

CONCLUSION

Early childhood experiences, both positive and negative, lay the groundwork for future growth and development. Of utmost importance during these years is the formation and maintenance of a positive attachment relationship with one or more caregivers. Traumatic events such as child maltreatment and DV can undermine the protective nature of these early relationships. Given the primacy of a positive attachment relationship for young children's growth and development, this relationship is the focal point of many interventions targeting young children who have experienced trauma. These interventions emphasize healing the parent-child relationship and aim to build resilience, as well as giving the child the opportunity to develop a narrative for the traumatic event (especially in the case of children who have experienced preverbal trauma).

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Tips for How to Intervene After a Traumatic Event (from The Child Mind Institute)

<https://childmind.org/guide/helping-children-cope-traumatic-event>

Videos

Toxic Stress Derails Healthy Development (1:51) <https://youtu.be/rVwFkcOZHJw>

Catch A Breath Exercise: Helping Kids Regulate Their Emotions (2:06)

www.youtube.com/watch?v=PUGXdnN--kk

The Attachment Theory: How Childhood Affects Life (7:35) www.youtube.com/watch?v=WjOowWxOXCg

7 Ways Childhood Trauma Follow You into Adulthood (4:28) www.youtube.com/watch?v=N2oUfg7qNG0

Through Our Eyes: Children, Violence, and Trauma-Introduction (7:53)

www.youtube.com/watch?v=z8vZxDa2KPM

Giving Traumatized Kids a Head Start in Healing (6:49) www.youtube.com/watch?v=bFJHbCMV7kc

Children, Violence, and Trauma-Interventions in Schools (7:49) www.youtube.com/watch?v=49GzqPP7YYk

Part 4: Post-Traumatic Stress Disorder-The Lingering Trauma of Child Abuse (6:37)

www.youtube.com/watch?v=7a96k3YOWXw

PBS: Whole Person Childhood Trauma (26:46) www.pbs.org/video/whole-people-101-childhood-trauma-3swqgb

Case Studies

www.complextrauma.ca/CASE-EXAMPLES

Websites

Center on the Developing Child, Harvard University <https://developingchild.harvard.edu>

Children's Hospital of Philadelphia (CHOP) BE-WEHL stands for **BE**havioral health-**WE**llness

Equity for a Healthy Life www.chop.edu/news/project-be-wehl-helps-families-reduce-stress-cope-trauma
Center for Pediatric Traumatic Stress www.chop.edu/centers-programs/center-pediatric-traumatic-stress
Child Trauma Academy www.childtrauma.org
Zero to Three. (n.d.). *Impact of trauma.* www.zerotothree.org/maltreatment/trauma/trauma.html

Bullying and Cyberbullying Resources

Stop Bullying www.stopbullying.gov
Positive Parenting Guide myflfamilies.com/service-programs/child-welfare/caregivers/healthy-social-development.shtml
Cyberbullying Warning Signs www.adl.org/resources/tools-and-strategies/cyberbullying-warning-signs
Cyberbullying: Spotting the Signs and Helping Your Child <https://raisingchildren.net.au/pre-teens/behaviour/bullying/cyberbullying-helping-your-child>
How to Help Kids Deal With Cyberbullying (Child Mind Institute) <https://childmind.org/article/help-kids-deal-cyberbullying>

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This chapter is a revision of the chapter that appeared in the first edition of this textbook. Dr. Staci Perlman, who passed away in 2015, was one of the authors; we honor and thank her for her original contribution here, as well as for all of her work in advocating for children and youth.

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CONCLUSION

Early childhood experiences, both positive and negative, lay the groundwork for future growth and development. Of utmost importance during these years is the formation and maintenance of a positive attachment relationship with one or more caregivers. Traumatic events such as child maltreatment and DV can undermine the protective nature of these early relationships. Given the primacy of a positive attachment relationship for young children's growth and development, this relationship is the focal point of many interventions targeting young children who have experienced trauma. These interventions emphasize healing the parent-child relationship and aim to build resilience, as well as giving the child the opportunity to develop a narrative for the traumatic event (especially in the case of children who have experienced preverbal trauma).

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Tips for How to Intervene After a Traumatic Event (from The Child Mind Institute)

<https://childmind.org/guide/helping-children-cope-traumatic-event>

Videos

Toxic Stress Derails Healthy Development (1:51) <https://youtu.be/rVwFkcOZHJw>

Catch A Breath Exercise: Helping Kids Regulate Their Emotions (2:06)

www.youtube.com/watch?v=PUGXdnN--kk

The Attachment Theory: How Childhood Affects Life (7:35) www.youtube.com/watch?v=WjOowWxOXCg

7 Ways Childhood Trauma Follow You into Adulthood (4:28) www.youtube.com/watch?v=N2oUfg7qNG0

Through Our Eyes: Children, Violence, and Trauma-Introduction (7:53)

www.youtube.com/watch?v=z8vZxDa2KPM

Giving Traumatized Kids a Head Start in Healing (6:49) www.youtube.com/watch?v=bFJHbCMV7kc

Children, Violence, and Trauma-Interventions in Schools (7:49) www.youtube.com/watch?v=49GzqPP7YYk

Part 4: Post-Traumatic Stress Disorder-The Lingering Trauma of Child Abuse (6:37)

www.youtube.com/watch?v=7a96k3YOWXw

PBS: Whole Person Childhood Trauma (26:46) www.pbs.org/video/whole-people-101-childhood-trauma-3swqgb

Case Studies

www.complextrauma.ca/CASE-EXAMPLES

Websites

Center on the Developing Child, Harvard University <https://developingchild.harvard.edu>

Children's Hospital of Philadelphia (CHOP) BE-WEHL stands for **BE**havioral health-**WE**llness

Equity for a Healthy Life www.chop.edu/news/project-be-wehl-helps-families-reduce-stress-cope-trauma
Center for Pediatric Traumatic Stress www.chop.edu/centers-programs/center-pediatric-traumatic-stress
Child Trauma Academy www.childtrauma.org
Zero to Three. (n.d.). *Impact of trauma.* www.zerotothree.org/maltreatment/trauma/trauma.html

Bullying and Cyberbullying Resources

Stop Bullying www.stopbullying.gov
Positive Parenting Guide myflfamilies.com/service-programs/child-welfare/caregivers/healthy-social-development.shtml
Cyberbullying Warning Signs www.adl.org/resources/tools-and-strategies/cyberbullying-warning-signs
Cyberbullying: Spotting the Signs and Helping Your Child <https://raisingchildren.net.au/pre-teens/behaviour/bullying/cyberbullying-helping-your-child>
How to Help Kids Deal With Cyberbullying (Child Mind Institute) <https://childmind.org/article/help-kids-deal-cyberbullying>

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This chapter is a revision of the chapter that appeared in the first edition of this textbook. Dr. Staci Perlman, who passed away in 2015, was one of the authors; we honor and thank her for her original contribution here, as well as for all of her work in advocating for children and youth.

CHAPTER 8

Trauma Experienced in Adolescence

ANDREA DOYLE AND STACI PERLMAN

CHAPTER OVERVIEW

The purpose of this chapter is to outline particular consequences of trauma when it occurs during adolescence, as well as what one might expect subsequent to earlier childhood traumatic events that occurred. This aim is accomplished in the following sections: (a) Trauma-Relevant Issues in Adolescence and (b) 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. Be cognizant of the developmental issues in adolescence that interface and complicate diagnosis; and
2. Be aware of the main treatment approaches to trauma in adolescents as well as how they differ and how they intersect.

INTRODUCTION

The national average of child abuse and neglect victims in 2019 was 8.9 victims per 1,000 children (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2021).

Both children and adolescents are subject to extremely high rates of abuse and neglect, victimization, and intentional and unintentional injury (Centers for Disease Control and Prevention, 2016; Finkelhor et al., 2009; McCaig & Ly, 2002; McDonald et al., 2006). Over 67% of children report at least one traumatic event by the age of 16 (Substance Abuse and Mental Health Services Association [SAMHSA], 2020). By the age of 11, 11% of youth have experienced a traumatic event; by the age of 18, 43% of youth have experienced such an event (Eckes & Radunovich, 2007). This increased exposure to and experience of trauma during adolescence is partly tied to behaviors characteristic of this particular developmental stage.

TRAUMA-RELEVANT ISSUES IN ADOLESCENCE

Stemming from the Latin *adolescere* "to grow up," adolescence is the phase between childhood and adulthood, generally considered to be the ages between 13 and 19. Characterized by a rush of hormones and a budding sexuality that leads to fundamental physical changes, it is also a time of experimentation and risk taking. Because of this risk taking, adolescents have a high probability of experiencing traumatic events (Ben-Zur & Zeidner, 2009; Tull et al., 2016). They also are at risk of trauma that is related to bullying at school, cyberbullying, violence in the home as well as the community, drug experimentation,

school, cyberbullying, violence in the home as well as the community, drug experimentation, and other dangerous situations (Gaete et al., 2017; Shaw, 2000). In the course of defining who they are, many teens take risks and defy their parents in an effort to differentiate boundaries between parents and self (Gilmore & Meersand, 2015; Hales & Yudofsky, 2003). Typical traumatic experiences specific to this stage include date rape (Rickert & Wiemann, 1998), gang shootings (depending on community context) (Kelly et al., 2012), and teen suicide. This section presents discussions about the issues that are relevant to the discourse on trauma experienced in adolescence: Stages of Development, Effects of Trauma, Typical Responses to Trauma, Gender Differences, Age- and Stage-Appropriate Considerations, Multiple Diagnostic Categories, and Family Issues.

Stages of Development

Adolescence is a period of rapid cognitive development, characterized by the capacity for abstract thinking (Piaget, 1952). The development of the prefrontal cortex, associated with executive functioning, allows for more coordination and management of thinking and behavior (Choudhury et al., 2006), which is necessary for the development of autonomy and engaging in relationships (Cook et al., 2005). Experiences during this developmental period play a major role in identity formation (Erikson, 1968), moral development (Gilligan, 1993; Kohlberg, 1958), and personality, thus shaping adulthood (Smith & Handler, 2007).

The developmental tasks of adolescence are as follows:

- Accepting the physical changes and sexual impulses brought on by puberty
- Attaining independence from parents (economically, emotionally)
- Developing mature relationships with peers and adults outside the family
- Developing the capacity for intimacy with a romantic partner
- Establishing a set of moral values and ethical behavior
- Consolidating a coherent social role (including gender, vocation, and ethnic identity)
- Pursuing a vocation or career (Becker et al., 2003; Gilmore & Meersand, 2015; Havighurst, 1949)

Although these stages are considered universal across cultures, for adolescents of color, ethnic identity has unique stages (Phinney, 1989). Ethnic and racial identity-achieved adolescents demonstrate more solid ego identity, psychological adjustment, and better health outcomes (Phinney, 1989; Phinney & Ong, 2007; Rivas-Drake et al., 2014). This period of development involves a search for an integrated and stable ego identity. This process proceeds as teens make sense of their current self-perceptions with their “self perceptions from earlier periods and with their cultural and biological heritage” (Brodzinsky, 1987, p. 37).

Effects of Trauma

Following a particular type of trauma, namely disaster, children assume greater responsibilities and face several morally challenging situations that may lead to premature moral development (Goenjian et al., 1999; Nucci & Turiel, 2009). By the same token, posttraumatic stress disorder (PTSD) symptoms and negative self-schemas may lead to lacunae in moral functioning (Chaplo et al., 2019; Goenjian et al., 1999). Trauma that is associated with disaster may beget further trauma. For example, we know that in Haiti, post-earthquake, there was a growing prevalence of sexual assaults, with accounts of girls as young as 12 years old being treated for sexually transmitted infections resulting from rapes (Bayard, 2010).

Within Erikson's theory of development, adolescence falls in the stage of identity versus identity diffusion. At the extreme, dissociative identity disorder can result from early trauma (Sanders & Giolas, 1991; Trond, 2005). A more frequent reaction of traumatized adolescents is premature closure of identity formation (Figley, 1985) or entrance into adulthood. Posttraumatic “acting out” can include absences from school, early sexual debut, and delinquency (Filipas & Ullman, 2006; Finkelhor, 1990; Margolin & Vickerman, 2011; Newman, 1976; Steiner et al., 1997). Substance use is often a way of self-medicating in an effort to affect decreased mood, but what starts out as experimentation and a way of coping

effort to offset depressed mood, but what starts out as experimentation and a way of coping, in the short term, can lead to problems in brain development and later addiction if used regularly (Gaete et al., 2017; Mayhew et al., 2000).

Adolescent survivors from the Jewish Holocaust of World War II, for example, experienced persistent identity diffusion, interpersonal distress, and difficulties with school and work (W. Koenig, 1964; L. Koenig et al., 2004). Unlike younger children, who are likely to misinterpret the trauma as something that resulted as a consequence of their own behavior, adolescents possess the developmental capacity for abstract and contextual understanding of the sequential nature of events over time and how their choices might fit into the chain of events leading up to a trauma (Figley, 1985). Finkelhor (1995) distinguishes between *localized* versus developmental effects of trauma. The symptoms associated with PTSD are considered localized and will dissipate over time or with treatment. Developmental effects are more generalized and pervasive and challenge the attainment of age-appropriate tasks such as emotional regulation and development of positive self-esteem (Finkelhor, 1995). Similarly, traumatic events must be distinguished between a single event versus a chronic process (Margolin & Vickerman, 2011; Shaw, 2000), the latter of which can have more generalized effects.

Adolescents may withdraw and become less communicative subsequent to a trauma, whereas toddlers are likely to cry, and grade school children may experience disturbances in sleep or somatic complaints (Zubenko & Capozzoli, 2002). As children become teenagers, their symptoms resemble those of adults (Wolfe & Mash, 2006). There is some evidence that a person's cognitive style may affect symptomatology. Moran and Eckenrode (1992) found that those with a higher internal locus of control were less depressed than those with a more external locus of control. Traditionally, the prevailing thinking in psychology has been that males externalize, whereas females tend to internalize negative life experiences (Leadbeater et al., 1999), and this thinking has been subject to some debate as gender roles have changed with time (Ara, 2016). However, this notion of internalizing or externalizing is worthy of comment, as it has implications for prognosis and treatment. *Internalizing* is an intrapsychic reaction to trauma that manifests itself as depression, anxiety, or low self-esteem (Feuer et al., 2001). Externalizing or "acting out" usually manifests in aggressive ways such as seen in conduct disorders. Disorders of internalization and externalization represent a breakdown of the developmental path as a response to crisis.

Typical Responses to Trauma

Research in the area of trauma demonstrates the primacy of human attachments in assessment, treatment, and adolescent development (Brown, 2008). Trauma undermines trust and human connections. When trust is damaged by adults failing to protect from or actually perpetrating trauma, basic worldviews and foundational aspects of relationships change (H. A. Barnes et al., 2019; Nader, 2007). The inability to trust caretakers, God, or the universe makes it challenging to feel safe again following trauma (H. A. Barnes et al., 2019; Nader, 2007).

Fear and anxiety, reexperiencing of the trauma, increased arousal, avoidance, anger and irritability, guilt, shame, grief, depression, negative self-image and worldview, disinterest in sex, and abuse of substances are all common reactions to trauma (Foa et al., 2011). Essentially, trauma is an assault to the brain (Steven Berkowitz, 2010 August 6, personal communication) that alters the way the brain performs, impairing cognitive, psychological, and neurological functioning. The potential for injury to the brain needs to be considered carefully within the context of the increased brain development during adolescence (Hales & Yudofsky, 2003). There is evidence that the stress associated with traumatic events can change major structural components of the central nervous system and the neuroendocrine system, leaving a lasting effect (Herringa, 2017; Shaw, 2000; Spear, 2000).

Gender Differences

Females are more at risk for victimization, especially sexual, in interpersonal relationships

Females are more at risk for victimization, especially sexual, in interpersonal relationships than males are, whereas males are at greater risk for physical abuse and assault (Capaldi et al., 2012; Feuer et al., 2001; Kessler et al., 1995; Yehuda, 2004). Young women and men tend to experience and process the distress associated with traumatic events differently (Briere & Scott, 2006). The counselor should be sensitive to ways in which traumatized adolescents display or suppress their emotional reactions based on gender expectations. Males are more likely to be exposed to traumatic stressors, but females are more likely to experience PTSD (Inslicht et al., 2013; Olff, 2017; Stuber et al., 2006). Gustafsson et al. (2009) found no difference in occurrence of trauma by gender, but found differences by age, with older adolescents reporting more trauma events, a finding noted also by Nucci and Turiel (2009). Margolin and Gordis (2004) found that females and Caucasians were less likely to be victims or perpetrators, that middle adolescents were more likely to be perpetrators only, and that adolescents with substance-using peers were more likely to be victims and/or perpetrators of violence. In their juvenile detainee sample, Abram et al. (2004) found slightly higher rates of traumatic incidents in males.

Horowitz et al. (1995) proposed the concept of "compounded community trauma" in their study of urban female adolescents, finding that they experienced a mean of 28 violent events. Of these young women, 90% experienced hyperarousal, 89% had symptoms of reexperiencing, 80% used avoidance as a coping mechanism, and 67% met criteria for PTSD. An increased number of types of violent events was positively correlated with meeting PTSD criteria and with greater symptom severity. The young women endured prolonged and repeated exposure to multiple types of community as well as domestic violent events over time, via multiple modalities of contact. The take-home message here is that the effects of trauma are cumulative. Regardless of gender, there is evidence that neighborhood violence is shaping teens' brains (Saxbe, 2018).

Age- and Stage-Appropriate Considerations

Evidence from studies of combat trauma, disasters, and rape results points to differential effects on adolescents. Adolescents who fought in Vietnam, for example, were more likely to develop PTSD than older soldiers; van der Kolk (1985) speculated that this differential effect was caused by the intensity of their attachment to their peer soldiers and the consequent magnitude of the loss that the young soldiers experienced when their friends were killed. When one considers that most young people are entering the military in their late teens and early 20s, and that PTSD as well as depression are serious problems for soldiers who return home from the war, it is important to keep in mind that the soldier is a developing adolescent. An average of 10% of returning soldiers from Iraq and Afghanistan suffer from PTSD and/or depression, with many displaying violent behavior as well (Thomas et al., 2010). Hardoff and Halevy (2006) note that the capacity for abstract thinking and planning for the future, typical of late adolescence, runs counter to the military demand for obedience, leaving family, and threats of physical injury and emotional stress.

Upon discharge from the military, the chronologically mature young adult faces the questions of the late teens, with normal adolescent growth having been forestalled by war (Hardoff & Halevy, 2006). The authors urge those who care for soldiers in their late teens and early 20s to consider the time of military service as an additional developmental stage of late adolescence. Additionally, adolescent children of deployed older soldiers also are affected by the trauma of war. In a study of stress levels among adolescents with family members serving in Iraq at the beginning of Operation Iraqi Freedom in March 2003 and at the end of the campaign in May of the same year, V. A. Barnes et al. (2007) found that at both time points, adolescents of military parents experienced PTSD symptoms; this finding was especially true if a parent had been deployed (issues related to veterans and trauma are detailed further in Chapter 25).

Davidson et al. (1996) found the greatest likelihood of later suicide attempts in those who were assaulted prior to age 16. Similarly, Breslau et al. (1997) found that women who experienced trauma of any kind prior to age 15 were more vulnerable to developing PTSD than were those whose trauma occurred at a later age. Two years after the Buffalo Creek disaster, adolescents were found to have higher levels of distress than younger children

disaster, adolescents were found to have higher levels of distress than younger children (Green et al., 1991). A major factor contributing to this tragedy was a loss of community as well as a belief in duplicity on the part of the mining company whose carelessness led to the disaster. These may have been particularly traumatic stresses for the adolescents, for whom normal development would dictate orienting socially outside the family and a realization that adults in authority are fallible.

