-age children across an array of traumatic experiences, including child sexual abuse, motor vehicle accidents, and natural/environmental disasters (Cohen et al., 2006, 2010; Scheeringa et al., 2007; Silverman et al., 2008; Vanderzee et al., 2019). A free training on TF-CBT is available to clinicians on the SAMHSA website (<https://tfcbt2.musc.edu>).

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Play Therapy

Given that trauma that is experienced in infancy and toddlerhood is stored as sensory experiences in the brain, symbolic play can offer children a chance to process and heal following trauma (Green et al., 2010; Malchiodi, 2020; A. Stewart et al., 2020). Young children can, in effect, reenact the traumatic experience through symbolic play. During these play experiences, children have control over how directly they interact with the traumatic experience and, with the guidance of a therapist, can begin to create a narrative surrounding the experience. The therapist's warm, empathic response to the child's play can begin to rebuild the child's sense of trust and attachment toward an adult caregiver. Sandtray therapy is one variation of play therapy that has been used successfully with children who have experienced trauma (e.g., Homeyer & Sweeney, 2017).

Promising Practices

In addition to interventions that have a strong empirical base such as CPP and play therapy, several new strategies have emerged for working with young children who have experienced trauma. These interventions, discussed briefly in the text that follows, include *Ways of Seeing*, mindfulness-based parenting programs, and bibliotherapy.

Ways of Seeing

A promising new strategy that addresses the importance of the parent-child relationship is *Ways of Seeing* (Tortora, 2010, 2019). This intervention is a "multisensory psychotherapeutic treatment approach" that incorporates "dance/movement principles" (p. 37). This method capitalizes on very young children's sensory processing of their experiences. In *Ways of Seeing*, the therapist observes interactions between the parent/caregiver and child in the following areas: (a) quality of eye gaze, (b) facial expression, (c) use of space, (d) quality and frequency of touch and/or physical contact, (e) body shapes, (f) tempo of nonverbal movement style, (g) vocal patterns, and (h) nonverbal behavior and regulation (Tortora, 2010). In this intervention model, the therapist meets weekly with the parent and child. These weekly sessions are videotaped and then viewed by the therapist and parent to examine nonverbal interactions between the parent and child. The nonverbal interactions form the basis of the intervention, with a focus on helping parents/caregivers to understand how their own childhood experiences influence their parenting and on improving the nonverbal interactions between the child and parent/caregiver. This approach most recently has been studied in young children with cancer (Tortora, 2019). Additionally, expressive therapies such as dance, as well as play, have a healing effect on the neurobiology of the traumatized child (Malchiodi, 2015).

Mindfulness-Based Parenting

Mindfulness-based parenting programs (MBPPs) are being used to address parent-child interactions (Burns, 2018; Cohen & Semple, 2010). These programs build on relationally oriented mindfulness programs to focus specifically on parent-child relationships by increasing self-awareness, intentionality, and resilience while also attending to cultural diversity (Beckley-Forest, 2021; Field & Ghoston, 2020). Recent research has suggested that positive psychology interventions, which are aimed at enhancing happiness, hope, and resilience among youth, may influence positive mental health experiences (Lenz, 2021). Yoga and other MBPPs are being used in clinical trials with traumatized children, with good outcomes (Ortiz & Sibinga, 2017).

Bibli'

A final intervention for young children who have experienced trauma, which warrants discussion, is bibliotherapy (De Vries et al., 2017; Duncan, 2010). This approach involves the use of children's literature as a way of helping young children process events. Children's literature can provide a means for helping children learn adaptive messages about coping with traumatic experiences (Duncan, 2010). Although this method has been found to reduce

with traumatic experiences (Duncan, 2010). Although this method has been found to reduce child behavioral problems, it should be used in conjunction with other forms of therapy (Jack & Ronan, 2008) and be culturally affirming (Field & Ghoston, 2020; P. E. Stewart & Ames, 2014).

COUNSELING IMPLICATIONS

While once an area of debate, over the last two decades, there has been a growing body of research that diminishes any doubt that children younger than 6 and as young as age 1 can develop posttraumatic stress symptoms (PTSS). There is also evidence that multi-tiered, systemic approaches are best for trauma-informed care; however, policy has not necessarily paralleled the evidence, and implementation of systemic approaches sometimes has been sidelined in favor of individual approaches, which is driven by the health insurance industry. Yet, in spite of policy issues and a lack of access to needed services, children continue to experience trauma, and children continue to face environmental risks that impede their developmental trajectories.

Identifying childhood risk factors is crucial in understanding the context for and the effects of child maltreatment and childhood trauma. However, it is important to identify existing childhood protective factors, as well as to advocate for strategies that can enhance existing protective factors and even construct new ones. Figure 7.1 illustrates a possible interaction between risk factors and protective factors.

Figure 7.1

Possible Interaction Between Risk Factors and Protective Factors



Source: Child Welfare Information Gateway. (2019). *Fact sheet: Long-term consequences of child abuse and neglect*. Retrieved from https://www.childwelfare.gov/pubPDFs/long_term_consequences.pdf

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