Adolescents may be less vulnerable than children or adults to certain kinds of trauma. Studies of Holocaust survivors of World War II indicate that the most devastating effects were on those who were infants during this massive trauma (Kestenbaum & Brenner, 1996); adolescents who survived did relatively well, faring better than adult survivors. The separation from parents was most detrimental for the youngest children; the thinking here is that older children and adolescents had at least a period of earlier healthy development to sustain them. Resourcefulness, group cohesion, a sense of invulnerability, rebelliousness, and a willingness to take risks were protective factors and enhanced the likelihood of adolescents surviving. Similar findings emerged from Weine et al.'s (1995, 1998) studies of Bosnian survivors of ethnic cleansing, which indicated that adolescents were less traumatized than were adults. In their sample, however, younger survivors tended to experience less torture and other extreme conditions than did adults. The authors suggest that the relatively low rate of PTSD, compared to adults and also in comparison to Cambodian adolescent survivors of the "killing fields," may be related to normal prior development, the time-limited nature of the trauma, adversity, lack of sexual or physical abuse, reuniting with family, or simply insufficient time for the development of delayed-onset PTSD. More optimistically, they suggest that these results may be owing to adolescent resilience.

Terr et al. (1997) studied the reactions of children and adolescents who had witnessed the 1986 Challenger space explosion on television while at school, which was particularly relevant to school children, because a teacher was among the crew members who all perished. In contrast to children who exhibited symptoms, teenagers had changes in their thinking. During the 14 months after the explosion, adolescents developed negative attitudes toward God, institutions, and the future.

Multiple Diagnostic Categories

PTSD frequently co-occurs with other diagnostic categories (Giaconia et al., 1995; Kessler et al., 1995). Traumatic experiences can lead to disruptive behavior disorders, other internalizing disorders, personality disorders, and physical illnesses (Ohan et al., 2002). Adolescents who have experienced trauma as children are more likely to develop anxiety-related disorders and fears and are more likely to show a pattern of risky sexual behaviors (Norwood et al., 2000). Different types of exposure to traumatic events lend themselves to different subsequent diagnoses. Children's exposure to violence often goes unnoticed or unreported; therefore, symptoms often are diagnosed as maladjustment (Margolin & Gordis, 2004; Margolin & Vickerman, 2011). In an epidemiological study of juvenile delinquents in detention, Abram et al. (2004) found that 11% of adolescents in jail met criteria for PTSD, and that 93% had experienced at least one trauma in their lifetime; the mean was 15 traumatic events. A history of family violence is the most significant difference between groups of delinquents and nondelinquent youth (Office of Juvenile Justice and Delinquency Prevention, 2013).

In a review of the relationships among eating disorders (EDs), trauma, and comorbid psychiatric disorders, with a particular focus on PTSD, Brewerton (2007) concluded the following: childhood sexual abuse (CSA) is a nonspecific risk factor for EDs; other forms of abuse and neglect, besides CSA, have been linked to EDs; trauma is more common in bulimia, compared to other EDs; multiple traumatic events and/or specific types of trauma are associated with EDs; ED severity is not necessarily associated with trauma, but trauma is associated with greater comorbidity (including and often mediated by PTSD) in research participants with ED; subthreshold PTSD also may be a risk factor for bulimia; and recovery from the ED and comorbid disorders is contingent upon the trauma and PTSD symptoms being addressed.

being addressed.

A range of posttraumatic responses does not necessarily meet full criteria for PTSD. Evidence from community samples suggests that partial syndromes are much more common than PTSD in the general population and also following a specific traumatic event such as a natural disaster. These subclinical conditions also can coincide with significant impairment. Adolescent posttraumatic symptoms can include avoidance, reexperiencing, and arousal that parallel those in adults who meet PTSD criteria (American Psychiatric Association, 2013). Trauma-specific fears, depression and anxiety, and hostility are also common. Even though full PTSD criteria may not be met, a young person can experience significant distress that may interfere with daily functioning. Other disorders may follow trauma, even if posttraumatic symptoms are not immediately present.

The ultimate outcome of experiencing trauma during adolescence may include increased sensitivity to loss and an increased vulnerability to anxiety and depression. More serious reactions include dissociation, ranging from chronic psychic numbing to dissociative identity disorders and interpersonal difficulty. Trauma-related psychopathology that is comorbid with depression, conduct disorder, or substance misuse markedly complicates treatment of the adolescent. Therefore, it is important to assess for a history of trauma and how the adolescent coped at the time of the event.

PTSD itself is difficult to detect without systematic screening (Abram et al., 2004; Havens et al., 2012). PTSD and child abuse often go unrecognized in adolescents (Cohen, 1998; Havens et al., 2012). Symptoms of PTSD overlap with other disorders such that it may be missed. For example, ADHD may be the diagnosis ascribed to the interpersonal problems, hyperactivity, and distractibility that accompany PTSD; this type of presentation necessitates looking beyond the presenting symptoms to assess for early trauma (Wolfe & Mash, 2006). Greenwald (2002) has asserted that trauma mediates the development of conduct problems in adolescence; the trauma can account for the lack of empathy and for the impulsivity, anger, and acting out. Community violence is a significant risk factor for conduct problems in early adolescence (age 10–14), according to Pearce et al. (2003). Protective factors that offset conduct problems include a strong religious faith and parental involvement. The involvement of a caring adult is a factor that mitigates most effects of community violence (Lynn-Whaley & Sugarmann, 2017) as well as witnessing intimate partner violence (Alaggia & Donohue, 2018).

As a final note on trauma in adolescents and differential diagnosis, let us consider the issue of substance use as possibly an antidote for trauma symptoms or symptoms of substance use looking like trauma symptoms. Equally, contributory factors to borderline personality disorder can include trauma as part of an early invalidating environment. Indeed, there was a push at one point for borderline personality disorder to be renamed complex trauma disorder, but the bid was lost in the latest edition of the *DSM*, and notwithstanding the fact that adolescence, by virtue of the developmental stage in and of itself, leads to risky experimental behavior. Untangling the host of symptoms to form a diagnosis depends on gathering a careful history of symptoms, with attention to frequency, intensity, duration, time of onset, and contextual factors such as the bioecological environment.

Family Issues

The impact of a traumatic event may depend on the extent to which it disrupts family functioning. Gustafsson et al. (2009) found that interpersonal violence was more strongly associated with symptoms than with non-interpersonal violence. The major categories of violence are child maltreatment, aggression between parents, and community violence, which often co-occur (Margolin & Gordis, 2004; Margolin & Vickerman, 2011). Each year, more than 10 million children witness physical aggression between their parents (Margolin & Gordis, 2004; Margolin & Vickerman, 2011). Exposure to violence very often occurs in familial settings. Possible consequences include break-up or relocation of family, family conflict, poverty, parental unemployment, parental substance misuse, and psychopathology. Thus, life stresses and trauma can become cyclical. Common short-term effects of exposure to violence are behavioral disorders such as aggression and delinquency, emotional and mood disorders,

posttraumatic stress, health-related problems, somatic symptoms, and academic and cognitive problems (Margolin & Gordis, 2004; Margolin & Vickerman, 2011).

COUNSELING IMPLICATIONS

Adolescence is an opportunity to rework earlier traumas (Blos, 1962). The importance of this favorable period for therapeutic action cannot be underestimated, as earlier interventions bode well for better adaptation in later developmental stages. This section offers discussions on stage-appropriate interventions and present-day promising practices.

Trauma-Informed Treatment Strategies or Clinical Models Specific to the Trauma

Cognitive behavioral therapy is particularly effective in treating symptomatic adolescents exposed to trauma (Villalba & Lewis, 2007). Eye Movement Desensitization and Reprocessing (EMDR) also can work with some traumatized individuals (Roth & Fonagy, 2005).

Trauma can affect several developmental domains such as attachment systems, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept. Bath (2008) examined trauma interventions for complex trauma and specified three pillars upon which interventions should be based. This three-pronged interactive approach involves steps that caregivers can take to strengthen the three pillars: safety, connections, and managing emotional impulses. The outcome of complex trauma is often PTSD; however, because the PTSD criteria are meant for adults, many adolescents go undiagnosed and untreated. Unfortunately, according to Bath and others (Gamache Martin et al., 2016), adolescents often come to view adults as threats instead of supports. But all home, school, and community caretakers who interact with traumatized children potentially contribute to their maturation and healing.

Bath argues that in order for healing to occur, safety, affect regulation, and coping and self-management skills must be established. The first pillar, safety, represents a core developmental need (Bowlby, 1988; Erikson, 1950; Maslow, 1943). Therefore, when working with adolescents who have experienced trauma, it is essential to create a sense of safety (transparency, availability, consistency). The second pillar demands the development of comfortable connections between the adolescent and their caretakers. The author further argues that third-pillar interventions should teach adolescents the ability to manage emotions or self-regulate. Similarly, Dombo and Sabatino (2019) have taken this notion of pillars and written a manual for creating trauma-informed schools.

Margolin and Gordis (2004) propose community interventions such as mentoring programs and structured school-based activities. Particularly for trauma symptoms stemming from community-based violence, community interventions without involving all of the community systems, such as police and schools, are less likely to succeed (Horowitz et al., 1995). Given the developmental shift to looking more toward peers than family, group interventions often are employed (Aronson & Kahn, 2004; van der Kolk, 1987). After the 1988 Armenian earthquake, trauma/grief-focused brief psychotherapy was employed in schools in order to mitigate PTSD symptoms and prevent aggravation of comorbid depression among young adolescents (Goenjian et al., 1997). The results support the broad use of such school-based interventions after major disasters and demonstrate the cross-cultural applicability of Western psychotherapeutic approaches.

Promising Practices

The *Community Service Foundation & Buxmont Academy* (CSF Buxmont) operates a Pennsylvania-based alternative school that uses restorative practices. A student confronts traumatic life challenges with the help of group problem-solving with supportive peers (Lange, 2008). The use of peer groups at this developmental stage is a recurring thread among best practices for traumatized youth.

The *Sanctuary Model of Trauma-Informed Organizational Change* (Bloom, 1997) builds

The *Sanctuary Model of Trauma-Informed Organizational Change* (Bloom, 1997) builds respectful culture in community mental health organizations and schools so that troubled youth and their caregivers are not subject to victimization. The therapeutic community focuses on the needs of traumatized youth through a psychoeducational model called SELF, which addresses the challenges of Safety, Emotional management, Loss, and Future.

The *UCLA Trauma Psychiatry Program* has developed a school-based intervention program for children and adolescents who have been exposed to trauma, and who are chronically distressed with resultant problems in school or with peer and family functioning (see Saltzman et al., 2001). The program includes a systematic approach to screening for trauma, a manual-based 16- to 20-week trauma/grief-focused group psychotherapy protocol, along with individual and family therapy and measurement scales to determine any reduction in symptomatology as well as any increase in adaptive functioning.

Miller Children's Abuse and Violence Intervention Center (MCAVIC) in Long Beach, California, created the *Integrative Treatment of Complex Trauma for Adolescents* (ITCT-A), which focuses on the treatment of multiple traumatized youth. This program is a comprehensive manual-based multimodal treatment (Briere & Lanktree, 2008), which is freely available to the public.

It is worth noting that dialectical behavioral therapy (DBT) is being widely used in various residential programs for youth who cannot remain in the home of the family of origin. Although not always articulated, many of these youths are in residential care because of a history of trauma. DBT has been conceptualized as a trauma-based model for those with borderline personality disorder (BPD; Swenson, 2000). Originally developed for women diagnosed with BPD who exhibited suicidal and parasuicidal behaviors and very often had histories of trauma, DBT has since been used in state-run adolescent residential programs such as Echo Glen in Washington State (see Trupin et al., 2002) and the McLean Adolescent Unit, affiliated with Harvard. Additionally, a community-based DBT program for adolescent females shows promise (Geddes et al., 2013). Two randomized controlled trials have demonstrated robust success with suicidal adolescents in reducing suicidal symptoms and hospitalization for self-injury (McCauley et al., 2018). The symptoms of BPD are similar to those of a risk-taking adolescent who is just learning how to modulate emotions, such that the skills offered by this approach resonate with the tasks of this developmental phase. DBT treatment consists of individual behavioral treatment, skills coaching, and a psychoeducational group, in which cognitive and behavioral skills, including mindfulness, can be learned and practiced. Critical to DBT with adolescents, and what distinguishes it from DBT with adults, is involvement of the parents, who learn the same skills that the adolescent learns so that they can coach the youth through any emergent distress.

By the same token, a mentalization approach to adolescents with borderline symptoms has gained some traction as an evidence-based approach (Abate et al., 2017; Taubner & Curth, 2013); there is now a treatment protocol, Mentalization-Based Treatment for Adolescents or MBT-A, available with a move toward therapist certification in this treatment modality (see Anna Freud Centre).

Trauma-focused CBT for children is a well-established best practice promoted by SAMHSA, with training material freely available on their website. There is now growing evidence for its use with teens in particular (Cohen et al., 2016).

What all of the sampling of available approaches, discussed previously, have in common are their multipronged, relational approaches with a strong peer group work component. This use of the mutual aid of peers is consistent with the importance of peers as well as self-determination at this stage of life. The use of cognitive behavioral procedures for identifying triggers and emotional responses is also a core component of these programs and consistent with traditional approaches to treating trauma in adults. Cognitive approaches promote exposure to and tolerance of the emotions that persons suffering from trauma often attempt to avoid (Lang & Sharma-Patel, 2011). Whatever the approach, there is some evidence that telling one's story and being able to do so in a coherent narrative is a good prognostic sign (Briere & Scott, 2006; Pennebaker, 1993). The cognitive skills and motivation necessary for constructing a coherent narrative related to one's life story normally develop during adolescence (Habermas & Bluck, 2000). Efforts in treatment are geared toward being able to

adolescence (Haberling & Bruck, 2009). Efforts in treatment are geared toward being able to face and articulate the trauma in a way that the adolescent can convey their experience without reliving it in the moment.

Clinical Tensions

Adolescence by its very nature is a time of conflict and contradiction (Box 8.1). Developmentally, at a time when there is a natural move away from parents, there is still a need to feel connected. Particularly with regard to a traumatic event or series of traumatic events, the need for a caring adult with whom to process is paramount. Adversity is the opportunity for growth and trauma can either hinder or enhance growth and development depending on supports available.

BOX 8.1

Normal Adolescent Contradictions

The contradictions of normal adolescence are described by Raphael-Leff (2011) as follows:

- Ideas of “invincibility” coupled with panic attacks and lack of confidence
- Social withdrawal yet deep concern regarding relationships
- Silence, need for privacy, sensitivity to external intrusions
- Talkativeness, loud music, barriers to block out internal intrusions
- Confusion, impulsiveness, sadness, resentment
- Self-preoccupation, exquisite sensitivity yet lower attunement to the emotions of others

The previous conflicts coincide with hope for the future and a sense of loss of childhood. Development does not occur in a straight line, but rather often involves the return of earlier childhood behavioral patterns, marshalled by the youth to manage the loss of childhood as well as the awakening of a sexual self. Family power dynamics shift as adolescents strive for independence. Ironically, as physical and psychological changes associated with puberty threaten confidence in competing with peers, or succeeding academically, the early adolescent seeks the reassurance of parents. Careful attention of caregivers to boundaries—flexible enough to adjust with the age of the youth—is important. The tendency to want to control the youth or abandon control completely is ever present. Either approach, too much control or too little,

increases the likelihood of the adolescent's "withdrawal or defiant rebellion in his/her search for adequate limit-setting coupled with warmth and support" (Raphael-Leff, 2011).

As previously discussed, it is important for teens to be able to talk to a caring adult, and to be able to respond in a validating way. Table 8.1 from the National Child and Traumatic Stress Network gives some very useful and nuanced responses to teens' experience of the disaster/trauma.

Table 8.1
Parent Tips for Helping Adolescents After Disasters

Reactions	Responses	Examples of Things to Do and Say
Detachment, shame, and guilt	• Provide a safe time to discuss with your teen the events and their feelings. • Emphasize that these feelings are common, and correct excessive self-blame with realistic explanations of what actually could have been done.	• "Many teens—and adults—feel like you do, angry and blaming themselves that they could have done more. You're not at fault. Remember even the firefighters said there was nothing more we could have done."
Self-consciousness: About their fears, sense of vulnerability, fear of being labeled abnormal	• Help teens understand that these feelings are common. • Encourage relationships with family and peers for needed support during the recovery period.	• "I was feeling the same thing. Scared and helpless. Most people feel like this when a disaster happens, even if they look calm on the outside." • "My cell phone is working again why don't you see if you can get a hold of Pete to see how he is doing." • "And thanks for playing the game with your little sister. She's much better now."
Acting out behavior: Using alcohol or drugs, sexually acting out, accident-prone behavior	• Help teens understand that acting out behavior is a dangerous way to express strong feelings (like anger) over what happened. • Limit access to alcohol and drugs. • Talk about the danger of high-risk sexual activity. • On a time-limited basis, keep a closer watch on where they are going and what they are planning to do.	• "Many teens—and some adults—feel out of control and angry after a disaster like this. They think drinking or taking drugs will help somehow. It's very normal to feel that way—but it's not a good idea to act on it." • "It's important during these times that I know where you are and how to contact you." Assure them that this extra checking-in is temporary, just until things have stabilized.
Fear of recurrence and reactions to reminders	• Help to identify different reminders (people, places, sounds, smells, feelings, time of day) and to clarify the difference between the event and the reminders that occur after it. • Explain to teens that media coverage of the disaster can trigger fears of it happening again.	• "When you're reminded, you might try saying to yourself, 'I am upset now because I am being reminded, but it is different now because there is no hurricane and I am safe.'" • Suggest, "Watching the news report could make it worse, because they are playing the same images over and over. How about turning it off now?"
Abrupt shifts in interpersonal relationships: Teens may pull away from parents, family, and even from peers; they may respond strongly	• Explain that the strain on relationship is expected. Emphasize that everyone needs family and friends for support during the recovery period.	• Spend more time talking as a family about how everyone is doing. Say, "You know, the fact that we're crabby with each other is completely normal,

to parent's reactions in the crisis.	• Encourage tolerance for different family members' courses of recovery. • Accept responsibility for your own feelings.	given what we've been through. I think we're handling things amazingly. It's a good thing we have each other." • You might say, "I appreciate your being calm when your brother was screaming last night. I know he woke you up, too." • "I want to apologize for being irritable with you yesterday. I am going to work harder to stay calm myself."
Radical changes in attitude	• Explain that changes in people's attitudes after a disaster are common, but often return back over time.	• "We are all under great stress. When people's lives are disrupted this way, we all feel more scared, angry—even full of revenge. It might not seem like it, but we all will feel better when we get back to a more structured routine."
Premature entrance into adulthood (wanting to leave school, get married)	• Encourage postponing major life decisions. Find other ways to make the teens feel more in control.	• "I know you're thinking about quitting school and getting a job to help out. But it's important not to make big decisions right now. A crisis time is not a great time to make major changes."
Concern for other survivors and families	• Encourage constructive activities on behalf of others, but do not let them burden themselves with undue responsibility.	• Help teens to identify projects that are age-appropriate and meaningful (clearing rubble from school grounds, collecting money or supplies for those in need).

Source: Reproduced with permission from the Psychological First Aid Field Operations Guide (PFA), 2nd Edition (2006).

Examining the response to the various reactions to disaster, or trauma, listed in [Table 8.1](#) essentially instructs us that the response is one of validation of the youth's experiences, which can mitigate any emotional dysregulation, and also serves to contextualize the reaction leading to cognitive understanding.

CONCLUSION

Adolescence is not only a time when there is increased risk for trauma because of the risk-taking typical of this developmental stage, but it also offers an opportunity to rework earlier traumas, a "second chance" (Blos, 1967; Eissler, 1958; Raphael-Leff, 2011). Intervention approaches typically include cognitive behavioral techniques to assist the young person in identifying triggers to deal with symptoms associated with PTSD; group interventions also are key during this developmental phase, when peers become much more important. Being able to tell one's story in a linear coherent narrative, without the intrusion of posttraumatic stress symptoms, assists in the identity formation so crucial to this developmental stage of life.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Publication

Briere, J., Lanktree, C., & Escott, A. (2020). *Trauma teletherapy in the era of the COVID-19 pandemic: Adapting evidence-based treatment approaches*. University of Southern California, Adolescent Trauma Training Center. https://keck.usc.edu/adolescent-trauma-training-center/wp-content/uploads/sites/169/2020/07/Trauma_Teletherapy_Final_2020702.pdf

Ted Talk

Sarah-Jayne Blakemore, *The Mysterious Workings of the Adolescent Brain*. TED Talk. www.ted.com/talks/sarah_jayne_blakemore_the_mysterious_workings_of_the_adolescent_brain?language=en

Website

The National Child Traumatic Stress Network. *Child and family traumatic stress intervention*. www.nctsn.org/interventions/child-and-family-traumatic-stress-intervention

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PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Publication

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CHAPTER 9

Treating Adults With Complex Trauma or a Complexity of Traumas

CAROL M. SMITH

CHAPTER OVERVIEW

This chapter reviews current knowledge in the helping professions regarding adults with complex trauma. *Complex trauma* is defined and deconstructed, locating the individual within relevant social systems. The chapter clarifies otherwise inexplicable characteristics of adults carrying significant trauma histories. The neurobiology of trauma informs treatment planning. Phases of treatment are reinforced, as well as current best practices and limits of what psychotherapy or mental health counseling can achieve. The chapter briefly compares Eastern and Western approaches to emotional discomfort and offers relevant guidance. The chapter closes with counseling implications of current treatment models and evidence-based best practices, which are discussed in more detail in later chapters.

best practices, which are discussed in more detail in later chapters.

LEARNING OBJECTIVES

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

1. Distinguish multiple meanings about what is meant by the phrase *complex trauma*;
2. Recognize typical clinical characteristics of adults with significant trauma;
3. Describe the treatment implications of the *neurobiology* of complex trauma;
4. Review current best practice approaches in treating complex trauma; and,
5. Recognize the limits of treatment for complex trauma.

INTRODUCTION

This chapter focuses on the therapeutic encounter with adult survivors of developmental (complex) trauma and those who present with a *complexity of traumas*. Working with adults who have significant trauma histories is uniquely challenging. Challenges include characteristics that some label as mistrust (or naivete), resistance (or anxious attachment), acting out (or self-harm), emotional blunting/flat affect (or emotional outbursts/histrionics), lack of engagement (or manipulation), or shame (or shamelessness). These behavioral *labels* are not ends in themselves; rather, they point to a person living with a history of significant trauma.

This chapter addresses the clinical *footnotes* of working with adults who have survived some of the worst experiences conceivable, some of which are nearly incomprehensible in intensity and scope. Unpacking a trauma history includes consideration of the neural substrates of trauma; how trauma *inhabits* a body, emotions, and thought patterns; and how survivors learn to survive in ways that were uniquely ingenious at the time of the trauma(s) but that now create more problems than they solve. A comparison of *Western and Eastern* approaches to emotional pain facilitates making sense of a traumatic history and provides a foundation for posttraumatic growth and development. This chapter emphasizes the importance of following a phasic approach to treatment and why. While planning what treatment can accomplish for adults living with significant trauma histories, it is also incumbent on the therapist to explain the limits of therapy. The chapter introduces current best practices and addresses the implications for counselors providing counseling to adults with significant trauma.

COMPLEX TRAUMA AND CLINICAL TENSIONS

Mental health professionals use the phrase "*complex trauma*" in at least two ways. "*Complex trauma*" can refer either to "*developmental trauma*," which typically occurs in childhood as an enduring characteristic of household or generational patterns (Courtois, 2004; Ford & Smith, 2008; van der Kolk, 2005; van Dijke et al., 2015), or to a "*complexity of traumas*," which refers to any combination of sequential or contemporaneous traumatic events (traumas within traumas), or simultaneous preexisting mental health disorders or addiction(s) and either sequential or contemporaneous traumatic events, or all of the above (Briere & Scott, 2015; Lawson, 2017). For example, refugee immigrants, who have typically lost their homes, livelihoods, and many family members, experience long stays in displacement camps, significant cultural intolerance, stigma, and physical or sexual assault in host countries, and find it nearly impossible to find meaningful work by which they can rebuild their lives (Panter-Brick et al., 2018; Riber, 2017; Ter Heide et al., 2016). (Further details regarding immigration-related trauma appear in Chapter 17, "Racial, Ethnic, and Immigration Intolerance: A Framework for Understanding Violence and Trauma.")

Knowing that the phrase "*complex trauma*" refers either to developmental trauma or to a complexity of traumas (or both) helps the therapist to recognize multiple types and instances of traumatic stress, or traumas within traumas, that manifest in a bewildering array of

or traumatic stress, or traumas within traumas, that manifest in a bewildering array of characteristics in clients, and which can significantly complicate treatment. A clinical example of someone experiencing complex trauma appears in [Box 9.1](#).

BOX 9.1

Clinical Vignette: Christa

Christa (*composite example*) provides an example of a complexity of traumas: Christa left home and eighth grade at age 14 to escape the neglect of her addicted mother and the sexual predation of her third stepfather, only to fall in with sex traffickers who provided food and a place to stay in exchange for trafficking her. They plied her with heroin to blunt the pains of being trafficked. At 18 she managed to escape and hitchhiked across the country. Still addicted, she pitched a tent on railway land and found a job waiting tables. When COVID-19 shut the restaurants to which she could walk or take the bus, she tried to find space in a women's shelter and get help obtaining a car so she could find additional work. While unable to find permanent shelter or a car, she attended shelter workshops whenever possible and sought medication-assisted treatment to overcome her addiction. Christa became pregnant while working on her GED and obtaining skills training through a local Job Corps. Christa delivered a baby girl, Destiny, in the emergency department and was discharged later that day with a bag of diapers, a stroller, and formula vouchers. Job Corps secured an efficiency apartment for them when Destiny was 2 months old. As Destiny's needs have increased in the ensuing months, Christa cannot afford childcare and finds it hard to concentrate or sustain her energy for her GED and work training. She is unable to make ends meet. She is not sleeping and is considering returning to sex work because the sisterhood of workers will watch Destiny when she is working. While she knows her situation is not ideal, Christa does not consider herself to be victimized or out of the ordinary, because almost everyone she knows shares a similar history.

Despite the potential complexity of a given trauma history, whether an adult seeks mental healthcare for a traumatic childhood, or a series of traumatic experiences, both the presentation and treatment planning are similar ([Briere & Scott, 2015](#); [Lawson, 2017](#); [McCormack & Thomson, 2017](#)). Although the traumas are complex and seemingly overwhelming, it may be reassuring to know that treatment approaches remain clear and consistent for all adults with significant trauma histories.

CLIENT CHARACTERISTICS

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; [American Psychiatric Association \[APA\], 2013](#)) moved the diagnosis of Posttraumatic Stress Disorder (PTSD) from the section on Anxiety Disorders (*DSM-IV-TR*, [APA, 2000](#)) to a newly created section on Trauma and Stressor-Related Disorders, in recognition that traumatic stress is a distinct category ([APA, 2013](#); [McFarlane, 2014](#); [Miller et al., 2014](#)). The new *DSM* section includes Reactive Attachment Disorder (RAD), Disinhibited Social Engagement Disorder (DSED), Posttraumatic Stress Disorder (PTSD), and Adjustment Disorders. The section follows Anxiety Disorders and Obsessive-Compulsive and Related Disorders, and precedes *DSM* sections on Dissociative Disorders and Somatic Symptom and Related Disorders. The section's location in the *DSM-5* is pertinent to a broad understanding of trauma and underscores the etiological relevance of these clinical presentations, which can co-occur. The authors of the *DSM-5* not only recognize traumatic stress as its own distinct category, worthy of study and expertise, but also acknowledge that its etiology relates to the sections which precede and follow it in the manual. Trauma's neighboring sections in the *DSM* are near it because they relate to trauma, both conceptually and clinically. Interestingly, the potential entry of developmental trauma disorder (DTD) was proposed but not included in the *DSM-5* ([Bremness & Polzin, 2014](#)). Future editions of the *DSM* almost certainly will include more trauma-related diagnoses and recognition that both trauma, and reactions to trauma, occur on a continuum or *spectrum* ([Carmassi et al., 2020](#); [Monson et al., 2017](#); [O'Donnell et al.,](#)

on a continuum or *spectrum* (Carmassi et al., 2020; Monson et al., 2017; O'Donnell et al., 2011).

Any of the following may apply to adults with traumatic histories who are seeking mental healthcare:

- They may reveal that they have a difficult time with relationships (see V- and Z-codes in DSM-5);
- They do not remember much of their childhoods (dissociative amnesia);
- They may be self-medicating with marijuana, alcohol, or multiple substances (substance use disorders [SUD]); and,
- They may qualify for an anxiety disorder or major depressive disorder (MDD), dissociative identity disorder (DID), panic disorder, somatic disorders, sleep-wake disorders, sexual dysfunctions, conduct disorders, personality disorders, or paraphilic disorders.

In short—excluding schizophrenia and neurocognitive and neurodevelopmental disorders—adults with a complexity of traumas may spend years collecting diagnoses spanning the *DSM-5* and still not have an accurate clinical explanation for what is wrong. While this can feel completely overwhelming to an inexperienced clinician, it is reassuring to understand that “what is wrong” is actually *trauma*. If mental health professionals can recognize and treat trauma, the majority of diagnoses in the *DSM* can be eliminated (Breuer & Freud, 1893; Kira et al., 2013; McCormack & Thomson, 2017; Zanville & Cattaneo, 2009).

Trust and Boundaries

Adults with substantial histories of trauma have great difficulty trusting others or forming healthy attachments—for good reason—given their histories (Garcia, 2017; Larsen et al., 2011; Miranda et al., 2020; Unthank, 2019). Therefore, these clients initially may frustrate clinicians with an aloof, guarded, and blunted presentation. They do not seem to engage in the counseling process, offer little information or detail when asked open questions, appear to withhold candid answers, or deflect inquiries that even modestly approach trauma or victimization. On the other hand, they may present as angry, irritable, defensive, suspicious about the clinician's motives or line of inquiry, or doubt the clinician's credentials or competence to work compatibly with them. Alternatively, they can be charming, manipulative, disingenuous, and bafflingly opaque in their initial sessions, giving the impression that nothing is wrong and there is no reason for therapy to take place. Because interpersonal trauma unavoidably ruptures the fundamental trust on which human relationships are built, adults with substantial trauma histories have compelling reasons *not* to trust relationships with others (Garcia, 2017; Larsen et al., 2011).

A lack of confidence in others creates an unsolvable dilemma in a world that essentially requires human beings to form trusting relationships in order to live healthy lives (Garcia, 2017; Larsen et al., 2011; Unthank, 2019). Therefore, a fundamental goal of therapy is to establish a trusting relationship. A trusting relationship grows through the intentional use of unconditional positive regard (Rogers, 1957), patience, appreciating that *trust issues* are evidence of the quality of previous relationships rather than current therapeutic rapport, and tolerating repeated *tests* of the therapeutic relationship while maintaining consistent interpersonal boundaries of the professional—rather than personal—relationship. It is essential to remember that a therapeutic encounter represents a professional relationship, despite the intensely intimate content and topics addressed in therapy.

Adults with complex histories of trauma may use *self-blame* and a deep sense of *shame* to keep others at a distance (Unthank, 2019). They may have very little regard for their own personal boundaries, considering themselves unworthy of respect or genuine caring (Blanco et al., 2016; Horowitz & Stermac, 2018; Unthank, 2019). Client mistrust regarding the therapeutic relationship and related disturbances in the client's interpersonal boundaries with others are characteristics of trauma rather than interpersonal deficits. Further, they do not reflect the quality of the therapist. Clinicians are wise to remind themselves, frequently, that trauma disrupts many assumptions about how the world works. Therefore, trauma manifests characteristics that otherwise would sabotage the clinical encounter. In the end,

competent clinicians will be patient, soft-spoken, and tolerant. As trust in the therapeutic relationship builds, therapeutic progress accelerates.

Dysregulation

Adults with a complexity of traumas present with an array of other emotional characteristics. For example, they may struggle with regulation, pivoting between a dull, flat affect and emotional lability, sometimes within the same session (Frei et al., 2020; Horowitz & Stermac, 2018; Poole et al., 2017; Siegel, 2009). Clients may seek relief in self-injury (Frei et al., 2020; Horowitz & Stermac, 2018), risky behavior (Felitti et al., 1998; Modrowski & Kerig, 2019), or substance use as a way of self-medicating (Ghorbani et al., 2019). Clients describe an overwhelming spectrum of somatic complaints (headaches, gastrointestinal complaints, muscle aches, stiffness, unexplained pain), and benefit from therapists who recognize how uncomfortable it can be for individuals who have been physically violated, targeted, or seriously injured simply to inhabit a human body (McGuire, 2018), which feels chronically unsafe (Herman, 1992; van der Kolk, 2014).

Triggers

Traumatic experiences may not be accessible as thoughts or part of a personal narrative. Rather, the experiences are stored as fragments of senses throughout the body, and restored by relevant body positions, pains, smells, sights, or sounds (Ogden & Fisher, 2015; Stein & Kendall, 2004; van der Kolk, 2005, 2014). Memories or disjointed sensations of “something wrong” can be triggered by subtle or obvious cues. They can be caused by anniversaries or relevant circumstances: such as having one’s child reach the survivor’s age of abuse; the physical gestures used by authoritative figures; or cues like smells, textures, or patterns in carpet, fabric, music, or artwork. Interestingly, *trigger warnings* on college campuses and in media are not only unhelpful, paradoxically, they reinforce survivors’ views of their trauma as “central to their identity” (Jones et al., 2020, p. 905).

Dissociation

Finally, adults with complex histories of traumas may be unaware of one of their most effective defense mechanisms—*dissociation*. Dissociation refers to an automatic and spontaneous division of pieces of thought processes from personal awareness. In other words, dissociation serves to create conceptual and categorical distance between a person and the unbearable things that person has experienced. Dissociation allows a person to sustain two or more incompatible actualities without recognizing the incompatibility (APA, 2013).

Dissociation allows a child to love an abusive figure, a teen to feel safe in a dangerous family, and an adult to remain devoted to a violent partner. Dissociation occurs when individuals must choose between the two major needs of *safety* and *belonging*, outlined by Maslow’s hierarchy of needs (Maslow, 1943) as *mutually exclusive categories*. They can either be safe without belonging, or they can belong without safety, but not both simultaneously. The ingenious psychological and self-preserving answer to this existential conundrum is *dissociation*. Dissociative symptoms include dynamics like a fragmented sense of one’s personality, *derealization* (distancing from the actuality of an experience; this is not really happening), and *depersonalization* (detaching from one’s sense of living in the experience; this is not really happening to me) (APA, 2013). In extreme cases, people with extensive histories of trauma may qualify for DID (APA, 2013), which is characterized by more than one distinct personality and sense of history existing in the same person. DID is an elegant solution to an unsolvable problem for a youngster growing up in a dangerous and violating environment. When something unbearable and unconscionable occurs to a person (typically a developing child), the mind distances itself from the experience, to the extent that “it not only did not really happen; and did not happen to me; it actually happened to someone else altogether.”

Some learn to dissociate as a tool for survival (Alayarian, 2019; Kumar et al., 2019; Lawson

& Akay-Sullivan, 2020; McGuire, 2018) and grow up without knowing that they dissociate. Difficulties ensue when individuals engage in dissociation whenever circumstances feel overwhelming, with an accompanying degradation to the mean, meaning that it takes less stress to produce a dissociative response. This is especially problematic when individuals have difficulty piecing together a coherent personal historical narrative for almost any span of their life stories (Alayarian, 2019). The challenge in treatment is to distinguish between healthy and self-defeating forms of dissociation, and to help clients know that, as adults, they have more coping strategies at their disposal than they did as children. They can use healthier and more life-affirming methods, such as dosing and distancing, to process distressing events in manageable ways.

NEUROBIOLOGY OF COMPLEX TRAUMA

To explain the neurobiology of complex trauma, it is helpful to revisit an historic evolutionary model, an oversimplification now replaced by clearer scientific understanding of physical development. The triune brain model (MacLean, 1990) nevertheless serves as a metaphorical organization of brain *functioning* rather than *development*. The triune brain model describes three systems: the *brainstem* (which controls fine motor movements, smooth muscle function, regulation of heart rate and breathing, and the ability to maintain consciousness); the *limbic system* (which is the emotion and memory center of the brain), and the *cerebral cortex* (which controls executive functions like the ability to sustain attention, make choices between right and wrong, put things in sequence, find the right word, and make sense of experiences).

Bessel van der Kolk (2014) maintains that the structures deepest within the brain and closest to the midline (a.k.a. the *corpus callosum*) are those which are most relevant to the individual's sense of self, while the structures toward the surfaces of the brain have to do with social relationships and interactions with the world. Given the limbic system's location in the center of the brain, the limbic system is where the *sense of self* resides. The limbic system houses basic emotions, memories, alertness to danger, and self-in-environment. The function of two key structures—the *amygdala* and the *hippocampus*—are essential to a contemporary understanding of the neurobiology of trauma. The neuroscience of trauma is explored in more detail in Chapter 2, "Theoretical Contexts of Trauma Counseling."

Amygdala and Hippocampus

The amygdalae are two almond-shaped structures, one on either side of the midline (*corpus callosum*) of the brain. The hippocampi are two seahorse-shaped structures, one on either side of the corpus callosum. The amygdala uses the neurotransmitter norepinephrine to determine *how* perceived external stimuli are encoded and consolidated as memories through the amygdala-hippocampal connection. The effect of this relationship is an upside-down U-shaped curve (a.k.a. the Yerkes-Dodson curve). Too little norepinephrine means that memories are not likely to be consolidated and stored. A medium ("just right") amount of norepinephrine enhances alertness, focus, and memories. Too much norepinephrine "hijacks" memory consolidation and facilitates amnesia and dissociation, which is the typical signature of a life of complex trauma.

Executive Functions: Flipping Our Lids

When an individual is frightened or sufficiently stressed, the upper cortical layer in the brain (where all of the executive functions and self-regulation skills reside) goes offline, and the limbic system takes over, doing whatever it can to fight, flee, freeze, or faint, in order to avoid a stressor. This is called *flipping one's lid* because it is like unwrapping the cortex from the midbrain (Box 9.2).

BOX 9.2

Brain Function Illustration

An illustration of the brain's trauma process is to make a fist with one's fingers curled over the thumb, and then to flip the fingers up straight and open. In the model, the wrist represents the brainstem. The thumb represents the limbic system, and wrapped fingers represent the cortex. When trauma, stress, or both occur, "flip the lid," by uncurling the fingers from over the thumb. In this model, the cortex (represented by the fingers) "goes off-line," leaving the limbic system (emotions; represented by the thumb) and brainstem (represented by the wrist) to manage the situation with more basic responses and instincts.

When a person is exposed to multiple, uncontrollable sources of stress, particularly traumatic stress, the amygdala becomes primed or sensitized to excrete norepinephrine, and in greater amounts. This priming increases not only the volume of neurotransmitters (primarily norepinephrine) employed by the amygdala, but also the physical size of the amygdala (Kuo et al., 2012). Increased norepinephrine in the brain, over time, impairs the functioning of the prefrontal cortex. Higher levels of stress lead to higher amounts of norepinephrine circulating in the brain and body. Over time, progressively less stress is required to reach a high level of norepinephrine in the brain. This process is also known as *kindling*.

Neural Pathways

Neural pathways are the paths through which nerve signals travel, using neurons in the brain or body. Simple neural pathways control things like a knee-jerk response in the leg. More complex neural pathways control things like habits, or well-learned coordinated skills (such as typing, musical passages on an instrument, dance, or athletic moves). Neural pathways are also significantly involved in cognitive activities such as memories, mind-sets, worldviews, and schemas.

Each time the brain is stimulated by information, the brain creates new neural pathways. Specifically, neural stimulation encourages new dendritic growth (branching of the nerve cells) in the brain. As these fibers lengthen, they increase the physical surface available both for receiving information and for passing it along to the next nerve. Increased dendrites (short, branched extensions of the nerve cells) are central to thought, memory, and information processing in the brain. The more dendrites the brain has at its disposal, the more quickly and smoothly it can process information, make connections, see patterns, form meanings, predict implications, and so on. Just as physical bridges and roadways provide faster travel for cars, neural pathways provide faster and smoother transfers for communication within the cortex, or between the cortex and connected structures, such as the limbic system. Neural pathways increase processing power in the brain by dedicating familiar information to familiar pathways, which frees the cortex to attend to new information. The more a given pathway is stimulated, the stronger it becomes. For example, if a person accentuates negative schemas or mind-sets, the brain programs cognitive neural pathways toward negativity. Likewise, traumatic stress tends to emphasize negative, vulnerable, and hypervigilant mind-sets. In order to counteract these negative neural pathways, people with complex trauma benefit from purposefully working on and exposing themselves to new, positive, and trustworthy information and experiences. Essentially, if a person emphasizes positive materials and mind-set, the brain accommodates by creating and reinforcing positive neural pathways. Simple repetition of behaviors, motions, or thoughts strengthen and deepen neural pathways.

Broca's Area

One of the key areas in the prefrontal cortex that shuts down during traumatic stress is *Broca's area*, or the area in the cortex responsible for producing speech. This is one reason why van der Kolk (2001, 2005, 2014) describes traumatized people as those who are *frozen in speechless terror*. This means that people who have experienced traumatic stress have an exceptionally difficult time talking about what exactly happened. This is not because it is too

challenging, emotionally, to talk about it (although this is partly true), but because Broca's area has become inactivated during the traumatic stress, and therefore cannot assist in the typically easy process of putting experiences into words. The physiological underpinnings of words and descriptive language are simply not available. It also means that many cognitively based talk therapies, while necessary, are insufficient to resolve a traumatic experience.

Inability to talk about a trauma does not mean, however, that the individual is unaffected by—or is not thinking about—the trauma. Exactly the opposite occurs. *Because* the person cannot put it into words, *because* Broca's area was offline, and *because* the person cannot talk it out, the person tends to become developmentally stuck and unable to move forward. The person becomes stuck in a frustrating process of trying to make sense of the events, trying to put them into words (generally without success), and trying to organize thoughts about what happened, why, and what the events *mean*. This expressive work is no small task.

Some adults with complex trauma not only have difficulty generating speech about their traumatic stress, they also have difficulty recognizing and processing language, especially feelings-based language, about traumatic stress. A study of veterans (Freeman et al., 2009) showed that those with PTSD displayed significant inability to comprehend or discriminate between components of affective (emotions-based) speech. The degree of difficulty recognizing and understanding emotional language for the veterans with PTSD was similar to those who have ischemic brain injury (stroke). Please see Box 9.3 for a recap of the neurological implications of trauma.

BOX 9.3

Neural Recap

Quick recap: Traumatic stress decreases neural connections, and ultimately cellular volume, in the hippocampus (it gets smaller and less efficient). Traumatic stress increases the size of the amygdalae on both sides of the brain, making them more sensitive and alert to any signs of threat in the environment. Traumatic stress causes breakdown in the connectivity of the two hemispheres of the brain via the corpus callosum, diminishing the ability of the two brain halves to communicate and integrate with each other. Traumatic stress decreases whole brain volume (Perry, 2009; van der Kolk, 2014), especially in the cortex, where the majority of thinking and sense making occurs. Not only does traumatic stress kindle the fight-flight-freeze-faint response, but it also deregulates it so that the response is both less predictable and less manageable when it occurs. Traumatic stress also dysregulates neurotransmitters and hormones in the brain (and the body) so that they are out of balance with one another, leading to mood swings, impulse control problems, difficulty regulating affect, and self-awareness. This lack of balance also characterizes classic depression and anxiety disorders, as well as anger control problems.

TRAUMA AND THE DEVELOPING BRAIN

Brain development occurs from the bottom up, both physically and in terms of functionality (Perry, 2009). It is sequential, in a predetermined order, and higher levels of development depend on lower levels having developed appropriately first. Brain development starts before birth and a series of critical windows of development must happen in a sequential order for a brain to be fully developed and healthy. Critical windows are periods of potential in brain development that are critical to functionality. Therefore, the same trauma will affect a younger child more profoundly than an older child because of the sequential nature of brain development. Trauma early in life makes a person more vulnerable to future trauma. Brain development concludes around ages 28 to 30, and then slowly declines over the rest of one's lifetime.

Timing is everything regarding trauma and development. The earlier a trauma occurs, the more profoundly it affects brain development (Garner, 2013; Perry, 2009; Whittle et al., 2013). The longer a trauma lasts, the worse it is. The more it is directed personally at a child, the

The longer a trauma lasts, the worse it is. The more it is directed personally at a child, the more pervasive its consequences (Perry, 2009; Shonkoff & Garner, 2012). A salutary feature of brain development is "*malleability*," meaning that a very young brain (neonatal until about age 4) is more malleable, meaning that it changes and develops easily with learning and experience. However, very young brains are also more vulnerable (McCrary et al., 2010). A young brain (ages 5 to 25) is less vulnerable than a very young brain, but also less malleable. An old brain (after about age 65) is less malleable and more vulnerable to physical insults such as head injury or stroke. Trauma early in life is so profound, because a young child is creating templates for expectations about the world, other people, and the child's place in the world. Children learn at very early ages (less than 24 months) whether the world is safe, whether others are trustworthy and predictable, and whether the environment is safe and caring (Perry, 2009). Children also learn whether they are essentially okay and acceptable, whether they belong to the family group, and whether they have personal agency.

EAST-WEST UNDERSTANDINGS OF SUFFERING AND PAIN

Lifetime prevalence for anxiety disorders in the United States is 31.2% (National Comorbidity Survey, 2007) compared to 5% in China (Shen et al., 2006). Likewise, lifetime prevalence for depression in the United States is 21.4% (National Comorbidity Survey, 2007) compared to 2.5% in Japan (Kawakami et al., 2005). While people who live in eastern countries may be less happy overall, they experience fewer mental health disorders (DeVaus et al., 2018). Because individuals from different cultures think in different ways about their emotions, and their responses also differ (DeVaus et al., 2018), it is instructive to contrast East and West systems of thought (Nisbett et al., 2001).

People from Western cultures tend to favor analytical thinking, breaking things down into a binomial either/or taxonomy of exclusive categories, for example: sadness/happiness; myself/others; good/evil; cause/effect; wellness/illness (Nisbett et al., 2001). People from Eastern cultures employ holistic thinking (both/and), and, rather than separating opposites, see them as coexisting simultaneously; for example, yin/yang symbolism, and events within context, and the interdependence of individuals within the collective (DeVaus et al., 2018; Spokas, 2019).

Eastern conceptions of emotions can be instructive for people in the West, particularly those coming to terms with a history of complex trauma. First, in Eastern conceptualizations, emotions co-occur (Goetz & Peng, 2019; Nisbett et al., 2001; Spokas, 2019); happiness can be found even in sad events—such as funerals, relationships that end, leaving home—and sadness can accompany positive experiences—such as weddings, childbirth, promotions, and birthdays. Second, emotions about the same event evolve over time (Nisbett et al., 2001; Spokas, 2019); for example, realizing that a divorce, while painful at the time, was also a relief and a release from painful interactions. This is important because it conveys the impermanence of feelings and events. Negative events, even trauma, become less threatening, because they are temporary (DeVaus et al., 2018). Finally, emotions are embedded in context (Goetz & Peng, 2019; Nisbett et al., 2001), meaning that negative experiences can be reframed. It is possible to do something about one's current emotional state by taking care of oneself currently, rather than ruminating on what happened previously. One way to manage negative feelings is to pay less attention to them, while attending to the needs of the situation (Adler, 1927) and one's effect on other people. The focus of one's attention affects one's beliefs about the world and causality (Goetz & Peng, 2019; Nisbett et al., 2001). Westerners turn inward and tend to conceptualize negative affect states as "What is wrong with me?" asking "How can I feel better?" By contrast, Easterners consider the self-in-context and ask, "What is wrong with the situation?" and "What can be done about it?"

Therefore, mental health professionals can provide clear cognitive tools to assist adults with histories of complex trauma, by emphasizing the duality and impermanence of emotions. While emotions provide the fuel for action (Adler, 1927), the specific *choice* of action can be made by the executive functions of the individual. Emotions co-occur (more than one emotion can happen simultaneously), they are embedded in a context (time, place, role), and they

information. Further, it may be a relief to expand one's conceptualization of a traumatic event by considering the individual in the *context* of other people, circumstances, roles, and the needs of a given situation. An individual may, by shifting perspectives, and by considering context and the passage of time, rally current, more developed ways of coping, and situate a personal event in the larger narrative of one's loved ones, community, culture, overall life history, goals for the future, and desires for positive change. Larger perspective and contextualization can foster significant change and posttraumatic growth.

PHASES AND ESSENTIAL ELEMENTS OF TREATMENT

Herman's (1992) phasic approach to treatment provides a structural framework for planning treatment. Three phases—establishing safety, working through, and consolidating gains—provide a roadmap for best practices. Some clients do not proceed through all three phases, and competent therapists do well to recognize that each client is unique with unique needs. It is not best practice to plunge into a debriefing of “what happened” unless the client is confident of the safety of the therapeutic relationship and context and wishes to tell the story. Some clients are satisfied with establishing safety and have no desire to rehash or unpack negative experiences—and being forced to do so, by well-intentioned therapists, actually can cause additional harm. Although it used to be axiomatic that, in order to heal, the traumatic history needs to be spoken and examined in detail, that is no longer the case (**Webber & Mascari, 2017**). In fact, some clients do not want or need to tell their story at all, ever. Mental health therapists can be content not to know what happened, because they do not need to know in order to help clients significantly and in lasting ways.

Essential elements of treating individuals with a complexity of traumas include matching the intervention to the functionality of the client (**Perry, 2006, 2009**); valuing the client while validating the client's feelings, thoughts, and experiences (**Rogers, 1957**); providing clear structure for both individual sessions and the overall span of treatment; dosing difficult emotions and affect (should the client choose to work through a given trauma); co-creating anchors for emotional grounding and tolerance; containment of content; installation of hope (**Yalom & Leszcz, 2005**); experiential fostering of creativity and spontaneity; and finally, reconceptualizing *trauma* as a *superpower*. While some of these essential elements are self-evident and are covered in detail elsewhere in this textbook, others deserve more discussion here.

Matching Intervention to Functionality

Perry (2006, 2009), in introducing the Neurosequential Model of Therapeutics (NMT), clarified that it is fruitless to provide therapy that does not match the developmental need of a given child. Perry discovered that some children, due to the traumatic nature of their upbringing, missed critical windows of development and therefore benefit more readily from remediation at specific areas of neurological development. For example, a child who has a poorly organized brainstem struggles with emotional self-regulation, focus, and impulsivity, and therefore would benefit from repetitive physical activities to balance emotional and physiological regulation (**Perry, 2009**). Examples of such activities include patterned breathing, a game of repeating verbal call and response, gently rolling a ball back and forth, learning to take turns, and simple yoga poses and stretches. These needs may persist into adulthood for people with a complexity of traumas, and therefore such lower level, somatic and physiological interventions are very helpful in learning to inhabit a human body safely, in the here and now.

Structuring, Dosing, Anchors, and Containment

Structuring, dosing, anchors, and containment refer to the calming and encouraging provision of bringing order to the chaos of feelings, flashbacks, and somatic experiences of humans with complex trauma histories. “*Structuring*” simply refers to the intentional and

humans with complex trauma histories. Structuring simply refers to the intentional and repeated use of words like "first," "before," "after," "later," "then," and "finally" to provide order and continuity in the process of any given therapeutic encounter as well as the overarching plan of treatment, in general, from beginning to end. This is good practice, because it provides a road map and a sense of progression for the client. "Dosing" is a specific type of structuring, which guides the client in managing negative affect and difficult memories. The client is empowered to determine how much will be managed in a given session or even in a given intervention, with the options of slowing down, backing off, hitting the proverbial brakes, and recognizing that enough has been accomplished for a given intervention, day, or season of working through a memory or history. Dosing in mental health treatment parallels medication prescriptions—take two a day in the morning, guidance for exercise—do three sets of 20 once a day, or building muscle—hold for 60 seconds.

Anchors

Anchors refer to identified examples of somatosensory phenomena in the immediate environment to assist with coming back to the here and now. A counselor can ask the client to identify two objects in the room (e.g., flower vase, yellow figurine) to serve as visual anchors, two sounds in the environment (ventilation inside, birdsong outside) to serve as auditory anchors, and, if it feels right, two textures or feelings (soft blanket, sitting down) to reconnect to current circumstances when working with emotionally challenging material. The counselor can use the identified anchors to help the client return to the here and now, should the client seem to be dissociating or getting lost in a given memory. The counselor can ask the client, who seems to be dissociating, to name the two visual anchors and focus on them, to name the two auditory anchors and experience them, to activate the two feelings by touching the textures or shifting postures—this brings the client out of the troubling memory and back to the here and now in the therapeutic encounter.

Containment

Containment refers to providing a physiological or metaphorical way to hold, or keep safe, the traumatic material discussed in therapy. For example, some clients choose to build a physical box themselves, or decorate a premade box and use it to *contain* writings, symbolic objects, poetry, photographs, and the *essence* of a trauma history. At the end of the session, everything goes back into the box, and the box either can stay in the therapy room for safekeeping, or the client can take the box, with the understanding that any intrusive thoughts or feelings that happen between sessions are moved into the box to be dealt with later at the next session. [Langberg \(1999\)](#) provided therapy in a converted turn-of-the-century house still containing an ornate cast-iron pot-bellied stove. A client spontaneously asked to leave her trauma in the stove for safekeeping until the next week, thus creating a containment mechanism that was also extended to other clients. The strategic employment of structuring, dosing, anchors, and containment provides clients with control, empowerment, tangible handles, and indicators of progress through the duration of the therapeutic relationship.

Tolerance of Emotions and Installation of Hope

[Frei et al. \(2020\)](#) found that those who were preoccupied with their feelings or mood were significantly more likely to engage in self-harm. These clients can benefit immensely from learning to tolerate negative affect, to regard negative feeling states as temporary and flowing, and to make sense of such feelings in life-affirming ways. The therapist, by creating a safe space for experiencing, staying with, and tolerating emotions as they arise in therapy, teaches clients that emotions are not, after all, frightening or overwhelming, and *can* be tolerated by allowing them to happen; to begin, wax, wane, and conclude, like waves on the surface of the water. Like being in waves of the ocean, clients may first feel tossed around and as if they are drowning. However, with guidance and support, clients learn not only to navigate, but also to discover that the seas become gentler, and the waves of emotions are less intense, less unfamiliar, and easier to endure; eventually, clients even learn to honor and value the full spectrum of emotions.

value the full spectrum of emotions.

Yalom and Leszcz (2005) wrote about the *installation of hope* as an essential element of group counseling. This holds true for individual counseling as well, especially for adults with a complexity of traumas who may have lost sight of what hope feels like. Therapists gently and persistently express trust and hope in the client with phrases like, *it is okay that this feels overwhelming now; stay with it, stay with me; you are finding your way through this feeling; I trust that you can do this; as long as there is breath there is hope; we fall down seven and get up eight; I am eager to see what life is like for you on the other side of this; I know you can do this*; and so on. The adult client may have very little self-confidence, and may be plagued with self-doubts, and double guessing every thought. The therapeutic alliance is strengthened as the mental health professional consistently repeats phrases of trust, confidence, and hope, metaphorically leaning toward a future of health and life-affirming wholeness that the client may not yet be able to consider. The installation of hope is a key element of restoring the ability to live life as it comes, without being stuck in a dark and painful past.

Experiential Creativity and Spontaneity

Suffering has long been recognized as a source of creativity. Many of the greatest works of art and musical compositions were born of suffering, persecution, longing, or loss. Nevertheless, people with complex histories of trauma may have lost all sense of creativity, experiencing joy, or savoring any moment. Instead, they survive in a grey haze of "just hold it together" or "feeling dead inside" and existing, rather than living. Talk therapy alone is insufficient for helping many clients overcome trauma and re-engage with the full experience of living a human life. Instead, trauma-competent counselors purposely engage as many sense modalities (sight, hearing, taste, smell, touch, and posture) as possible to help the client re-experience what it feels like to *live* rather than *exist*. Each activity in the therapeutic encounter is strengthened as it capitalizes on *current experiences* which counteract and balance the old darkness and sadness of traumatic memories. Experiences that involve successive accomplishments (e.g., gentle exposure to unsettling material, paired with progressive relaxation and increased tolerance); multiple senses combined with creativity such as artwork, music, movement, and making something that expresses healing; and intentional uses of creating new, positive, and symbolically meaningful memories will—due to their salience and immediacy—accelerate healing and solidify gains achieved in the therapeutic encounter.

Trauma as a Superpower

Almost all superheroes have a traumatic backstory involving loss, bereavement, vulnerability, betrayal, exclusion, or rejection. Adler (1927) declared that a central component of a person's development is the overcoming of a felt sense of defectiveness or inadequacy. Nietzsche and Large (1888/1998) claimed that that which does not kill us makes us stronger. Inspirational speakers, people held in high honor, nearly every Olympic athlete, and many unsung heroes carry astonishingly difficult histories, most of which will never be known by the general public. The suffering and emotional complexity of these difficult histories become transformed as a motivational force for overcoming, for striving for strength and competence. Adults with complex trauma histories can be assured that they have joined the ranks of superheroes, by virtue of having survived their ordeal, and by doing the deeply personal and difficult work of therapy. This is not an observation that a counselor shares flippantly in early sessions, but rather, it is revealed gently, toward the end of therapy, while gains are being solidified and the client is moving toward the closing of the therapeutic encounter. Trauma is actually a secret superpower. It once subjugated, but now enervates and motivates with surprisingly enduring drive and intensity. One's history does not need to be shared with everyone (or even anyone), but as the trauma is transformed and transcended, it can be kept to oneself with a smile.

LIMITATIONS OF TREATMENT

Adults with complex trauma histories need to know that mental health therapy alone will not solve everything. Even the best mental health treatment has limitations. For example, psychotherapy and/or counseling alone, for many people, works best when combined with tailored psychopharmacology (Brown et al., 2021; Fortney et al., 2018; Johnson & Possemato, 2019). Even when the best physical healthcare is combined with the best mental healthcare, other facets of human experience such as physical fitness, nutrition, spirituality, creativity, economics and finances, politics, social supports, and community environment are beyond the scope of mental health intervention. In order to experience true holistic vitality, it is incumbent on the individual to address each and every sphere of life, and this effort represents lifelong work for all people, regardless of immediate circumstances.

Furthermore, trauma treatment cannot change the fact that the trauma occurred. Something awful happened, and nothing can turn back the clock and make it as if it never happened. It did. Coming to terms with the reality of the trauma is a major element of processing a traumatic history, but nothing can alter the fact of its existence in a person's life history. Therapeutic treatment can address the existential ruptures—such as betrayal; breaches of trust; usurpation of naïve beliefs about safety, belonging, and the reliability of others; the despair of helplessness and horror; loss of agency; and the realization that truly awful things happen in the best of all possible worlds—but treatment cannot undo the fact that these ruptures occurred. They, too, like the trauma itself, actually happened and have an inevitable effect on an individual's worldview and approach to life. Clients and therapists alike confront the limitations of the human condition, and the ability to change or adapt to the world. Some limitations are painful and impervious to change. It is then up to the individual to adjust and accommodate because no other options exist. Sometimes trauma therapy means coming face to face with unbearable pain and somehow learning to live with it. Sometimes bearing witness in silence is the only appropriate response.

Finally, there are individual limitations that must be faced as well. Sometimes a therapist is confronted with a client's history and clinical presentation that is essentially and personally overwhelming. Even seasoned therapists need the self-awareness to know when to ask for supervision, consultation, and even referral to a more experienced clinician. More frequently, clients are not ready to make the changes required by therapy. They may not be ready to step into the unknown. They may not feel safe enough, or they may not have enough self-confidence, or they may feel like they do not have enough therapeutic resources at their immediate disposal to work through the more challenging and painful aspects of trauma work. Sometimes they simply are not ready, and there is no reprehensibility in this. A wise therapist knows when to recognize that a client needs more time before moving forward and can propose either a break or an end to therapy, at least for the time. In the end, an experienced clinician knows when it is time to let go and release the client to live their life without further therapy. It is commendable to know "when the work is enough, and it is time to move on."

CURRENT MODELS OF TREATMENT

While the American Counseling Association does not yet offer practice guidelines on trauma, the Clinical Practice Guideline from the American Psychological Association (2017) strongly recommends cognitive behavioral therapy (CBT), including trauma-focused cognitive behavioral therapy (TF-CBT), cognitive processing therapy (CPT), and prolonged exposure therapy (PE). It suggests the use of brief eclectic psychotherapy (BEP), Eye Movement Desensitization and Reprocessing (EMDR), and narrative exposure therapy (NET). The guidelines suggest that pharmacology, including fluoxetine, paroxetine, sertraline, and venlafaxine, is helpful but notes "there is insufficient evidence from the systematic review on direct comparisons between psychotherapy and medications for PTSD" (American Psychological Association, 2017, p. ES-7). The guideline is based on empirical studies, especially double-blind, placebo-control studies in the research literature (Guideline Development Panel for the Treatment of PTSD in Adults, American Psychological Association,

Development Panel for the Treatment of PTSD in Adults, American Psychological Association, 2019).

Practice guides are limited by their inclusion criteria, which exclude approaches that do not lend themselves to double-blind, placebo-controlled studies. Therapeutic approaches to traumatic stress do not always lend themselves to quantitative reductions, and therefore, by definition, cannot be included in research that depends on a reductionistic, quantitative approach. Like many things in life, trauma and its recovery are ideographic, nonbinary, holistic, and qualitative, defying categories, taxonomies, and quantitative principles of accounting. Nevertheless, the most promising and effective approaches to therapy for trauma in adults include elements of many sensory modalities, and select interventions based on the neurocognitive needs of the client. In other words, the best approaches provide for basic physiological and emotional regulation and grounding first, and then move through therapy that focuses on emotions and emotion tolerance, followed by cognitive approaches, and finishes with meaning-making and other existential considerations.

Therapeutic models proliferate today, but the most prominent include the NMT (Perry, 2006), sensorimotor psychotherapy (Ogden & Minton, 2000), emotion-focused coping (Folkman & Lazarus, 1985; Guerreiro et al., 2013), EMDR (Shapiro, 1993), TF-CBT (Cohen et al., 2000), Brainspotting (Corrigan & Grand, 2013), and somatic experiencing and integration (Levine, 1997, 2010). While emotion-focused coping is viewed as a promising outpatient treatment for trauma, it should be used with caution, as a recent study found that it predicted inpatient self-harm in response to psychiatric hospitalization (Frei et al., 2020). The most experienced therapists use a multimodal approach, tailoring planning to the needs of the individual, and, like sensorimotor psychotherapy (Ogden & Fisher, 2015), include elements that access multiple senses (e.g., sight, hearing, smell, taste, touch, body posture, and bodily awareness). They also integrate music (Bensimon, 2021), movement, nature, animal therapy, creativity, spirituality, symbolism and symbolic objects, therapeutic ritual, and meaning-making in treatment planning.

COUNSELING IMPLICATIONS

Counseling implications for treating adults with complex trauma or a complexity of traumas include the need for creativity, patience, and analytic synthesis by the clinician. *Analytic synthesis* refers to the ability to analyze the needs of the client, and synthesize what the clinician knows about trauma, the neurobiology of trauma, and available best practices in trauma treatment to create tailored and bespoke treatment plans for the benefit of *this* particular client at *this* particular point in the client's journey of healing.

The information in this chapter implies that mental health clinicians continually renew familiarity with emerging best practices in the field and understand that an integrative approach is most effective. Mental health professionals recognize their own cultural limitations and approach therapy with cultural humility and an appreciation of both Western and Eastern approaches to mental pain and suffering. An understanding of the neural substrates of trauma is essential so that the clinician accurately can match a planned intervention with the demonstrated needs of the client (e.g., basic neurophysiological regulation, emotional grounding, cognitive processing, and existential meaning-making). Adults with complex trauma histories, or who have endured a complexity of trauma, represent both the most challenging and the most rewarding work in the mental health field. When trust and a therapeutic bond can be established, and when the client has developed the courage to step into change, the shared labor of healing is manifestly rewarding and meaningful for both the client and the clinician.

CONCLUSION

This chapter addressed the therapeutic encounter with adult survivors of developmental (complex) trauma and those who present with a *complexity of traumas*. The challenges of working with adults with significant trauma histories include seemingly internally inconsistent characteristics such as too little or too much trust, difficulties in forming

inconsistent characteristics such as too little or too much trust, difficulties in forming attachments, acting out or self-defeating behaviors, emotional flatness or lability, disengagement, manipulation, shame, and shamelessness. These characteristics indicate that the person is living with a history of significant trauma.

This chapter addressed the clinical *footnotes* of working with adults who have survived traumatic experiences, to inform a clinician's tailoring and choice of interventions. The neural substrates of trauma explain how trauma *inhabits* a body, emotions, and thought patterns, and how survivors learn to survive in ways that were uniquely ingenious at the time the trauma(s) occurred but ultimately create more problems than they solve. A comparison of *Western* and *Eastern* approaches to emotional pain facilitates making sense of a traumatic history and provides a foundation for posttraumatic growth and development. This chapter emphasized the importance of following a phasic approach to treatment and explained the importance of its sequence. While planning what treatment can accomplish for adults living with significant trauma histories, it is also incumbent on the therapist to recognize the limits of therapy, and explain these, when appropriate, to clients. The chapter described current best practices and addressed the implications for counselors providing counseling to adults with significant trauma.

Wise therapists carry a wealth of knowledge about trauma and renew their familiarity with best practices on a regular basis. Essentially, the best therapy occurs in a solid and trustworthy therapeutic encounter, when interventions are intentionally tailored to the specific needs of the client and involve as many sensory modalities and positive, creative experiences as possible. The therapist is wise to express unshakeable faith in the process and growth of the client, and to provide structure in an otherwise chaotic sense of personal history. Therapy with adults who have a complexity of traumas is both uniquely complex and challenging, and deeply rewarding work for both the therapist and client. By working through the disruption of life caused by a complicated history of trauma, clients' futures change permanently for the better, for them, and for all the lives they subsequently touch. It is an honor to work with these brave clients, and to be entrusted with their courage.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

A Mistake Practitioners Might Make When a Patient Is Stuck in an Attachment Based Trauma Response (2020; 2:21) www.youtube.com/watch?v=pPg69Tb1M68

A Simple Strategy for Dissociative Clients Who Lose Time With Ruth Lanius, MD, PhD (2020; 1:25) www.youtube.com/watch?v=kM8mkB082c0

Brain Facts—3D Brain Model www.brainfacts.org/3d-brain#intro=true

Complex PTSD From Surviving to Thriving (2016; 1:17:37) www.youtube.com/watch?v=6sbYIKC7-Tw

Complex Trauma—Part 1 (2017; 45:38) www.youtube.com/watch?v=6IxewPMqB-c

Fight, Flight, Freeze—A Visual Guide to Anxiety (2019; 2:12) www.youtube.com/watch?v=FfSbWc3O_5M

Harvard Center on the Developing Child: Science of Resilience <https://developingchild.harvard.edu/resourcetag/resilience>

How Childhood Trauma Can Make You A Sick Adult (2015; 7:15) <https://bigthink.com/videos/vincent-felitti-on-childhood-trauma>

Integrative Treatment for Trauma and Complex PTSD (2020; SAMHSA Webinar; 1:25:34)

Integrative Treatment for Trauma and Complex PTSD (2020; SAMHSA Webinar; 1:23:34) www.youtube.com/watch?v=Ce6wzxBFuzk

Managing Complex Post-Traumatic Stress Disorder (2016; 16:32) www.youtube.com/watch?v=YGVR8ZIRtA

Robert Woods Johnson Foundation: The Truth About ACES - Infographic www.rwjf.org/en/library/infographics/the-truth-about-aces.html

The Differences in Dissociation Triggered by Shame and Terror—and How to Work With Each (2020; 3:31) www.youtube.com/watch?v=QHA8j5PK6Mg

Understanding Trauma: Learning Brain vs. Survival Brain (2017; 4:57) www.youtube.com/watch?v=KoqaUANGvpa

What Is C-PTSD? (Complex Post Traumatic Stress Disorder) (2018; 8:23) www.youtube.com/watch?v=NeQ8bgUANFg

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PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

- A Mistake Practitioners Might Make When a Patient Is Stuck in an Attachment Based Trauma Response* (2020; 2:21) www.youtube.com/watch?v=pPg69Tb1M68
- A Simple Strategy for Dissociative Clients Who Lose Time With Ruth Lanius, MD, PhD* (2020; 1:25) www.youtube.com/watch?v=kM8mkB082c0
- Brain Facts—3D Brain Model www.brainfacts.org/3d-brain#intro=true
- Complex PTSD—From Surviving to Thriving* (2016; 1:17:37) www.youtube.com/watch?v=6sbYIKC7-Tw
- Complex Trauma—Part 1* (2017; 45:38) www.youtube.com/watch?v=6IxewPMqB-c
- Fight, Flight, Freeze—A Visual Guide to Anxiety* (2019; 2:12) www.youtube.com/watch?v=FfSbWc3O_5M
- Harvard Center on the Developing Child: Science of Resilience <https://developingchild.harvard.edu/resourcetag/resilience>
- How Childhood Trauma Can Make You A Sick Adult* (2015; 7:15) <https://bigthink.com/videos/vincent-felitti-on-childhood-trauma>
- Integrative Treatment for Trauma and Complex PTSD* (2020; SAMHSA Webinar; 1:25:34) www.youtube.com/watch?v=Ce6wzxBFuzk
- Managing Complex Post-Traumatic Stress Disorder* (2016; 16:32) www.youtube.com/watch?v=YGVrA8ZIRtA
- Robert Wood Johnson Foundation: The Truth About ACEs - Infographic www.rwjf.org/en/library/infographics/the-truth-about-aces.html
- The Differences in Dissociation Triggered by Shame and Terror—and How to Work With Each* (2020; 3:31) www.youtube.com/watch?v=QHA8j5PK6Mg
- Understanding Trauma: Learning Brain vs. Survival Brain* (2017; 4:57) www.youtube.com/watch?v=KoqaUANGvpa
- What Is C-PTSD? (Complex Post Traumatic Stress Disorder)* (2018; 8:23) www.youtube.com/watch?v=NeQ8bgUANFg

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CHAPTER 10

Intimate Partner Violence

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CHAPTER OVERVIEW

This chapter focuses on issues associated with intimate partner violence (IPV). It examines the impact on survivors of IPV as well as on families, communities, and societies. The chapter presents theories for contextualizing and understanding IPV as well as offering strategies for counseling survivors of IPV.

LEARNING OBJECTIVES

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

1. Define important terms that are associated with IPV;
2. Develop an awareness of the prevailing theories related to IPV;
3. Identify trauma issues concerning the experience of IPV;
4. Recognize the prevalence of IPV across all sectors of society;
5. Develop insight regarding the implications of IPV for survivors; and,
6. Summarize effective counseling approaches for working with IPV.

INTRODUCTION

In order to understand some of the powerful dynamics associated with the lived experiences of intimate partner violence (IPV), we begin by offering an illustrative case. By way of introducing the topic, we present the real-life case of Kristin in [Box 10.1](#).

BOX 10.1

From the Field: The Strange Case of Kristin

In August of 1973, a Swedish bank teller in Stockholm was taken hostage and held in a bank vault for several days by two armed assailants, one named Olsson and the other named Olofsson. By the end of her captivity, the young bank teller, Kristin, had become enamored with Olsson, to the point where she broke off her engagement to her fiancé and spoke vigorously in defense of her captor to the Swedish prime minister.

Shortly after the incident in Sweden, one of the authors of this chapter (F. M. O.), who was the psychiatrist on the National Task Force on Terrorism and Disorder, became intrigued by the case, which was one of a rash of hostage events that occurred in the 1970s. Law enforcement officials and behavioral scientists were just beginning to

collaborate intensely on cases like Kristin's, which involved an unexpected bond forming between captive and captor. Kidnap and hostage experts already had been aware of such cases, and psychoanalyst Anna Freud had described similar situations in Nazi concentration camps as "identification with the aggressor."

Interviews in the Stockholm case and many others afterward, however, did not support the idea that captives were identifying with an aggressor; rather, the hostages described being stunned, shocked, and certain they would die. A human being in such a situation then becomes like an infant—dependent on captors for food, water, and other basic necessities.

In each one of these cases, small acts of kindness by the captors gradually began to evoke feelings much deeper than relief. As one Dutch ex-hostage stated about the men who chose not to kill him, "We knew they were killers, but they gave us blankets, cigarettes." What the hostages seemed to experience was more like an infant's primitive feelings of security, calm, and, in a way, gratitude when basic needs are met. These are the feelings that eventually develop and differentiate into varieties of affection and love (Ochberg, 1988). The attachment goes both ways, with the captor often developing reciprocal feelings toward the hostage. When this occurs, both captive and captor usually have developed a distrust of outsiders, including the rescuers, who then become the common enemy.

The dynamics of hostage situations that involve the formation of a bond between captor and captive were identified as a pattern (Ochberg, 1975, personal communication) that later came to be known as the Stockholm syndrome. Although the syndrome was identified for the purpose of assisting negotiators in developing effective strategies for facilitating hostage release in rare situations like Kristin's, it also is especially useful for helping clinicians to understand the bonds of attachment that often exist in abusive intimate partner relationships (Martinez, 2001; Ochberg, 1998). As Graham et al. (1994) summarized, the four conditions of the syndrome are (a) the victim's perception of threat to survival; (b) the victim's perception of some kindness, no matter how small, from the abuser; (c) the victim's isolation from others who might offer an alternative perspective to the abuser's; and, (d) the victim's perception that there is no escape.

In addition to applying the lessons learned from hostage situations to the trauma of IPV, this chapter examines various effects, social costs, contextual theories, and implications for counseling regarding survivors of IPV. This is achieved in the following sections: defining relevant terms, offering background statistics, discussing the trauma associated with IPV, outlining the theoretical contexts for understanding IPV, identifying the counseling implications, and summarizing the salient points. This chapter concludes with a listing of helpful resources for instructors, clinicians, students, and clients.

DEFINITIONS

IPV, as a topic, has been studied in multiple academic disciplines and has been described using a variety of terms. To enhance the reader's understanding of IPV in this chapter, some of the terms and constructs are defined in the following subsections: Victims and Abusers, Intimate Partners, and Intimate Partner Violence.

Victims and Abusers

Violence is an unfortunate fact of our human existence. The cruelty of war, sexual assault, revenge and honor-motivated killings, bullying, and hate crimes assault our senses on a daily basis. Efforts to identify root causes have produced volumes of theoretical and research data that have added to the public understanding of the social, biological, and emotional origins of violence; unfortunately, these efforts have not reduced the prevalence of victimization. IPV, a relatively new term, is an area that has been the subject of copious research under a variety of labels, including *domestic abuse*, *wife beating*, and *domestic violence*.

While IPV research includes studies of female violence against male partners (e.g., Straus et al., 1980) as well as same-sex and transgender IPV (e.g., Rollé et al., 2018; Yerke & DeFeo,

2016), most partner-abuse victims have been, and continue to be, overwhelmingly female. The historic roots of spousal abuse run deep and reflect the male dominance that is prevalent in many societies. Women have been bought, sold, and traded as chattel for centuries; they have been denied education and land ownership, and they are not yet considered fully independent human beings in many cultures. Politically, even in the industrialized West, women's rights have been granted nominally but continue to be undermined or ignored by certain male groups, and often in their own homes by their partners (Ochberg, 1978/2008, 1988, 1998). Estimates from the National Crime Victimization Survey (NCVS) have indicated that, in 1998, about one million violent crimes qualifying as IPV were committed against individuals. Of that one million, 876,340 or about 85% were against women. More recent statistics from the NCVS have indicated that "For the 10-year aggregate period 2003 to 2012, domestic violence accounted for 21% of all violent victimizations" (Truman & Morgan, 2014, p. 1). Tjaden and Thoennes (2000) have studied the prevalence and consequences of male-to-female and female-to-male IPV, finding that women experienced higher rates of violence by marital/opposite sex partners than did men. Women have reported more frequent, longer lasting violence, as well as more threats and fear of bodily harm. Women victims of IPV have been significantly more likely than men to report that they had been injured, have received medical care and mental health counseling, have lost time from work, and have sought legal intervention.

Studies have expanded the definition of interpersonal violence beyond that of physical assaults to include psychological violence, defined as "put-downs, name calling, and controlling behavior" (Thompson et al., 2006, p. 4). These expansive definitions, over time, have raised awareness resulting in recognition that IPV is not just a justice system issue, but also a serious public health issue (Karakurt et al., 2016). This recognition has provided the opportunity for obtaining increased surveillance and prevalence data and encourages a broad-brushstroke, multisystemic approach to understanding and addressing interpersonal violence in society. Based on the criminal justice statistics that continue to indicate that women are victimized more often by intimate partners, references to abusers in this chapter use the pronoun "he," whereas victims are referred to as "she." However, the authors fully acknowledge the presence of victims and perpetrators of all genders, including within the context of same-sex couples, a subject that is explored in detail in later sections of this chapter.

Intimate Partners

The federal definition of intimate partners has changed over the last couple of decades. Previously, intimate partners were defined by the U.S. Department of Justice (Rennison & Welchans, 2000, p. 1) as "current or former spouses, boyfriends, or girlfriends," and the term assumed that the partnerships may be either heterosexual or homosexual. However, the current federal definition of intimate partners has been broadened, legislatively, and an IPV victim now is viewed as:

a spouse or former spouse, a person who shares a child in common with the abuser, a person who cohabits or has cohabited as a spouse with the abuser, or a person who is or has been in a social relationship of a romantic or intimate nature with the abuser, as determined by the length of the relationship, the type of relationship, and the frequency of interaction between the persons involved in the relationship, and any other person similarly situated to a spouse who is protected by the domestic or family violence laws of the state or tribal jurisdiction in which the injury occurred or where the victim resides. (U.S. Code of Federal Regulations, Section 2266(7), n.d.)

This definition is mirrored in other federal laws related to IPV including Title 25 of the Code of Federal Regulations Section 11.454 as well as in the reauthorized *Violence Against Women's Act of 2013* (Public Law 113-4). While named the *Violence Against Women's Act* (VAWA), it is gender-neutral in providing these protections, based upon the acts and the relationships of the parties, not the sex or sexual orientation of the victim or perpetrator.

Intimate Partner Violence

In 1994, Congress passed the VAWA as part of the Violent Crime Control and Law Enforcement Act of 1994. The Act was brought forth in recognition of the severity of the crimes associated with domestic violence, sexual assault, and stalking and marked the first comprehensive federal legislative package designed to end violence against women. This was done in recognition that the states were failing in their duty to offer this protection. The protections provided through this Act subsequently were expanded and improved in the *Violence Against Women Act of 2000* (H.R.1248—106th Congress, VAWA, 2000), the *Violence Against Women and Department of Justice Reauthorization Act of 2005* (USDOJ, 2005), the *Violence Against Women Reauthorization Act of 2013* (S.47—[113th], VAWA, 2013), and the *Violence Against Women Reauthorization Act of 2021* (H.R.1620—117th Congress, VAWA, 2021). This legislation also has provided for federal grants to assist in developing protections and services that uphold the civil rights of women experiencing gender-based crimes and for the collection of extensive data concerning these crimes (Women's Legal Defense and Education Fund, n.d.).

The passage of VAWA took interpersonal violence out from the shadows, bringing it into the light of day. While originally focused on the narrower definition of spouse abuse and domestic violence, with each iteration of VAWA came greater exposition of the comprehensive nature of these crimes and of the other social justice issues that required attention, within the context of civil rights, implicit bias, and systemic racism. VAWA is a federal act, which, in many ways, has an impact on a minority of U.S. citizens for whom federal law has jurisdictional preference. State, local, and tribal laws rely on different definitions of interpersonal violence passed by their respective legislative body; local practices in enforcement differ as much as the locations in which they exist. However, VAWA, with its "guidance" of how to define and address gender-based, relational violence, is coupled with its substantial funding streams to those in compliance with its recommendations, as well as with requirements such as providing for Full Faith and credit to domestic violence protection (18 USC 2265) across state lines. This funding "carrot" has made a major impact in changing laws, practices, hearts, and minds.

BACKGROUND STATISTICS

The numbers of individuals affected by IPV, including victims, family members, and society as a whole, are staggering. IPV may result in any number of criminal charges ranging from trespass, to disturbing the peace, to sexual assault, to homicide—and every type of crime in between. Criminal justice statistics are perhaps the least reliable, however, in judging the scale and scope of IPV. How crimes are reported by law enforcement and subsequently charged by prosecutors is a very subjective process, one that is rife with the potential for bias, problems surrounding the differences in definitions, and idiosyncrasies. This partly is due to the new electronic data gathering systems such as the Uniform Crime Reporting program, which only allows for a limited number of crimes to be reported upon an arrest. VAWA grantees, required to fill out copious statistical reports in return for the receipt of grant funds, find it difficult to report accurate data, as they are required to report local data into a "one size fits all" type of reporting form. Additionally, for the various reasons to be discussed later in this chapter, victims also underreport IPV. Therefore, statistics purporting to capture this information should be viewed as indicative but not entirely correct in providing the breadth and depth of the issue. The following statistics, therefore, are only suggestive of the scope of IPV, both in the United States and abroad.

The Centers for Disease Control and Prevention's (CDC) National Intimate Partner and Sexual Violence Survey (NISVS; CDC, 2015) indicates that about one in four women and nearly one in ten men have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and have reported some form of IPV-related impact. Over 43 million women and 38 million men have experienced psychological aggression by an intimate partner in their lifetime. When IPV occurs in adolescence, it is called teen dating violence (TDV), and it affects millions of U.S. teens each year. About 11

called teen dating violence (TDV), and it affects millions of U.S. teens each year. About 11 million women and five million men who reported experiencing contact sexual violence, physical violence, or stalking by an intimate partner in their lifetime said that they first experienced these forms of violence before age 18 (CDC, 2015).

IPV is a significant public health issue, with both individual and societal costs (Breiding et al., 2014; Karakurt et al., 2016). About 35% of female IPV survivors and more than 11% of male IPV survivors have experienced some form of physical injury related to IPV. IPV is a pattern; many victims experience repeat acts of violence not captured in the number of 10 million adults abused annually (National Congress of American Indians [NCAI], 2013). Data from U.S. crime reports have indicated that one in five homicide victims are killed by an intimate partner. From 2016 to 2018, the number of IPV victimizations in the United States increased 42%, and in 2018, partner violence accounted for 20% of all reported violent crime (Morgan & Oudekerk, 2019). Of U.S. women homicide victims, over 50% were killed by a current or former male intimate partner (Niolon et al., 2017). An abuser's access to a firearm increases the risk of femicide by at least 400% (J. D. Campbell et al., 2003). The Federal Bureau of Investigation reports that 6,410 women were murdered by an intimate partner using a gun between 2001 and 2012 (cited in Gerney & Parsons, 2014).

Reports of increasing international rates of IPV during the COVID-19 pandemic have been alarming (Boserup et al., 2020; Rodriguez, 2021; Roesch et al., 2020). The home page of the National Coalition Against Domestic Violence (NCADV, 2021) has a rolling count calendar of data collected from its coalition members across the United States. On December 27, 2020, they reported the following: there were 621 gun-related domestic violence deaths in 2020; 10 million people a year were physically abused by an intimate partner; 20,000 calls a day were placed to domestic violence hotlines; and, 20% of women in the United States reported being raped. (NCADV, 2021). These advocacy-based data sources contain grassroots data that often are missing from more institutional statistical sources.

Racial and Sexual Minorities

As profound as the previously noted statistics may be, research statistics regarding IPV among racial groups and sexual minorities in the United States are even more compelling (Petrosky et al., 2017). Black et al. (2011) provided the following 2010 rates of reported contact sexual violence, physical violence, and/or stalking for women in their lifetimes by race/ethnicity:

- 53.8% multiracial non-Hispanic women—38.95% multiracial non-Hispanic men;
- 46.0% American Indian/Alaskan Native women—45.3% of American Indian/Alaskan Native men;
- 45.1% of non-Hispanic Black women—40.1% of non-Hispanic Black men;
- 34.6% non-Hispanic White women—27.4% of non-Hispanic White men;
- 34.4% of Hispanic women—30% of Hispanic men; and,
- 19.6% of Asian or Pacific Islander women—13.7% of Asian or Pacific Islander men.

As startling as these 2010 data are, they still appear to be the tip of the iceberg on this issue among the “statistically insignificant” populations reported out as “other” or not reported out at all. Rosay (2016) delineated the findings of a National Institute of Justice study on violence against American Indian/Alaskan Native women and men; the results showed that 83.3% of American Indian/Alaskan women and 81.6% of American Indian/Alaska Native men have experienced violence in their lifetime. Among the women, 56.1% experienced sexual violence, 55.5% experienced physical violence by an intimate partner, and 46.8% experienced stalking. Among the men, 27.5% experienced sexual violence, 43.2% experienced physical violence by an intimate partner, and 18.6% experienced stalking (Rosay, 2016). According to the Bureau of Justice Statistics (n.d.) and the U.S. Department of Justice (2005), the violent victimizations experienced by American Indians are committed by persons not of the same race and at a substantially higher rate of interracial violence than experienced by White or Black victims. The Asian Pacific Institute on Gender-Based Violence (2020) has been collecting statistics on physical abuse and sexual assault since 2001. In its

(2020) has been collecting statistics on physical abuse and sexual assault since 2001. In its *Facts & Stats Report*, Yoshihama et al. (2020) reported that, based upon studies that used some type of probability samples, 16% to 55% of Asian women report experiencing intimate physical and/or sexual violence during their lifetime.

The CDC (2015) reported that 43.8% of lesbians and 61.1% of bisexual women experienced IPV or sexual assault, physical violence, or stalking, while 26% of gay men and 37.3% of bisexual men reported such violence. The 2015 U.S. Transgender Survey (James et al., 2016) found that 54% of transgender and nonbinary respondents experienced IPV in their lifetimes. Balsam et al. (2005) compared lesbian, gay, and bisexual (LGB) adults to their heterosexual siblings' experiences, with multiple types of violence across the life-span, and found that sexual orientation was a significant predictor of most of the victimization variables, including partner psychological abuse and physical victimization in adulthood.

Adolescent IPV is being measured through use of the CDC's (2019) *Youth Risk Behavior Surveillance System* (YRBSS). This survey monitors six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults. YBRSS is a school-based survey conducted in a majority of states/jurisdictions by the CDC through local education and health agencies. In 2019, 12.2% of youth reported that they experienced physical dating violence, and 3.0% that they experienced sexual dating violence. However, when reviewing the microdata, 22.3% of LGB and 18.7% "not sure" gender respondents reported physical dating violence, and 5.8% of LGB and 9.4% of "not sure" gender respondents reported experiencing sexual dating violence. The sexual identity categories of choice were heterosexual, lesbian, gay or bisexual, and not sure (CDC, 2019). LGBTQ+ youth of color are also at greater risk for physical and sexual dating violence, when compared to non-LGBTQ+ White youth. In a *Women of Color Network factsheet* (2018a), citing the work of Breiding et al. (2014), these issues were illuminated in the following way: "Domestic Violence (DV) occurs among all race/ethnicities and socio-economic classes. DV is a pattern of many behaviors directed at achieving and maintaining power and control over an intimate partner, such as physical violence, psychological aggression, stalking, and coercion" (p. 1). For victims of color, as well as for other marginalized populations, distrust of law enforcement (fear of subjecting themselves and loved ones to a criminal and civil justice system they see as sexist, and/or racially and culturally biased) and obtaining safety (physical, economic, emotional, and legal) become even more challenging (Breiding et al., 2014; Yoshihama et al., 2020).

Intimate Partner Violence and Women With Disabilities

Women with developmental disabilities have among the highest rates of physical, sexual, and emotional violence perpetrated by intimate partners and family members. Women with disabilities have a 40% greater risk of violence than women without disabilities and are at particular risk for severe violence. Studies estimate that 80% of women with disabilities have been sexually assaulted, and that they are three times more likely to have been assaulted than women without disabilities. A nationally representative sample has shown that both men and women living with disabilities in the United States "were at increased risk for recent sexual violence, compared to those without a disability" (Basile et al., 2016, p. 928). Additionally, victims with disabilities have increased challenges in acquiring access to services including limited resources, lack of transportation (especially in rural communities), and lack of knowledge or ability to obtain resources. Victims with disabilities are more vulnerable to threats by their abusers, if they report the abuse (Brownridge, 2006).

Findings From a Multicountry Study

As a part of the World Health Organization's (WHO) project on women and domestic violence, Garcia-Moreno et al. (2006) interviewed 24,097 women about IPV at 15 sites in 11 countries, including Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia, Montenegro, Thailand, and the United Republic of Tanzania. The findings indicated a lifetime prevalence of physical and/or sexual partner violence from between 15% and 71%, with two sites having a prevalence of less than 25%, seven between 25% and 50%, and six between 50% and 75%. In all but one of the sites, women were at much greater risk of violence by a partner than from

all but one of the sites, women were at much greater risk of violence by a partner than from violence by other people. The findings confirmed that physical and sexual violence against women is a worldwide problem, with the variations in prevalence indicating that risk factors vary by culture and that these factors can be addressed.

THE TRAUMA OF INTIMATE PARTNER VIOLENCE

A poster produced by the San Francisco District Attorney's Family Violence Project and appearing in the medical journal *The Lancet* (J. C. Campbell, 2002) displays an x-ray of a fractured skull, along with the statement "A bad relationship can hurt more than your feelings." The message is shockingly direct in its ability to draw our attention to the often-tragic results of IPV. The broken bones leave no room for ambiguity in the mind of the reader as to the real and permanent damage that can be caused by IPV. Not visible in the poster, and less easily conveyed to an observer, are other serious long-term consequences of IPV. These include physical health effects not visible on x-rays, mental health problems such as chronic posttraumatic stress disorder (PTSD), and the subsequent social issues that inevitably occur in cultures where violence and trauma are common events.

The Traumatic Consequences of Intimate Partner Violence on Individuals

The traumatic consequences of IPV are numerous and far reaching. Some of the physical and psychological effects are detailed in the following subsections of this chapter.

Physical Effects

IPV has been recognized as a significant public health issue that has many individual and societal costs (M. A. Dutton et al., 2015). The physical effects of IPV often are first discovered in medical settings, such as emergency departments, physicians' offices, or clinics. This may occur when victims are seeking care for conditions related to injuries or as part of a routine checkup. According to J. C. Campbell (2002), battered women are more likely to have been injured in the head, face, neck, thorax, and abdomen than women hurt in nonbattering incidents. The short-term physical effects of violence can encompass minor injuries or serious conditions. They can include bruises, cuts, broken bones, or injuries to organs and other parts of the body and can be difficult or impossible to see without scans, x-rays, or other medical tests (U.S. Department of Health and Human Services [USDHHS], 2019). J. C. Campbell and Messing (2017) also describes the long-term consequences of battering, such as fear and stress that can result in chronic conditions like headaches, neck pain, and back problems. However, these conditions also can be related to traumatic brain injuries (TBIs; including concussion) and to damage caused by strangulation, two conditions that historically have not been given the attention they need, considering their seriousness as well as their frequency in IPV. This lack of attention is due to unawareness by victims of the seriousness of these injuries, unfamiliarity by physicians and mental health professionals about these conditions as IPV related, and by systemic bias that often dismisses complaints by women as emotional instead of physical conditions. Recent studies show that 34% of abused pregnant women report being "choked," while 47% of women victims of IPV report being "choked." When IPV women were asked, in both a shelter and hospital study, what made them believe they were in danger or not, the majority of women perceiving a great amount of danger mentioned "choking" as a tactic used against them that made them believe their partner might kill them (J. C. Campbell & Messing, 2017; Stuart & Campbell, 1989). In fact, we now know that victims of prior non-fatal strangulations are 800% more likely, later, to become a homicide victim at the hands of the same batterer.

It is important to note that strangulation actually is not choking, the word most commonly used to describe the act by a victim, or suffocation in the true sense of the word. Strangulation is the external compression of the neck that either directly can block the airway, thus preventing breathing, or can impede the flow of blood to and from the brain by closing off arteries and jugular veins. When a victim is strangled, research findings indicate that loss of consciousness can occur within 5 to 10 seconds and brain death within 4 to 5

minutes. The seriousness of internal injuries may take a few hours to be discerned, and death can occur even days later. The absence of visible injury can result in the minimization of the assault, even by the victim, who actually may not remember much of the event, due to the nature of the assault (McClane et al., 2001). Signs and symptoms of strangulation include voice changes in 50% of victims, swallowing and breathing changes, mental status changes, involuntary urination or defecation, visible injuries to neck, petechiae (tiny purple, red, or brown spots on the skin), ligature marks, lung changes, or brain damage. The largest nonfatal strangulation case study conducted to date (the San Diego Study) found that most cases lacked physical evidence or visible injury of strangulation; while major signs and symptoms of strangulation corroborated the assaults, little visible injury was detected, and no symptoms were documented or reported in 67% of cases (McClane et al., 2001).

The scope of the problem of TBI in the context of IPV is enormous. Upwards of 90% of all individuals with a history of interpersonal violence have concomitant signs and symptoms of TBI (Lifshitz et al., 2019). In addition to strangulation-related brain injuries, a serious risk of physical abuse is concussion and other TBIs from being hit on the head or falling and hitting the head. TBI can cause any of the following: headache or a feeling of pressure, loss of consciousness, confusion, dizziness, nausea and vomiting, slurred speech, memory loss, trouble concentrating, and sleep loss. Some symptoms of TBI may take a few days to show up, while others may last a year or longer, depending upon the severity or cause; some injuries may be permanent, especially when there are multiple battering events over time. TBI can cause depression and anxiety and interfere with the ability to plan and carry out tasks. This, in turn, can make it more difficult for women who are in an abusive relationship to leave (USDHHS, 2019). The connections among these common conditions and their antecedent causes often are unclear to healthcare clinicians, as well as to victims themselves, resulting in neglect for those clients who repeatedly seek medical care for vague and persistent symptoms while the traumatic origins of the problem remain unaddressed. Overlooked, strangulation and TBI effects can be mistaken as emotional or psychological issues related to the assaults, and the survivors may be referred to mental health professionals for treatment, while the physical needs of the victims go unmet.

Large-scale research conducted by Felitti et al. (1998) establishes the connection between adverse childhood experiences (ACE study) and problems in adulthood, ranging from chronic physical health issues to long-term psychiatric disorders. It also is well established that children exposed to domestic violence are at increased risk for physical abuse and other forms of child maltreatment (Appel & Holden, 1998; Edleson, 1999; Jouriles et al., 2008; Osofsky, 2003). It is perhaps less understood, however, that children who experience a head injury before young adulthood report greater interpersonal violence in young adulthood than participants who had never had a head injury, thus supporting findings that link a history of head injury to later interpersonal violence (Stoddard & Zimmerman, 2011). This information stresses the importance of a holistic approach to assessing for unseen injuries that affect the physical and psychological well-being of victims of IPV.

The CDC (2020) reports that negative health outcomes associated with IPV include a range of conditions, many of which are chronic, affecting the circulatory, digestive, reproductive, musculoskeletal, and nervous systems. J. C. Campbell (2002) notes that gynecological problems related to forced sex by intimate partners are "the most consistent, longest lasting, and largest physical health difference between battered and non-battered women" (p. 1332). Women's vulnerabilities that result from domestic violence create risk for contracting HIV, additional violence, and not obtaining and adhering to treatment (Bent-Goodley, 2017). Women in abusive relationships may be forced to engage in sexual acts both with a partner and with others (Lichtenstein, 2006). J. C. Campbell's findings among heterosexual women are extended by Heintz and Melendez (2006), who report an increased risk of HIV/STDs among lesbian, gay, bisexual, and transgendered (LGBT) individuals as a result of forced sex by intimate partners. Members of sexual minorities also report a higher incidence of battering as a direct consequence of asking their partners to practice safe sex.

The identification and treatment of IPV-related injury and illness often is hindered by the reluctance of victims to report their partners' violence to medical personnel. They fear that reliance on legal intervention may follow, further jeopardizing their physical safety and

police and legal intervention may follow, further jeopardizing their physical safety and financial security, as their family or community support system may take the side of the abuser. They also fear not being believed, especially when they may have difficulty explaining the attack, due to distortion of memory related to the trauma or to related physical injuries. Lack of a prompt and appropriate law enforcement response in many communities of color and in rural areas is another common reason for nonreporting. In addition, shame and social stigma, which may be attached to being battered by a partner or spouse, prevent many victims from seeking medical help for all but the most severe injuries, which then, often, are attributed to falls or other accidents.

Cultural and religious beliefs also factor into nonreporting of IPV, especially in minority and marginalized populations. If the victim is a member of a minority population, personal experiences of racism and prejudices may contribute to a reluctance to seek help for physical problems associated with IPV. The [Women of Color Network Report \(2018b\)](#) provides an in-depth analysis of the factors that contribute to the underreporting of IPV among minority groups. Historically, the relationship between intimate partners has been considered private, particularly in cultures that tacitly or overtly condone men's domination of women. In many heterosexual marriages, women are subject to the control of their husbands, a situation that often is supported through selective interpretation of religious teachings. These beliefs may present barriers for those needing or seeking mental health treatment.

Many women who have experienced violence cope with this trauma by using drugs, drinking alcohol, smoking, or overeating. Research shows that about 90% of women with substance abuse problems have experienced physical or sexual violence ([USDHHS, 2019](#)). This leads to credibility issues with law enforcement officials, who may be biased against the victim due to intoxication, thus placing the victim at further risk if police do not remove the abuser or take the victim to safe shelter. People who perpetrate IPV intentionally may use mental health and substance use issues to undermine and control their partners, deliberately keeping them from achieving their treatment and recovery goals. For example, it is not uncommon for abusive partners to introduce a partner to opioids or other illicit substances. The abuser then may control the drug supply and threaten the victim with withdrawal, loss of custody of children, incarceration, or physical violence when the victim tries to reduce use, access treatment, call police, or resist demands to engage in illegal activities, including participating in human trafficking. These forms of abuse—referred to as mental health and substance use coercion—jeopardize the well-being of survivors

and their children. They can compromise the effectiveness of mental health and substance abuse treatment, underscoring the need for physicians and behavioral health agencies to implement policies and practices for addressing IPV (National Center on Domestic Violence, Trauma & Mental Health, 2019).

Psychological Effects

A meta-analysis (Golding, 1999) and a systematic review (Lagdon et al., 2014) of studies of the psychological effects of IPV have revealed that depression and PTSD, which have a high degree of comorbidity, are the most prevalent mental health problems associated with intimate partner trauma; the occurrence of PTSD in battered women is statistically much higher than in non-abused women. Diez et al. (2009) observed psychological health indicators such as antidepressant intake, sleep disorders, lack of concentration, loss of energy, and difficulties making decisions to be higher in abused women. Coker et al. (2002) confirmed that behaviors that may have an adverse effect on mental well-being, such as alcohol consumption and drug use, tend to be more prevalent in female victims of IPV. We know that the brain injuries and related chronic physical conditions also contribute to the prevalence of these mental health symptoms in this population.

PTSD has been defined as applying equally to military trauma, criminal violence, and natural disaster. Ochberg (1988), however, has proposed that victims of deliberate cruelty such as IPV are likely to suffer from symptoms that represent “victimization” rather than “traumatization”—a distinction that recognizes the *perpetrator’s behavior* rather than the victim’s reaction as the source of deleterious effects associated with IPV. Victims frequently suffer from a wide range of abuse, over a period of time, and have no way of knowing when or if they will be safe. Law enforcement personnel have been reluctant to intervene in domestic violence situations because attempts to separate the abuser from the victim may result in the formation of a united front against the police—a phenomenon that leads us back to the Stockholm syndrome principle of alliance between abuser and victim that was introduced at the beginning of this chapter. Misunderstanding of the complex dynamics involved in IPV relationships has led to general skepticism about the abused person’s status as a victim or as a sufferer of traumatic stress, although social science research has begun to change these misperceptions. These misperceptions may be further traumatizing to the survivors of IPV events.

The Consequences of Intimate Partner Violence on Society

The consequences of IPV on individual victims, as we have detailed earlier, can be measured in the lives of those who suffer its effects. In the previous section of this chapter, we examined some of the physical and psychological effects of IPV on individual victims. This section explores some of the consequences of IPV on society, including its likely contribution to the intergenerational transmission of violence, termed the *cycle of violence* by Widom (1989) in her critical examination of the literature linking IPV, child abuse, and other social stressors. In discussing the intergenerational nature of violence, it is important to recognize that most individuals who have been abused as children do not go on to become abusers as adults (Lisak et al., 1996; Rakovec-Felser, 2014). However, it is equally important to know that studies have clearly identified childhood abuse as a crucial risk factor for later violence (Lisak & Miller, 2003; Maxfield et al., 2000; Weeks & Widom, 1998; Widom, 2000). These seemingly contradictory statistics are more easily understood if we are able to picture victims of abuse as a relatively large group of individuals, while recognizing that victimizers represent only a small number of those who have been abused and may not belong to the victimized group at all, but generally victimize more than one person. Among victimizers, however, as stated earlier, studies have shown that a large percentage of this group *has* been victimized, thus implicating childhood victimization as a risk factor for becoming a violent adult. The following subsections describe the less quantifiable but pervasive social costs of IPV.

The Cycle of Violence in Relationships

People in abusive relationships often describe a pattern of behavior, which has been characterized as the cycle of violence; this pattern may serve as a mechanism for locking someone into an abusive relationship. The perpetrator uses abusive behavior to exert power and control over another person—or persons, in the case of a family setting. The abuser “needs” a victim to control, and without intervention, may become a serial abuser. The cycle of violence dynamics can be expressed as three phases: the tension-building phase, the acute or crisis phase of abuse, and the “honeymoon” phase, in which a sense of relief or calm is restored (Walker, 1980). During the tension phase, the abuser may become tense or irritable, prompting the victim to “walk on eggshells.” In the abuse phase, the perpetrator acts violently (physically, sexually, and/or emotionally) toward the victim. The relief or honeymoon phase is characterized by abuser behaviors that include apologies, remorse, and promises to change. It is during this latter phase that the blame shifts away from the abuser (e.g., it was the alcohol, drugs, or a hard day at the office), or the abuser finds something that the woman did or did not do as the excuse for his abusive behavior, rather than accepting responsibility for his actions. This gaslighting type of behavior is designed to erode the woman’s self-esteem, discredit her within the family, and manipulate her to try harder to mend the broken relationship/family unit. Walker points out that the perpetrators of the cycle of violence are found in all socioeconomic classes and professions. Some professions, in which abusers have heightened responsibility for their performance but lack ultimate control over the desired outcomes (e.g., lawyers, doctors, law enforcement officers, professional athletes), may lend to greater vulnerability, in terms of the power-and-control coping style afforded by the cycle of violence. Similarly, their victims often (but not necessarily) are those engaged in helping professions (e.g., counselors, nurses, physicians, teachers, social workers) who believe that their efforts can help change the relational dynamic (Walker, 1980).

Social Costs and Multiple Losses

The social costs of IPV can be expressed in several ways. Societal resources are required to evaluate and treat the victims of violence; these resources include victim service organizations, child welfare agencies, mental health services, and medical facilities. The willingness of taxpayers and governments to fund resources is not commensurate with the need. While funding from the *Violence Against Women Act* has assisted in developing necessary services over the years, the majority of these funds are provided through competitive grant solicitations that are time limited. This leaves the costs of services to local communities competing for other necessary resources. States also receive federal funds for victim services and provide small grants for victim-witness support services within their district attorney offices; they may offer small competitive grants to local governments, tribes, and other nonprofit groups. It is important for everyone involved in this work to become knowledgeable of existing resources that can aid in services to clients and that can point toward other avenues of assistance that may be available. The most stable source of funds for victim services in each state flows through a victim compensation account, generally administered by state and federal attorney general offices. The most frequently allowed costs include payment for medical expenses incurred due to the abuse, mental health counseling services for the victim (and secondary victims of the crime, like children and non-offending family members), reimbursement for lost employment revenue, and childcare or transportation related to seeking care and investigative/court appearances. Funeral expenses also may be compensated, up to a certain amount, in the case of homicide victims.

One of the most damaging effects of IPV is its impact on succeeding generations of human relationships and its profound reduction of quality of life. Lisak and Beszterczey (2007) reviewed the life histories of 43 death row inmates, finding that more than 80% of the men had witnessed IPV in their childhood homes and 100% had experienced some form of neglect, along with other forms of abuse. The researchers also found that subjects who had been abused were likely to have come from families with multigenerational histories of abuse. Although the study sample represented the extreme end of the continuum of long-term effects of familial violence, the consequences for the lives of the participants gives us a glimpse of

of familial violence, the consequences for the lives of the participants gives us a glimpse of the pervasive effects of IPV.

An insightful overview of children exposed to violence is provided in the *Report of the Attorney General's National Task Force on Children Exposed to Violence* (Listenbee et al., 2012); the report indicates that exposure to violence is a national crisis that affects almost two in every three children, nationwide. The report provides comprehensive data on the extent of violence in the daily lives of children, indicating that approximately one in 15 youths, or 6.6%, had been exposed to some form of physical assault between their parents in the past year. If exposure to other forms of family violence in the household is included, then one in nine youths (11.1%) were exposed to physical or psychological violence in the family during the previous year. Lifetime percentages were higher, reflecting the longer period of possible exposure. The lifetime percentage was 17.8% for exposure to physical IPV alone. If, in addition to IPV exposure, parental assault of a sibling and violence between other teens and adults in the household are included, then lifetime exposure to physical or psychological violence within the family rises to 25.6% (Finkelhor et al., 2015). A focus solely on IPV misses a substantial amount of the violence to which children are exposed within the "safety" of their home. Given the effects of IPV on victims, the reported figures still may minimize the actual amount and severity of violence. Exposure to IPV is distressing to children and is associated with a host of mental health symptoms, both in childhood and later in life. The losses suffered by victims of IPV include and exceed those of individuals who have been traumatized by non-IPV events (Koss et al., 1994). Loss of health, financial security, home, children, pregnancies, and even life itself are tragic legacies of victims of IPV.

Less easily observable losses can include a decreased ability to assess one's situation, as caused by shock, grief, and despair. Koss et al. (1994) point out that as victims deploy more *internal* coping strategies (e.g., denial, dissociation, numbing), there is often a decrease in *external* activity that would be more likely to change the IPV situation. This often is expressed in terms of victims needing to use their energy to stay alive and cope with the dangerous situation; this is energy that, if redirected, could be used to seek assistance, or escape the situation. Symonds (1978) speculated on a "state of terror" experienced by a victim, which can contribute to a sense of loss of control or agency within one's life, seriously impairing the victim's ability to appraise her own situation. We once again are reminded of Ochberg's (1988) list of complex symptoms, which may be seen in survivors of intentional cruelty. The presence of any or all of these difficulties, identified in Box 10.2, implies a loss to the individual as well as a loss to society.

BOX 10.2

Clinical Information: Ochberg's (1988) List of Complex Symptoms

1. **Shame:** Implies an impairment of a person's ability to relate to self and others accurately, thereby depriving society of the full benefit of that individual's selfhood and gifts.
2. **Self-blame:** Implies that the victim carries a sense of being somehow responsible for her own victimization, thereby diverting attention from the perpetrator's culpability.
3. **Subjugation:** Implies that the victim's sense of powerlessness may prevent her from effectively protecting herself and her children, thus perpetuating the cycle of violence.
4. **Morbid hatred:** Implies that the victim's life energy may be diverted from self-actualization to obsession with rage/vengeance, increasing the possibility of mental illness, addiction, and legal problems.
5. **Paradoxical gratitude:** Implies that the victim may employ a survival strategy that keeps her in an abusive relationship.
6. **Defilement:** Implies that the sense of being "damaged" by the abuse will be likely to affect the victim's sense of self and may contribute to problems with eating disorders, body image, and identity.
7. **Sexual inhibition:** Implies that the victim may be less able to engage in healthy intimate relationships and may live out a pattern of choosing battering partners due to a confused notion of intimacy and the nature of sexual relationships.

tion of intimacy and the nature of sexual relationships.

8. **Resignation:** Implies loss of the victim's ability to persevere, resulting in lifelong struggles with depression, learned helplessness, and unfulfilled potential.
9. **Second injury or second wound:** Implies the likelihood that the victim will experience retraumatization at the hands of those agencies and individuals charged with helping victims, thus creating multiple layers of wounding and dysfunction. Implicit biases (gender, sexual, racial, and cultural) in the American justice, health, and social care systems clearly have an impact.
10. **Socioeconomic status downward drift:** Implies that the victim's situation may result in a decreased ability to work and to care for herself and her children, resulting in dependence on welfare, foster care, or disability funds for survival. Between 21% and 60% of victims of domestic violence lose their jobs due to reasons stemming from the abuse (NCADV, 2015).

So far in this chapter, we have examined some of the characteristics of IPV and its prevalence, as well as having identified individual and social costs related to IPV. In the following section, we review relevant literature for the purpose of identifying theoretical contexts for understanding IPV.

THEORETICAL CONTEXTS FOR UNDERSTANDING INTIMATE PARTNER VIOLENCE

According to Koss et al. (1994), early literature on the subject of IPV tended to speculate on possible psychopathological characteristics of the victims rather than social contributions to the problem or perpetrator characteristics. Women's verbal and emotional aggression against their partners was viewed as a precipitant to male violence, whereas other studies (e.g., Straus, 1993) sought to evaluate IPV from a gender-neutral standpoint, asserting that males were victims of IPV as often as females. However, our understandings about the dynamics of IPV have increased over the ensuing years. The literature on this topic has evolved, and a number of theories have emerged that have elucidated societal assessments of IPV over the decades. The following subsections briefly identify and describe some of the most commonly held theories about IPV, as well as specific risk factors for IPV. These subsections include perspectives from feminist theory; family systems theory; the biomedical model; and more contemporary and comprehensive paradigms, such as an ecological development model, attachment theory, and Polyvagal Theory (PVT). Disciplines represented in these perspectives range from psychology and counseling to nursing, medicine, and criminal justice.

Feminist Theory

Feminist theories of IPV originated with the upsurge in attention brought to the victimization of women in the 1970s, defining IPV as primarily a social problem to be corrected by empowering women and reeducating men. Feminist theories identify gender-based power differentials as central to the issue of IPV, citing the domestic relationship's structure as a parallel process mirroring the patriarchal pattern of society's organizational structures (Healey et al., 1998; Shore, 2019).

Strengths and Weaknesses of Feminist Theory

We need only to look at the history of batterer intervention programs in the United States to recognize the impact of feminist theory on the subject of IPV. Healey et al. (1998) note that treatment programs for batterers were established as a result of feminist activism and focused on changing sex role attitudes, which claim that women's behavior provokes men's violence. Some theorists have claimed that feminist theory relies too heavily on a social model of IPV, to the exclusion of other factors, such as childhood abuse and personality disorders (D. G. Dutton & Painter, 1993a; Namy et al., 2017). According to critics, feminist theory fails to predict which men will become violent, assuming that all men are exposed to similar patriarchal values.

Family Systems Theory

Family systems theory advances the idea that each individual should be viewed not in isolation, but rather in terms of the interactions, transitions, and relationships within the family. In its most fundamental application, family systems theory offers a framework for observing and understanding patterns of relationships as well as the transmission of behavioral patterns over multiple generations, which is particularly important when attempting to understand IPV. It also emphasizes that families are a subsystem within larger systems, such as the community, which interact with and influence one another, as well as contributing to the maintenance of particular patterns of behavior (Hyde-Nolan & Juliao, 2012). Family systems theory further supports an understanding of individual behavior and its reciprocal effect upon the family unit, rather than focusing on the individual pathology of any singular family member.

Strengths and Criticisms of the Family Systems Theory

The family systems theory provides a treatment framework for IPV couples who may want to remain together and for those who wish to address the intergenerational cycle of violence within the family. Some cite the model's emphasis on relationship strengths, rather than pathology, as a useful approach, particularly in light of statistics indicating that more than half of IPV couples remain together (Murray, 2006; Sirles et al., 1993). Counseling models using this approach also have been rated as highly effective within some cultural settings, for example, those living in extended-family groups, in cultural enclaves (including American Indian/Alaskan Native communities), and for families experiencing intergenerational trauma, especially as related to substance use disorder (see Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). In a robust systematic review and meta-analysis, Karakurt et al. (2016, p. 567) have stated that "Preliminary data suggest that couple's therapy is a viable treatment in select situations."

Predictably, most criticisms of the model's use with IPV couples cite concern for victim safety. Given the inequities of power intrinsic to IPV, critics speculate that speaking honestly in the presence of the batterer is inherently dangerous, particularly if the couple continues to live together. Other critics note the potential for victim blaming, while the victimizer is not held responsible for the violence (Healey et al., 1998; Murray, 2006). Professional expertise should be used in assessing when to introduce or whether to select this approach, in view of cultural and safety considerations.

The Biomedical Model

The biomedical model is a framework in which victims' psychological symptoms are catalogued and the individual is then assigned a diagnosis. The connections between symptoms displayed and antecedent trauma are deemed secondary, if not irrelevant, to client treatment. Treatment is predicated upon the assumption that many psychological disorders arise from faulty brain chemistry that requires psychiatric medication for correction, with or without adjunctive psychotherapy. However, as a result of the identification of trauma-based disorders, particularly PTSD, research into the origins of trauma as well as its connection to common mental health diagnoses have made a purely biomedical model less relevant in working with IPV (Herman, 1992; van der Kolk et al., 1996). Problems such as anxiety, dissociation, depression, and personality disorders all have been the subjects of extensive study, linking them to traumatic antecedent events in the lives of the victim, perpetrator, or both (van der Kolk et al., 1996).

Strengths and Criticisms of the Biomedical Model

The primary utility of the biomedical model is its acceptance as the prevailing paradigm by which diagnosable mental difficulties are understood. Some perceive this as a way toward destigmatization of mental illness, through promotion of the diagnosis as just another form of medical illness, on par with heart disease and diabetes and substance abuse disorder. The

medical illness, on par with heart disease and diabetes and substance abuse disorder. The downside of this view is that medicalization of the symptoms suffered by trauma survivors requires the sufferer to accept her symptoms as a mental illness rather than to understand them as the natural outcomes of traumatic experience. This may result in the secondary wounding and decreased credibility of the victim described earlier in this chapter (Ochberg, 1998). It also can discount or overlook actual medical conditions resulting from TBI in or strangulation of IPV victims, when the underlying cause (traumatic abuse) is not considered as the presenting condition, and only psychological approaches are being considered. The original biomedical perspective, within the contemporary landscape, more often is combined with an integrated approach to care that is trauma-informed as well as infused with knowledge derived from brain research. The latter is comprised of modern medical technologies including SPECT (single photon computed tomography) scans and functional MRI (magnetic resonance imagery) scans, which also serve to improve diagnosis and pharmaceutical approaches. Precisely because IPV-related causes of physical injuries often are not reported when a victim seeks medical treatment, it becomes essential that the biomedical model include an integrative, trauma-informed approach.

Ecological Development, Attachment, and Polyvagal Theory

In attempting to understand the complexity of IPV, the reader may wish to consider comprehensive models of human development and behavior that take into account the biological, developmental, and psychosocial factors that contribute to the genesis of IPV. Bronfenbrenner's (1979) ecological development model and Bowlby's (1969) attachment model offer broader developmental and relational models for conceptualizing IPV; Porges' (2007, 2011) PVT is especially helpful in understanding the neurobiological effects of trauma on the IPV survivor.

Bronfenbrenner's (1979) ecological development model, when applied to a framework for understanding IPV, implies an acknowledgment of the biological characteristics with which humans are endowed, along with developmentally mediated psychological factors, as seen within a multifaceted social context. Bronfenbrenner's reference to *micro-, meso-, exo-, macro-, and chronosystem* structures in an individual's ecology acknowledges the impact of multiple layers of the relational environment upon an individual's experience at any given moment. The ecological model, along with attachment theory (Bowlby, 1969), which focuses predominantly on the impact of children's early relationships with caregivers, and the more recent understanding of the neurobiology of trauma, together provide a more balanced view of the factors associated with IPV.

Attachment theory is a framework upon which extensive enhancements have been constructed by social scientists from a variety of disciplines. Bowlby (1969) based his theory on his observations and his belief that human infants have a biologically driven developmental need to be cared for by a person who is older and wiser (usually the mother) for purposes of safety and survival as well as regulation of affect. The quality of this initial attachment bond acts as a template for future adult attachments. If early attachment is disrupted by separation, illness, or trauma, the child's ability to soothe herself in the presence of stress may be underdeveloped; this is a deficit that has particular relevance to IPV, because attachment-seeking behavior continues throughout the life-span (Bowlby, 1984).

Based on Bowlby's (1984) work, Fonagy (1999) proposed that adult relationship violence is an exaggerated response of the attachment system. As stated previously, seeking solace through close relationships is a normal human behavior and one that may erupt into intimate partner discord if early dysfunctional attachment patterns are experienced as being present in the adult romantic relationship. Bronfenbrenner (1979) emphasized the importance of *experience* as key, because it is the experience of the individual in a particular context that takes precedence over any objective observations that may be made regarding the situation. An emotional experience template, forged in a childhood of abuse and domestic violence, has been implicated in the prevalence of IPV in adulthood (Fonagy, 1999).

Studies on the neurobiology of attachment (e.g., Schore, 1999; Siegel, 1999) have provided support for attachment theory by demonstrating the link between biological and

support for attachment theory by demonstrating the link between biological and psychological models of development, thereby deconstructing artificial barriers that historically have existed between the two. Of particular relevance is the recent neurobiological research (e.g., [Porges, 2007, 2011](#)), which has elucidated the engagement of the autonomic nervous system (ANS) during a traumatic event, as well as the effects of trauma on the vagus nerve and its interactions with the brain and other major organs of the body. Although these issues have been detailed throughout this textbook, particularly in Chapters 2 and 4, it is essential to note here that these same physiological processes are engaged before, during, and after IPV events.

In a situation that usually is unsafe, the IPV victim may be in a constant state of hypervigilance, with the ANS continually scanning the environment in an effort to detect any existing threats. Being in a constant state of alertness—ready for mobilization, ready for fight or flight—has numerous physiological and psychological consequences. Conversely, in a situation that usually is unsafe, the IPV victim may be too fearful to mobilize, and therefore becomes unable to respond in any meaningful way, thus becoming too immobilized to protect herself. A full discussion of PVT and its implications for IPV is beyond the scope of this chapter. However, the professional literature (e.g., [Dana, 2018](#); [Porges & Dana, 2018](#)) describes clinical applications of PVT, and, as one research example, PVT has been used as the theoretical framework for investigating intimate partner stalking/pursuit and attachment style ([Creamer & Hand, 2021](#)). The advances in this area of study, particularly relative to brain science, have provided new dimensions in our understanding of traumas, such as IPV, as the result of a complex interplay of biological, psychological, social, and cultural risk factors for both victim and perpetrator.

Risk Factors—The Victim

As we demonstrated earlier in this chapter, the Stockholm syndrome pattern of attachment between captive and captor is echoed in many IPV situations, where the cycle of tension, abuse, and relief reoccurs in the life of the victim, with the relief phase offering intermittent moments of hope and optimism that may keep the victim in the relationship ([Ochberg, 1998](#)). [D. G. Dutton and Painter \(1993b\)](#), in fact, cite the intermittency of abuse as a factor in the level of stress experienced by women who chose to leave their batterers, with extremes of negative and positive batterer behavior associated with the most post-separation distress. In other words, women whose abusers were extremely violent, but who *also displayed the most kindness and remorse* during the relief phase of the IPV cycle, had the most difficulty separating from their batterers.

[Bornstein \(2006\)](#) cites economic and emotional dependency as risk factors in the etiology of IPV relationships for both women and men. For women in particular, the cultural traditions of economic dependency and social disempowerment contribute to the possibility of victimization by a male partner, as does her partner's excessive emotional dependency. Economic dependency may escalate to economic abuse, which refers to when an abuser takes control of or limits access to shared or individual assets, or when the abuser limits the current or future earning potential of the victim as a strategy for power and control. In economic abuse, the abuser separates the victim from her own resources, rights, and choices, isolating the victim financially and creating a forced dependence for the victim and other family members ([NCADV, 2015](#)). [Cunradi et al. \(2000\)](#) found that couples living in impoverished neighborhoods are at increased risk for IPV. [Wallace \(2007\)](#) reminds us that most women in IPV relationships are looking for signs that the perpetrator is not all bad. The woman has invested a lot in the relationship and hopes for a future for herself and for any children she might have with the perpetrator. [Wallace \(2007, p. 33\)](#) also lists the following beliefs and behaviors that may result from the conditions imposed by the Stockholm syndrome-type pattern of perceived threats and social isolation imposed by batterers:

- She develops an overwhelming need to pacify the batterer, in order to survive;
- She adopts the batterer's perspective of the world;
- She feels intense feelings of gratitude toward the batterer; and,
- She rejects offers of help or rescue, which she may believe could aggravate the batterer.

Kearney (2001) supports the argument for a multifactorial model of IPV, in that it includes influences from social and cultural institutions (e.g., religions, traditional expectations of women) as well as factors that possibly could be connected to attachment patterns or childhood experiences of witnessing domestic violence (e.g., caretaker role, use of denial). The women in Kearney's study also reported that changes in their relationships (for the worse) had occurred over time, with most of the women endorsing a definition of love that included a need to endure. We can conclude that women's interpersonal relational style (**Gilligan, 1982**), combined with attachment experiences and viewed within an IPV context, may make them vulnerable to a pattern of coping strategies that often is misunderstood by those outside the relationship who may focus on the perceived shortcomings of the victim rather than the actions of the perpetrator.

Risk Factors—The Perpetrator

Fonagy (1999) suggests that many men who commit violent acts against women lack the ability to mentalize, that is, to imagine their attachment figure's thoughts. This is a state that Fonagy attributes to a childhood rendered so physically or emotionally unsafe that the child copes by refusing to imagine the state of mind of a parent who wishes to harm him. This pattern, persisting into adulthood, may form the basis for IPV relationships between batterers and their partners (who in some cases also may be attachment disordered). Similarly, **Meloy (2002)** believes that men who fail to develop secure attachments in childhood are at greatest risk for IPV, basing this hypothesis on a growing body of research that empirically supports the connection between insecure attachments and adult (often intergenerational) relationship violence.

A study by **Mauricio et al. (2007)** found that both antisocial and borderline personality disorders were related to attachment styles that served as mechanisms for both physical and psychological violence in a sample of male batterers referred for treatment. The authors state that their findings suggest that intervention programs may need to address batterers' personality disorders more directly to improve outcomes. **Heyman and Slep (2002)** found that the frequency of family of origin violence predicted adulthood child and partner abuse in a retrospective study of more than 6,000 participants in a national family violence survey. **Israel and Stover (2009)** studied distress levels in children exposed to violent father figures and reported significantly more symptoms in these children, leading us to speculate about the interconnectedness of these studies' findings as well as the implications for society.

As the majority of IPV continues to be perpetrated by males against females, it is germane to include information on the topic of the culture of male privilege and entitlement found in our society. This underlying construct is found across cultural and racial groups and forms an important basis upon which interpersonal violence against women is perpetrated. Examples of male privilege and entitlement include the following: He is trusted and seen as more credible than women; he experiences fewer barriers and more access to money, jobs, status, and so forth; he gets to do what he wants, when he wants; he has an expectation that women should be accommodating; he feels entitled to make big decisions alone, expecting women to "make it happen"; his (men's) way is the right way and more valuable than a woman's; he views male roles as superior and female roles as inferior; he faces no consequences for bad behaviors; he feels entitled to monopolize conversations and discussions; and he feels entitled to interrupt and/or ignore women (**Hill, 2020**). Male privilege and entitlement are found in minority cultural communities as well as in dominant cultures where, in some settings, they have replaced more egalitarian traditions. Teaching of misogynic beliefs and exposure to this behavior in the family and in a culture further leads to the lack of agency and dehumanization of women, thus serving to sanction IPV.

Openings: Integrating Ecological, Attachment, and Neurobiological Paradigm With Interpersonal Violence

Specific features of the ecological model, attachment theory, and recent neurobiological research offer a broad context for understanding IPV. For this reason, a succinct discussion of the strengths and criticisms of this paradigmatic approach is far more complex than merely presenting the details of the models, such as criticism requiring greater comprehension

presenting these details of the models; such a critique requires greater comprehensive theoretical explication, and therefore is beyond the scope of this chapter. However, there are several reasons why this paradigm merits further investigation by therapists working with IPV and trauma:

1. The ecological model provides a multilevel social systems framework that accommodates strengths from feminist and family systems theories;
2. Attachment theory includes elements from the biomedical model and family systems theory;
3. PVT facilitates an understanding of recent neurobiological research, the effects of trauma on the brain, and the application of brain science in working with IPV; and
4. The ecological model, attachment theory, and PVT combined offer social and individual developmental as well as neurobiological dimensions to the study of IPV and trauma.

COUNSELING IMPLICATIONS

Given the prevalence of IPV in our culture, professional counselors are likely to encounter victims and perpetrators among their clientele over the course of their careers, whether the IPV is disclosed or goes undisclosed. To work effectively with these clients, the counselor can benefit from increasing their knowledge base about IPV. The following subsections refer to aspects of IPV with which professional counselors may want to become familiar.

Treatment for Victims

Given that there are many forms, facets, and stages within the IPV cycle, generalizations about victim interventions should be avoided. Those who are still in physical danger need to acquire physical safety, financial assistance, and legal protection. Providers of these services include victim advocates, domestic violence shelters, attorneys and legal aid programs, and others with relevant experience and resources. It is only after basic needs are met and safety is achieved that the victim may be able to address the effects of trauma more fully, as well as to address any self-defeating patterns of her own in therapy with a trauma-competent counselor (Ochberg, 1998).

Counselors should be aware that shelters are often the safest refuges for victims, because the family of origin may represent another source of betrayal and abuse for the battered individual. Shelters offer protection from the abuser and have the added benefit of esteem-building groups for residents. Careful discussion about what constitutes supportive behavior can help counselors and their clients to identify an appropriate crisis plan along with trustworthy contacts (DiBlasi & Smith, 2020; Ochberg, 1998). Some shelter programs provide transitional housing, along with life skills and counseling services, and many offer after-shelter support groups that can assist survivors of IPV as they rebuild their lives. Shelters are much less available in rural and tribal communities, thus making safe shelter and transportation to a safe shelter challenging. However, other ways of meeting these emergency needs may be available through community resources.

Once the client's safety is established and the therapy process begins, it is important for counselors to use an empowerment approach, in which the client is given as many choices as possible in determining the course of her own life. Counselors also need to be prepared to encounter the depression as well as the often contradictory or paradoxical behavior patterns of abused women. These behavior patterns may confuse the therapist, especially as these clients often are labeled "borderline," due to the frequent limit-testing and emotional demands (Walker, 1991). Maintaining a professional relationship without implying friendship beyond appropriate boundaries is the most helpful response (Ochberg, 1998). A successful competent intervention usually incorporates an awareness of one's own biases and prejudices, cultural humility, and recognition of professional power (the power differential between the counselor and the client), in order to avoid imposing one's own values on others. Counselors need to remember to offer respect, not rescue, and suggestions, not orders, thus minimizing trigger effects in the victim, building trust, and supporting cultural healing traditions and spiritual practices that may aid in recovery.

Treatment for Batterers

The challenge of IPV is that while violence is the common denominator in the definition, the causes and conditions of individual abusers are as varied as the types of violence that they perpetrate. No “one size fits all.” However, as the majority of perpetrators may end up in treatment through court referrals, it is important to review the research on the models used and recidivism rates found within the justice system involved. The Duluth model (Pence & Paymar, 1993) uses group-facilitated exercises to change abusive and threatening behavior in males who engage in IPV. The Duluth model views the principal cause of domestic violence as being determined by a social, cultural, and personal ideology that imposes power and control through violence. The model focuses on changing offenders’ dominant and controlling behaviors.

An evaluation by the National Institute of Justice (NIJ, 2019) indicated that the efficacy of batterer intervention programs showed mixed results. An NIJ meta-analysis (2013b) assessed the Duluth model as effective for reducing recidivism, as this applies to violent offenses; the same study determined the model to be promising in terms of the reduction of victimization. The results found fewer partner reports for violence in the intervention group relative to comparison groups. Because the Duluth model is psychoeducational in nature, it should be used as an *adjunct* to other forms of therapy that may be necessary. A similar analysis by the NIJ (2013a) rated cognitive behavioral therapy (CBT) as *not effective* as a batterers’ intervention model, citing analyses of four randomized trials, which found no statistically significant effect of CBT on the likelihood that CBT participants would not commit violence against their partners. This affirmed three quasi-experimental studies (Babcock et al., 2004), using partner reports of violence for analysis and finding no statistically significant effect on victimization rates of partners of domestic violence offenders who participated in CBT.

One efficacious method for working with batterers blends attachment theory and cognitive approaches, taking into account the early childhood risk factors mentioned earlier in this chapter (Bowen, n.d.). Lawson et al. (2006) have reported significant changes in abuser attachment styles as well as decreased violent behavior in men who participated in a 17-week course of integrated cognitive behavioral/psychodynamic group treatment. Renn (2009) has advocated for couple

therapy in certain batterer cases, following a careful risk assessment. Renn has asserted the following:

Couple violence ... is a complex phenomenon and has both relational and individual origins. Understanding the traumas and adult attachment styles that people bring to their intimate relationships in the context of their early attachment histories may help us to assess whether or not, and under what specific circumstances, couple violence is more likely to occur. (p. 2)

Regardless of the model applied in the treatment of batterers, true personal change that generalizes into societal change only can be accomplished by holding batterers and social institutions accountable for the damage that they inflict or fail to prevent. It is equally important to address underlying substance abuse and mental health conditions that contribute to the violence as well as to focus on the wellness of the person and his ability to engage in healthy relationships. The cost to society is too great for these issues to be ignored.

Multicultural Considerations

In order for counselors to address IPV effectively, it is necessary first to address our own biases and myths about IPV along with those of the dominant culture in which we live or practice. This includes considerations of implicit bias concerning racial, ethnic, religious, cultural, socio-economic backgrounds, gender identity, gender roles, disability issues, and beliefs regarding the types of intimate partner relationships that make up society. When clinicians are working with IPV victims from different cultural backgrounds, they need to assist clients in understanding the meaning of victimization within that cultural group; counselors then need to explore how treatment issues can be effective and appropriate. Cultural and spiritual practices should be encouraged, if desired by the client, as an adjunct to other Western models of treatment. Of course, everyone is an individual, and even among cultural groups, diversity exists concerning beliefs and norms, overlaid by specific family and community conditions. In general, the overarching hope expressed by survivors of IPV is that they want the violence to stop, they want to feel safe, and they want to heal.

Prevention

The focus of this chapter has been on defining and identifying IPV, along with exploring how its sequelae may present major public health and social problems for the entire culture, as well as for individuals and their families. Primary and secondary prevention programs have been made available through the CDC (Niolon et al., 2017), SAMHSA (2020), the U.S. Department of Justice (2014), and the National Institute of Justice (2007). The burden of effecting such preventative changes, however, cannot and should not be borne by victim service and public health agencies alone. True cultural change requires public acknowledgment of the problem by political forces, as well as action by governmental agencies responsible for defining needs; allocating funds; and upholding the rights of women, children, and other marginalized populations. Personal and professional activity that holds public officials accountable for initiating and supporting measures to protect vulnerable members of the population may be one of the most important ways in which counselors can advocate for their clients, as well as for their work, and for society as a whole.

The Importance of Education and Self-Reflection

In closing this chapter, the authors wish to acknowledge the critical need for undergraduate and graduate education that addresses IPV trauma and its effects on individuals and society. Few professional counseling or other preservice training programs offer courses that teach students how to identify and work with trauma, and those that do so usually offer them as elective courses (Kitzrow, 2002). Based on the statistics presented in this chapter, the likelihood of a counselor encountering clients affected by IPV is high. Therefore, the following

suggestions are offered for counselors to:

1. Seek out and use continuing education to learn how to deal effectively and compassionately with IPV and trauma in general. Such advanced training should include the use of self-reflection as a professional development strategy, enabling the counselor to identify their own biases, feelings, and values;
2. Engage in clinical supervision, preferably with a clinically advanced professional who understands and works with IPV or other types of trauma;
3. Find like-minded colleagues with whom the challenges and rewards of working with IPV clients may be shared; and,
4. Finally, and perhaps most importantly, develop a system of self-care that acknowledges the secondary stress and vicarious trauma that may arise from working with trauma survivors, and that addresses any personal IPV trauma.

Counseling victims of IPV is difficult but rewarding work, requiring not only an understanding of the complex dynamics of the individuals involved, but also awareness of the multiple factors that enter into the creation of an IPV social environment. As Gold (2000) so aptly states, referring to childhood abuse survivors, "Their best hope, and consequently that of the rest of us, is to recognize that although they have been abandoned and feel alienated and alone, their destiny, and that of society as a whole, are in actuality inextricably intertwined" (p. 244).

CONCLUSION

In this chapter, we have presented the concept of IPV as trauma experienced mainly by females at the hands of males, but one that exists as a form of power differential that can include same-sex couples as well. We introduced this chapter with the case of Kristin, the Swedish bank teller, whose paradoxical bonding with her kidnapper became known as the Stockholm syndrome—a pattern of primitive attachment that is echoed in the lives of many victims of IPV. Although viewed by the world as strange initially, Kristin's survival strategy has been rendered more understandable through research that identifies the connections between PTSD and victimization of all types.

The effects of trauma are reflected in the physical, psychological, emotional, and social aspects of the victim's life and often are entwined, intricately, in the individual's earliest development due to the intergenerational transmission of violence. The losses associated with IPV are many—for the victim and for society. Perhaps among the most profound are the loss of a sense of interpersonal safety and facing the betrayal that abuse by an intimate partner brings to the relationship. The interdependent nature of human existence dictates that individual trauma truly does not happen in isolation; rather, it affects the entire culture through subsequent generations of traumatized children, who may grow up to be traumatized adults who, in their turn, create traumatized societies.

The risk factors associated with IPV may originate from within social, biological, or developmental contexts, or, most likely, a combination of all three. Just as individual trauma exists within a larger cultural context, the environment of IPV is created within that same complex contextual framework. IPV is a part of our cultural tapestry; no single thread representing IPV can be followed from beginning to end, nor can it be removed from the larger picture, into which it has been interwoven, without changing the prevailing pattern, all of which imply serious challenges for counselors involved in the change process inherent in working with IPV.

ADDITIONAL RESOURCES

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